Client directed, outcome informed therapy in an intensive family therapy unit

--A study of the use of research generated knowledge in clinical practice

Rolf Sundet

Psychological Institute

Faculty of Social Science

University of Oslo/Buskerud University College

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To my father, Aage Sundet, war-time seaman, construction worker and wood carver; 1920-2006

Contents

Abstract

This dissertation explores family therapy practice developed in a family unit within the Department of Child and Adolescent Mental Health, Norway with the aim of describing and better understanding this practice. A qualitative study was carried out in order to investigate the following research questions: (1).What are the ingredients families and their therapists identify as essential for a helpful therapeutic practice? (2). How do families and their therapists describe and evaluate the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work? The findings of the study are connected to the following questions: (a) What happens to the forms of practice of the guiding methods of the Family Unit when they are put to use by families and therapists?; (b) What are the differences and similarities between the perspectives of the families and their therapists and how do they supplement each other?; (c) How can these measures be understood within the therapeutic context? and; (d) What is the relationship between the results of this study and results within the general field of psychotherapy research? The first three questions are addressed in the three articles and the last is the focus of this presentation of the project.

The study data are interviews of four therapists and ten families. Data were analysed using a modification of grounded theory. The analysis generated sets of categories specified by subcategories supplying answers to the two research questions. The question of what comprises helpful therapy converged on three overarching concepts: conversation, participation and relationship. The SRS and ORS were evaluated as feasible for clinical use but involved deflections and difficulties that had to be attended to in the actual clinical situation. The measures were described as conversational tools that gave rise to different conversational types and processes, an extension of their use beyond monitoring practice and supplying feedback on process and outcomes.

The three articles in this dissertation discuss what these results communicate with regard to the first three questions above. Expansions of the guiding models of practice, especially connected to the relationship between language and action and use of professional knowledge are discussed. The differences between the family and therapist perspectives also advise therapists to pay more attention to giving feedback

to families, especially on problematic or negative interaction; to the importance of structure; to the use of professional knowledge and authority and to take active part in fighting violation, disparagement and degradation. The use of tools emerges as an important aspect of therapeutic work in this study. This element can be seen as contrary to the nature of the guiding sources of the Family Unit. A perspective grounded in the work of Vygotsky and Bakhtin is suggested as a way of reconciling post modern, language oriented methods with more research based practices in which knowledge generated from patient focused research is particularly central.

This study is of a local practice. In comparison of the results of the study with findings in the field of psychotherapy in general, those that fit with the broader research field are strengthened. The primary conclusions on this topic highlight collaboration between families and their therapists. The professional knowledge of the therapists is a necessary contribution to this collaborative venture but must be constrained within a helpful therapeutic relationship. Under conditions of detrimental development and lack of change it is decisive that the therapist change. This change must be guided by prompts, ideas and the theory of change of the service users. Combining professional skills, professional knowledge and responses from the service users under the condition of no change is found to be in accordance with a radical eclectic position in which all kinds of therapeutic tools and manners of working are braided together and guided and constrained by the responses of the service users. Results that are not corroborated within the broader field invite further research. Lastly, by relating and discussing the results of this study with the broader field of psychotherapy research, a conceptualisation of psychotherapy that fits these finding is suggested. This definition underlines client resources, the therapeutic alliance, and the theory of change of the client; it highlights therapy as a process of co-evolution and collaboration; and it confirms therapy as a process in which the responsibility of therapists is to make space for, secure and strengthen both the family and the relationship with them.

Acknowledgements

As long as I have been working in mental health and even as a teenager, my interest has been in understanding psychotherapy. What is this practice that has developed over the past 125 years? Until this project, my sources of information and experience have been reading about it and doing it. The opportunity that I was given when I was offered a position as a research fellow at the University College of Buskerud (HIBU), was to find a new source for understanding this practice. Asking questions and being informed by service users and other service suppliers of this practice opened up a new avenue of knowledge. Three separate and equal perspectives and contributions that have made this dissertation possible must therefore be acknowledged: the 10 families that were interviewed, the four therapists, my colleagues who were interviewed, and my supervisor Professor Sissel Reichelt. Without their contribution this project and this dissertation could not have been realized.

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Overview of the articles

Article 1. Collaboration: Family and therapist perspectives of helpful therapy.

The article is accepted for publication in Journal of Marital and Family Therapy.

Article 2. Collaboration: Working with process and outcome.

The article is under review for Journal of Marital and Family Therapy.

Article 3. Therapeutic collaboration and formalized feedback: Using perspectives from Vygotsky and Bakhtin to shed light on practices in a family therapy unit.

The article has been accepted for publication in Clinical Child Psychology and Psychiatry

1.0 Introduction

The aim of this dissertation is to explore and understand family therapy practice developed in a family unit within The Department of Child and Adolescent Mental Health. This is a local study about a local practice in a small family unit within the Department of Child and Adolescent Psychiatry, Hospital of Buskerud in Drammen, Norway. The word 'local' indicates connection to *a place, to place*, *to locate*, a *situation* and thus to being *situated.* This dissertation has as its theme a particular place, the Family Unit, Hospital of Buskerud, where it locates a certain situation, one of problem solving and healing - a therapeutic situation. It has grown out of a need to understand this locality and what happens within it and the practices that are situated within it.

The postmodern condition (Lyotard, 1984) has been described as one in which the "grand-narratives" had broken down and "…local narratives come into prominence." (Kvale 1992, s. 34). In this particular study, exploration of local narratives had basically to do with the needs and intentions of the participants of the Family Unit to understand the context and practice of which they were a part in order to secure a good practice with increased possibilities for accountability and transparency. The intention was one of "…developing knowledge that (was) societally located in particular societally relevant practices " (Chaiklin, 1992, s.198); to move from a little-described practice to a "more-described-practice" in order to learn more about themselves as therapists and colleagues, and to increase the relevance of the practices within the unit for all participants, both service users and therapists. The first big question, then, was whether the practices of the unit were relevant for the involved participants: what was helpful? This question inevitably led the Unit to research and the issue of finding answers to the question of relevance. From this point, a journey was begun that involved one person from the Unit taking the role of the researcher (the author) in addition to remaining a practicing therapist. His colleagues and a group of families were invited to be informants on the issues of description and relevance of the practice.

1.1. Central Research Questions and intentions

The general aim of this dissertation has been to contribute to an evolving understanding of what psychotherapy is. This was done through an investigation of a

local practice and comparison of the findings of this study with the guiding methods of the practice under investigation, and with other findings in the field of psychotherapy research. The following research questions guided the investigation:

1. What are the ingredients families and their therapists identify as essential for a helpful practice?
2. How do families and their therapists describe and evaluate the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work?

1.2. Psychotherapy research and evidence based practice

Part of this project has had as an implicit aim for the Family Unit to establish a concept of knowledge that suits and fits the clinical situation. Bjørkly (1996) makes a distinction between "the clinical researcher" and "the researching clinician" in which the latter position is closely connected to and constructs research questions based on actual, daily clinical practice in order to increase the relevance of results for clinicians and to bridge the gap between research and the clinic (Norcross, Beutler, and Levant, 2006). In the project reported on here, the ideal has been the researching clinician.

A journey in which scientific research is a main vehicle must also relate to the field of psychotherapy research in particular (Lambert, Garfield, & Bergin, 2004). This field is not without its problems, controversies and tensions. For instance in the mid-nineties in the Norwegian context, a debate erupted (Boland, 1997; Fyhn, 1998; Rønning, 1996, 1997a, b; Sørgaard, 1997; Vedeler, 1997). This debate concerned developments within mental health care for children and adolescents in the Northern districts of Norway concerning quality assurance (Rønning, 1996) and followed other international debates and discussions of research based practice and the researcher-clinician gap (Norcross et al., 2006).

One of the main effects of these debates was that different research positions and concepts of knowledge were put on the agenda with evidence based practice as one of the most central of these (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996). The history of the concept of evidence based practice in psychology is in many ways the history of psychology as a science. Going back to Wundt and the early experimental studies, clinical psychology has a strong connection with scientific psychology (Norcross, Beutler, and Levant, 2006). When evidence based medicine was made the catchword of the 1990s (Sackett, Rosenberg, Gray, Haynes &

Richardson, 1996) it fitted with the long standing ambitions of clinical psychology to build practice on a sound evidence base. Division 12 of the American Psychological Association (APA) (Chambless, Sanderson, Shoham, Bennett Johnson, Pope, Crits-Cristoph, et al., 1996; Chambless, Baker, M. Baucom, Beutler, Calhoun, Daiuto, et al., 1998) made a strong case for the implementation of EBPs in clinical practice, but not without debate and controversy. Reed and Eisman (2006) point to the omission of "…factors related to the therapist and the nature of the treatment relationship" (p.18), as especially problematic when considering the scientific bases for psychological interventions. In the APA this has not gone uncommented. Empirically supported relationships were documented through the work of Division 29 (Norcross, 2002) and Castonguay and Beutler (2006a) seek to integrate findings from both these divisions by explicating principles of therapeutic change that work. Part of the debate can be seen to concern the idea of building a hierarchy of evidence. Certain forms of knowledge, especially those produced through clinical trials are prioritised (Bower, 2007); the effect of this prioritisation not only concerns what is explicated as best clinical practice, but reaches beyond this in the establishing of power differentials that marginalize some participants and centralize others with regard to resources for both clinical practice and research. In the subsequent debates,"…this multifaceted and complex topic has been reduced to simplistic and polarized arguments…"(Norcross, Beutler, & Levant, 2006, p. 3). An at least temporary, integrating platform seems now to have been established through the APA Presidential Task Force on Evidence-Based Practice (2006). Central in the conclusions of the Task force is the underlining of the importance of "…an appreciation of the value of multiple sources of scientific evidence. " (p. 280). With this conclusion, the notion of a hierarchy delineating best evidence seems to have been exchanged for a concept of evidence that accepts that " (m)ultiple research designs contribute to evidence-based practice, and different research designs are better suited to address different types of questions (Greenberg & Newman, 1996)" (p.274).

The study reported here is grounded in a perspective of methodological multiplicity (APA Presidential Task Force on Evidence-Based Practice, 2006; Howard, 1983). Questions of best practice and evidence based practice are connected to an assessment that goes beyond the findings of the study itself. This assessment involves comparison and relation of the results of the study to the broader methodological horizon. The results of this study will be related to the broader field

of psychotherapy research. Within this methodological horizon, the APA states that evidence involves the treatment method, the individual psychologist, the treatment relationship and the patient as "…vital contributors to the success of psychological practice" (p.275).

1.3. The inspirational sources of the Family Unit

Before the increased focus on research, the main path to clinical knowledge was through theory. Theories of psychotherapeutic practice had their origin in diverse areas of science and philosophy. The biological, psychological and social sciences were suppliers of concepts, models, theories and metaphors, and philosophical positions like existentialism, hermeneutics and positivism provided perspectives on questions of epistemology and ontology. The clinical work under investigation here is embedded in the tradition of family therapy that uses ideas, concepts and theories from systemic sciences like general systems theory, information theory, communication theory and cybernetics. The main figure here was for many years Gregory Bateson (Bateson, 1973; Hoffman, 1981, 2002). Until the mid-eighties, with some dissenters (Altman 1982; Dell, 1980, 1982; Keeney, 1982), the focus of this field followed the path of traditional positivistic research and science with emphasis on the researcher generating objective models and descriptions of the observed system. From the mid-eighties, a change occurred connected both to changes within the systemic conceptualizations and epistemological positions within the field (Sundet, 1983) and to the introduction of social constructionism (McNamee and Gergen, 1992) and post-modern and post-structuralist thinking (Flaskas, 2002). These changes led to a linguistic turn within the field. Three groups representative of this linguistic turn have been central inspirational sources for the Family Unit. These are the collaborative language systems approach of Harlene Anderson and Harry Goolishian and the Houston Galveston Institute (Anderson 1997), the reflecting team and reflecting processes work of Tom Andersen and the Tromsø-group (Andersen 1987), and the narrative practice of Michael White and the Dulwich Centre (White 1995). Common to all three approaches is a focus on collaboration and language (Andersen 1993; Anderson & Goolishian, 1988; White; 1997), and emphasis on privileging the perspectives of the service user (Andersen 1992, 1993; Anderson, 1996; Anderson, Goolishian, Pulliam, & Winderman, 1986; Epston & White, 1992; White, 1993).

1.4. Organisation of the dissertation

This dissertation is organized into six main parts. Following this introduction, the inspirational and guiding sources of the Family Unit will be presented briefly. Thirdly, a review of psychotherapy research will be given concerning our knowledge base about the psychotherapist, the patient, theory-driven therapies, techniques, specific ingredients, common factors, children, adolescents, parents, family therapy, the therapeutic relationship, the alliance and lastly patient-focused research. These elements are identified in the literature as necessary and important within the therapeutic endeavour (APA, 2006; Castonguay and Beutler, 2006; Cooper, 2008). The fourth section provides a presentation of the informants and the methods used in this study, and the epistemological position taken in the study. Part five summarises the results of the study through a brief presentation of the three articles that constitute it. In the final section, the results are discussed in relation to the presented literature. In line with Lakoff and Johnson (1999) the focus will be on convergent evidence: how do the results of this study fit with the research presented in part three? This comparison will also note differences and discuss possible meaning and consequences of these differences concerning both therapeutic work and future research.

2.0. The inspirational sources

Why inspirational sources? Why not theory that is instructive for practice? In line with the perspective of Anderson (2007a) and Andersen (1997) referred to below, the term inspirational refers to the freedom to choose from any perspective, also from perspectives identified as belonging to traditions outside the identified inspirational sources. There is no loyalty to theory except the theoretical belief that what we do consists of ongoing inquiries with service users that lead to the identification of preferred actions by the participants.

2.1. Harry Goolishian, Harlene Anderson and the Houston Galveston Institute

In the beginning of the 80s, Harry Goolishian was invited to Norway by Tom Andersen, then based in Tromsø, and Einar Øritsland, head of the Christian Family Counselling Agencies in Norway. Harlene Anderson followed two years afterward and with Goolishian became a regular guest lecturer of the Norwegian family therapy community. I first met them when I was part of an Oslo based group that delivered preparatory material for a conference arranged by the Tromsø Group and Tom Andersen (Helmersen, 1988; Reichborn-Kjennerud, 1988; Sundet, 1988), the Greek Kitchen in the Arctic conference of June 1988. This conference gathered "epistemologists" such as Maturana, von Foerster, von Glazersfeldt and Bråthen, and clinicians such as Anderson, Goolishian, Boscolo, Cecchin, Flåm, Andersen and Hoffman.

In the middle of this conference, I heard Goolishian state that the time was ripe for changing the basic metaphors of family therapy from systems theory and cybernetics towards language and meaning. Instead of looking at theories of systems we should now turn our attention towards the ideas of postmodern thinking. For many of us these statements were the beginning of a new clinical era within family therapy. Although the importance of language was acknowledged within the field of systems science by Maturana and Varela (1980), the full clinical impact of this "linguistic turn" became most visible through the work of Goolishian and Anderson (Anderson and Goolishian, 1988; Goolishian and Anderson, 1987). The inspirational content of this work for the Family Unit will be given a brief presentation in the following.

Language, *meaning* and *relationships* will be used as key words to organize the inspirational ideas of the perspective taken up by the Family Unit. *Language* brings forth realities and reality is socially constructed through language. With this basic idea, clinical work is directed towards using language in new ways. To talk together, to have conversations and dialogues becomes one of the main agendas and arenas of therapy with two central positions for the therapist: that of talking and that of listening. In the first position, the use of questions has an important place. The second position underlines listening and hearing where the main processes are seen to be "…attending, interacting, and responding" (Anderson, 2007b, p. 36). For the Family Unit this has given inspiration to develop and use questions while trying to attend to, interact with and respond to the answers to these questions. Through this dual focus, the second keyword *meaning* comes to the fore. Through these conversational processes new meaning can arise; meaning is transformed and a new understanding of daily life and its problems can arise. Problems distinguish and constitute social systems; these are problem-determined systems and "…they only exist in language; they do not exist in social objectivity…" (Goolishian and Anderson, 1987, p. 4), and as such problems are not solved, they dis-solve (Anderson & Goolishian, 1988). With an increased focus on meaning, the importance of history, context, interplay and interaction between participants becomes apparent. This implies the third important keyword; *relationships*. The use of language and the creation of meaning happen in relationships and the understandings that arise are relational, that is, related to the involved persons, their histories and daily contexts of life. Relationships and being relational also imply a similarity of positions. What counts for one position can also count for the other. Family therapy has traditionally, in line with the work of Gregory Bateson (1973), described relationships through the concepts of symmetry and complementarity. In complementary relationships, the dominant behaviour of one participant elicits submissive behaviour from the other. In symmetrical relationships, the behaviour of one person elicits similar behaviours from the other. In the first instance, we see the development of increased difference that can end in separation. In the other, we see an increased similarity in the responses of each, such as in an increased escalating aggressive interchange with again separation as a result (Bateson, 1973; Carr, 2006). Watzlawick, Beavin and Jackson (1967) characterise symmetrical and complementary interactions in the following manner: symmetrical interactions are "characterized by equality and the minimization of

difference, while complementary interaction is based on the maximization of difference" (Watzlawick et al, 1967, p. 68-69). The relationship between client and therapist has traditionally been seen as a complementary relationship with the therapist in a one-up position, and difference in position is underlined more than similarity. Further, symmetrical relationships are seen as the result of reduction in difference as stated above. Difference here seems more to point towards questions of equality and power differential than mere distinction, or the difference that makes a difference (Bateson, 1980). The perspective of this dissertation is that this does not catch the fact that it is possible to have similar positions and still be different; similarity and difference are not oppositional concepts[i].

At this point it suffices to say that for Anderson and Goolishian it is important to recognise that there are huge similarities between therapists and their clients that highlight the necessity of giving equal space for the perspectives and voices of clients and at the same time recognise that there certainly also are differences between the therapist, client and family positions. This implies an increased focus on the knowledge and expertise of the Other, in addition to the traditional focus on the knowledge of the therapist. Due to the centrality of this traditional perspective, Anderson and Goolishian's underlining of the not-knowing position can be seen as a strategy to counterweight and equalize this traditional focus with the voices of clients and service users. This is an egalitarian and anti-hierarchical view of the participants and it makes all participants partners in a collaborative venture. Listening and hearing become central parts of the therapist's repertoire in establishing and participating in this collaboration. This also means that the participants in these relationships always have something that is uniquely theirs. From this acknowledgement comes the idea that when participating in such a collaborative venture you can never be sure of your knowledge of the other. Although the participants share many similarities there are also differences and this means that one cannot take anything for granted. Therefore the not-knowing position (Anderson, 2005) also becomes a central stance of the therapist in ensuring that difference is always related to. For the Family Unit, this stance leads directly to the stated value of always trying to be where the clients are.

Anderson (2007a) makes a distinction between a theoretical stance and a philosophical stance. Theory is seen as something that instructs practice; it tells you what to do and it can be used to justify the actions taken. "Philosophy involves

ongoing analysis, inquiry, and reflection with self and others. It is not about finding truth, scientific or otherwise, nor is it about objects or things: it is about people" (Anderson 2007a, p. 44). It is a stance that is communicated through the way therapists are towards and with their clients. Anderson refers to J. Shotter's concept of *withness* as distinct from a manner characterised by *aboutness* (Shotter, 2004). Therapists are with their clients in their quests and actions and do not objectify clients. Knowledge is not something used on clients but rather with clients. Transparency and sharing become the backbone of a collaborative therapy.

2.2. Tom Anderson and the Tromsø-group

Andersen (1997) stated that practice comes first. Concepts and theories are effects of experiences within clinical practice. These theories can suggest future practice with the qualification that the uniqueness of future situations always opens up for change of these possible generalizations. The work of the Tromsø-group and Tom Andersen can be seen as such a quest for new understandings and conceptualizations given important changes in therapeutic practice. The traditional systemic frame was to work with a team behind a one-way mirror. At a certain point in the session, the therapists left the family and went back to the team to discuss what had happened. On the basis of this discussion a message to the family was formulated (Selvini Palazzoli, Boscolo, Cecchin and Prata, 1978). At no point was the family part of the formulation of this message. Andersen and the Tromsø group made a radical change to this format; changing the direction of sound and light in the room with the one-way mirror, they gave the family the opportunity to listen to the team discuss and reflect upon their conversation (Andersen, 1987). One can say that, for the first time in the history of family therapy, the concept of democracy became an important clinical concept in the equal opportunity for all participants to have a voice, be heard and taken into account in the clinical situation. For those in the positions of client and family, the right to make decisions about one's own life and preferences within it became an overarching principle. Within this framework, a series of concepts and formulations by this group have inspired the Family Unit.

The concepts of difference and differences that make a difference are given a central position in this work (Bateson, 1980; Andersen, 1991). One principle at work is that when something is distinguished from its background new distinctions can be made on these. For Andersen this means that there are always possibilities for new

distinctions and differences. Whatever we distinguish and see, there is more to be seen, more differences to be distinguished. Stated differently; our distinguished descriptions of the world never include the full diversity of the world. Through language we make distinctions that bring forth aspects of this diversity and, as such, we cannot step outside language (Andersen, 2002; Sundet, 2006). This means that one always can make new distinctions; new differences that make a difference.

The next important perspective of Andersen is the existence of different differences. There are those so small that they do not make a difference and there are those so large that when meeting them "people close up…"(Andersen, 1991, p. 18). The difference that makes a difference is the one deemed "the appropriate different one" (p. 19) and this is decided by the person her- or himself. Thus the answer to what will make a difference must, in the end, be found within the life and preferences of this person. What matters is the unique situation and preferences of this person and what works for her or him. The response of the Other is always decisive for the therapist and for Andersen (1991) the protection of the integrity of the Other becomes a central agenda of therapy. A striking aspect of Andersen's work was the manner, pace and tempo of his participation. He used the words of the person, gave her or him ample space and time, and he followed the person in all his or her movements. This has inspired the Family Unit in terms of the use of questions, according space and time to the service users and the idea of following the lead of the clients and family members. In addition, the weight placed on attempting always to respect the state, perspectives and preferences of the service users follows directly from Andersen as an inspirational source.

Andersen (2007) defines language as all communicative expressions and considers language not only a social phenomenon but a bodily one as well. We express through our body, vocally, verbally and behaviourally and we receive these expressions from others as impressions arising within us. We are moved or touched by the expressions of the other. As a bodily phenomenon, language is also an emotional phenomenon. To work with language is both to work with verbal meaning and understanding and to emotionally touch and be touched by each others' expressions (Andersen, 1996). To participate in conversations then, is both about something and about being with someone. Andersen inspires the therapist to focus on being in language and in experiences with other persons. Participation and collaboration become experiential events. This also means that it becomes important

to know the experiences of others in their life situations to open up the context of therapy. It becomes important to work therapeutically with people in their preferred context. Therapy is moved out of the office and into the life context of the participants. This has inspired the Family Unit in working in as many different contexts as possible, only constrained by the preferences of the service users.

A main issue in the reflecting team (Andersen, 1987) and reflecting processes (Andersen, 1995) is to return a listener's response to the speaker. This response must be given in a respectful manner, banning strategizing responses where one tries to move the other in certain directions. This has inspired the Family Unit in trying to be open and transparent about one's thoughts, feelings and reactions and holding the aims and preferences of the other at the centre of these reflections. Conversations about conversations become an important way of trying to determine and stay in contact with where the Others are. This practice is a precursor for securing feedback from users through the use of standardized tools.

2.3. Michael White and the Dulwich Centre

Connected to Bateson and the systemic conceptualisation within family therapy (White, 1989a, 1989b), White, through working with children, developed a third path. With externalising the problem and the re-authoring of lives and relationships (White, 1989c), White introduced practices that allow for and increase the client's and his or her family's influence on the problem through separating persons and problems. The central idea of narrative practice is that life and the experiences of people living their lives are richer than the stories told about these people, their actions and their identities. Further, stories about people and their problems in a psychiatric context are most often formulated as pathological aspects of the person or as psychiatric diagnosis. This in turn tends to become a dominant story that excludes the aspects of life not definitional of these problems and diagnosis. The result is the production of thin descriptions of people and their lives. Through participation in conversation, and especially through the use of questions, therapists can contribute to richer and thicker descriptions that can give people access to new options for actions and identity (White, 2007).

White's work describes a change from seeing social and psychological structures (systems) as determining and causing problems to seeing the problem as causing suffering. One way of reading White is by looking into the descriptions and

specifications of forms of practice, called "maps" that he has developed. These are not theories but guidelines that can help the therapist manoeuvre without being instructed as White's maps are pedagogical and not instructional. They suggest manners and types of questions that can be asked and, as with other types of maps, guide the user about where to move in a landscape of experience and action. They help the therapist train and prepare for such movements and allow him or her to be with and follow the client and family in their quest. These maps point to important areas that clients and therapists often encounter and can be understood as sets of suggestions for how therapists, through asking questions, can be helpful in both creating thicker descriptions and influential in helping people move from one position to another in their lives. In the following, I will give a brief presentation of these maps.

White (2007) presents maps connected to externalizing conversations, reauthoring conversations, re-membering conversations, definitional ceremonies, and scaffolding conversations. Externalizing conversations concern the idea of separating persons and problems (White, 1989c). It is not the person that is the problem; the problem is the problem. The separation of the person and the problem is confirmed by giving the problem a name that positions it as external to the person. The aim is to take a position on the problem in order not to allow it to dominate one's life. This separation also gives the person distance to the problem and for White, this increases the possibility to stop or reduce the influence of the problem in the person's life. In addition, by formulating the relationship between the person and the problem in this manner, it becomes possible to identify and investigate all those times the influence of the problem is reduced or the problem is not present. This is called a unique outcome that again can give opportunity for thicker or richer descriptions of persons. This perspective is the foundation for two position maps, one concerning taking a position on the problem, the other on unique outcomes (White, 2007).

Reauthoring takes as its starting point the fact that persons can be described through what they do, and what these actions speak to concerning the identities of these persons. The description of a unique outcome, an action the person takes in order not to follow the demands of the problem, can give the basis for a characterization of the identity of the person. When a person with an eating problem eats, this can be seen as an action that diverges from the demands of anorexia and can lead to a characterization of the person as, for instance, brave or steadfast. These

specified identities can again originate new actions. Reauthoring, then, concerns producing descriptions of the movement between what people do and the identities that these actions can signify.

Re-membering is the next map. It invites us to see our lives as if we are members of a club. Through questions and the telling of stories, characters both past and the present, both literal and imaginary, are brought into the conversation. As members of the same club, these are persons that have been or are important in the life of the client or who can tell important things about him or her. Through investigations of their stories, perspectives and connections with the client, richer descriptions of the client's life, identities and actions can be constructed.

Definitional ceremony is a map with a specific way of structuring conversations. The format is based on the notion of first telling a story which then is retold by a listener who again provides the origins for a new retelling by the original speaker. The retelling by the listener follows a specific structure called an outside witness response. This invites the listener to first comment on the expressions that the original story evokes in her or him, then what images these expressions lead to. The third step concerns what White (2007) calls personal resonance; "why you were so drawn to these expressions, with a specific focus on your understanding of what these expressions struck a chord with in your personal history" (p.191). The last step focuses on transport, meaning the ways the listener has been moved by what he or she has heard. Where has it brought the listener with regard to his or her thoughts, reflections and understanding concerning his or her own life? This structure focuses on acknowledgment and recognition of the service users through a specific outside witness response, and again thicker descriptions are the result.

Lastly, scaffolding questions concern situations in which people want to move from a position of the known and familiar and into areas that are unknown to them. They might want to acquire a new skill for instance. Using Vygotsky's concept of the zone of proximal development and Wood, Bruner, and Ross' (1976) metaphor of scaffolding (see article 3), White develops maps of questions that can enable people to move from the known and familiar to what is possible to know, which again can originate plans for new actions in life.

2.4. Concluding remarks concerning the inspirational sources

Although different, these three inspirational sources have a joint focus on language, stories and meaning making as basic starting points for therapy. They all value questions as a main tool and they all can be seen to give content to therapy as a collaborative venture. Meanings arise and are brought forth as a joint venture and, as such, meaning must be understood as something co-constructed. At the same time, each source acknowledges that the meaning created belongs to those who have sought our help and therefore their meanings, perspectives, preferences and values must be privileged. These commonalities together with the differences between these three perspectives are all part of the conceptual baggage of the Family Unit.

3.0. Psychotherapy research

Research on psychotherapy goes back to the early 1920s (Lambert, 2004). Since Eysenck's (1952) controversial conclusions that the psychotherapy outcome does not exceed the rate of spontaneous remission, the hunt has been on for establishing a possible empirical status of psychotherapy as a method of change and healing (Wampold, 2001). The current status of psychotherapy includes overwhelming support for its efficacy and effectiveness (Castonguay & Beutler, 2006b; Cooper, 2008; Dawes, 1994; Lambert & Ogles, 2004; Wampold 2001). In spite of this clear conclusion there are controversial issues embedded in the field of psychotherapy research. Two of these are that it is difficult to establish differential effects of different theory-driven models of psychotherapy and of therapists with different educational and professional backgrounds (Beutler, Moleiro & Talebi, 2002; Dawes, 1994; Wampold, 2001). The latter aspect seems to have gone for the most part uncommented. This author views these findings as necessitating and providing the opportunity for a revision of the concept of psychotherapy. One by-product of the study reported on here is the presentation of a definition of psychotherapy (6.0.).

Within this research field a distinction is made between process and outcome: "Process refers to what happens in psychotherapy sessions (….), whereas outcome refers to immediate or long-term changes that occur as a result of therapy (….)" (Hill & Lambert, 2004, p 84). Orlinsky, Rønnestad & Willutzki (2004) present the Generic Model of Psychotherapy as a means of understanding the concepts of process and outcome in psychotherapy. This model depicts psychotherapy process through six aspects of therapy: organizational, technical, interpersonal, intrapersonal, clinical aspects of therapy and lastly, sequential aspects of process. Outcome has also accumulated divergent meanings. Orlinsky et al (2004) make a distinction between the observational perspectives of analysis. The question of who is doing the assessment of outcome, "…patient, therapist, an expert nonparticipant, or interested laypersons, such as the patients' family" (op. cit. pp. 314) is especially important for the study presented in this dissertation. It is the aim of this study to give descriptions of process aspects that families and therapists identify as important. Part of this is the assessment of process and outcome as an aspect of process, that is; the monitoring of process and outcome as feedback to both therapists and family members as a central ingredient of treatment.

APA's Presidential Task Force (2006) points to the individual psychotherapist, the patient, the treatment relationship and the treatment method as contributors to the success of psychotherapy. In the following discussion of the research literature, conclusions within these four areas together with research on children, adolescents, parents, family therapy and patient focused research will be presented.

3.1. The psychotherapist

"Is the particular therapist important?" (Wampold, 2001, p. 185). Do therapists affect the outcome of psychotherapy? The production of answers to such questions will definitely have consequences for how psychotherapy is viewed. In the research literature the answers are not necessarily clear cut. For example, two papers in Psychotherapy Research demonstrate the difficulties that confront clinicians who seek guidance from research. Elkin, Falconnier, Martinovich and Mahoney (2006) and Kim, Wampold and Bolt (2006) analyzed the same data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program to estimate proportion of variability in outcome resulting from therapists. The interesting but troubling result was that the two analyses of the same data gave clearly divergent results. The first paper found no significant therapist effects while the second found significant therapist effects. This certainly points to the need for further research but at the same time there are indications that therapist effects must be reckoned with and also that there are differential therapist effects. Later I will present some results of patient focused research (Lambert, 2007) and one important aspect here is the documentation of differential therapist effects (Lambert & Barley, 2002). Therapists matter but some therapists matter more than others (Miller, Hubble & Duncan, 2007).

Beutler, Malik, Alimohamed, Harwood, Talebi, Noble & Wong (2004) conclude that therapist sex, age, and race are poor predictors of outcome and that therapist training, skills, experience, and style are weak contributors to outcome. They also find that any one class of interventions and techniques used by therapists has little support but that "…evidence is accumulating on the role of patient moderators in determining the effectiveness of interventions" (p. 291). Matching patient and method is therefore a topic for further investigation. Therapist positivity, friendliness, well-being and cultural values are revealed as associated with good outcome, and criticism and hostility has the opposite effect. Lastly, Beutler at al.

(2004) give attention to the therapist's contribution to the therapeutic relationship and to the therapist's model of treatment. Their conclusion is that relationship quality is one of the stronger correlates of outcome, while the specific model does not matter much. Their conclusion and recommendation is to look towards an integrative and synergistic perspective. To this end, the therapist is a central agent and critical factor in good therapy (Wampold, 2001).

Ackerman and Hilsenroth (2003) examined which personal attributes of the therapist and which techniques positively influenced the therapeutic alliance. The following attributes - being flexible, honest, respectful, trustworthy, confident, warm, interested, and open, and the following techniques-exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience were found to contribute positively to the alliance. They also found that the therapist's attributes "…may influence the development of an alliance early and late in treatment"…and "(i)f a patient believes the treatment relationship is a collaborative effort between her/himself and the therapist, s/he may be more likely to invest more in the treatment process and in turn experience greater therapeutic gain" (Ackerman and Hilsenroth, 2003, p.7). They also point out that the therapist's contributions "…to the development and maintenance of the alliance are similar to the features identified as useful in the identification and repair of rupture in the alliance" (p. 29). Repair of alliance ruptures (Safran & Muran, 2000) is seen as a central part of therapeutic processes and the actual repair and resolution of the rupture is dependent upon the therapist acknowledging and pointing out his or her contribution to and part in the rupture event. They conclude that therapist attributes and contribution must be seen in relation to what the patient brings to the relationship. "(T)he most promising strategy for future research may be to examine the interpersonal exchanges between patient and therapist that impact alliance development" (Ackerman and Hilsenroth, 2003, p.29).

This is the aim of a study by Baldwin, Wampold and Imel (2007). They separated therapist and patient variability in the alliance by differentiating between within-therapist correlations which tell how alliance is related to outcome with a given therapist, and between-therapist correlations which tell how "… therapists' average alliance is related to their average outcome (Baldwin et al, 2007, p. 843). By doing this they could also test whether there was an interaction between the patients'

and therapists' variability. They found that therapists who formed stronger alliances with their patients showed statistically significant better outcomes than therapists who did not form as strong alliances. They did not find within-therapist alliance outcome correlations, meaning that variability among patients in the alliance was not related to outcome. This points to the fact that it is not the patient who is largely responsible for the alliance and the authors conclude in the following manner:

> "In situations in which therapists have trouble forming an alliance, it would behoove therapists to attend to their own contribution to the alliance and focus less on characteristics of the patient that impede the development of the alliance. Indeed, therapist attributions of resistance or maladaptive attachment styles as an explanation of a poor alliance according to our findings, would be irrelevant with regard to outcomes, although these explanations may be grist for therapeutic work" (Baldwin et al, 2007, p. 851).

What, then, about patient characteristics and attributes? Do they not matter at all? If they do, what is their relationship to outcome?

3.2. The patient

In line with Ackerman and Hilsenroth (2003) and Baldwin, Wampold and Imel (2007), Clarkin and Levy (2004) conclude that the important question is: "Which client and therapist characteristics interact most saliently and forcefully to produce symptom decline? (p.195). The classical aim of evidence-based or empirically supported treatments has been to establish a clear relationship between diagnoses and specific treatment interventions (Chambless, 1996; Chambless and Holon, 1998; Chambless, et al., 1996; Chambless, et al, 1998). The medical model (Wampold, 2001) builds directly on the idea that after a thorough assessment that results in a DSM/ICD- diagnosis, clinical trials will establish what method and theory driven package will be the best practice. Clarkin and Levy (2004) deem this an oversimplification and instead stress "…the interaction between client diagnosis and other salient client characteristics. .." (p.214).

Duncan and Miller (2000a) assert that psychiatric diagnosis lacks both reliability and validity in addition to leading to negative side effects like attributing blame to the client. At the same time, many therapists report that a diagnosis actually reduces blame because the problems and symptoms are given an explanation that does not involve personal intentionality of the patient and/or his or her family.

Clarkin and Levy's (2004) solution is to present a broad picture of client characteristics that goes way beyond simple diagnostic classification. First they review nondiagnostic client variables that are related to specific diagnoses. This is a question of possible moderators and mediators of change. One such moderator is attributional style (see also Whisman, 1993).

Severity of symptom is the next characteristic attended to by Clarkin and Levy (2004). Lower severity is related to better outcome, higher severity to lower outcome, but they report that with more therapy sessions high severity clients improved substantially compared with a lower number of sessions. They also make a distinction between severity and functional impairment, the latter "…either results from or precedes the symptoms and provides the context for the arousal of symptoms" (Clarkin & Levy, 2004, pp.200). Symptoms may vary in severity but functional impairment for instance in interpersonal relationships may be high or low or equal for the two. Again they find that high functional impairment is predictive of lower outcome across a series of diagnoses such as depression, bulimia and others. Other client characteristics that predicted outcome across different treatments (interpersonal therapy, cognitive behavioural therapy, medication and clinical management for depression) were social and cognitive dysfunction, expectation of improvement, classification of the depression as endogenous or double, and the duration of the current episode. The presence of personality disorders was listed as a main complicating factor.

Clarkin and Levy continue to explicate sociodemographic variables such as age, gender and race, and personality variables such as expectations concerning the therapeutic work and the therapist, how prepared the client is for change and properties like ego strength and psychological mindedness. Interpersonal variables such as interpersonal relatedness, quality of object relations, attachment patterns and in-therapy behaviour are important. A consistent thread running through all of these characteristics is that therapy outcome is dependent upon a match between what the client brings and how the therapist meets this. The more rigid the therapist is with less ability to tailor treatment, the bigger the effect this may have on outcome with the risk of the client becoming cast as the problem. Clarkin and Levy (2004) state a dilemma here: "(M)any symptomatic individuals with disorders needing treatment are the same ones who have troubled interpersonal relations that may disrupt the therapeutic venture" (p. 211). Stated differently, to suffer from a personality disorder

is to suffer from a condition that strikes at the core of what is considered helpful in psychotherapy, that is; the therapeutic relationship and the alliance between patient and therapist. Friendliness, flexibility and being genuine as a person seem a better way of entering such a situation than rigid methodological and confrontational manners of working.

We see that a set of characteristics, here patient characteristics, must be seen in relation to the persons with whom one enters into interaction. A recurring theme in this dissertation is the question of collaboration, how to establish it, how to maintain it, what to do when it does not function and where to put responsibility for what in establishing a therapeutic collaboration. In this regard, it is also important to discuss how techniques relate to the process and outcome of therapy.

3.3. Theory driven therapies, techniques, specific ingredients and common factors

As stated above, psychotherapy is efficacious and effective (Cooper, 2008, Lambert, 2004). About the differential effects of manual based therapies the conclusion in the literature is that "(d)ecades of research have not produced support for one superior treatment or set of techniques for specific disorders" (Lambert & Ogles, 2004, p.167). Instead:

> "It is possible that too much energy is being devoted to technique studies at the expense of examining therapists as persons and in interaction with techniques, as well as patient characteristics…..Such studies may well show not only potent therapist outcome but also that technique differences are inseparably bound with therapist and patient differences" (p.169).

One question here may be what to give the main weight of attention; therapist-patient interactions or the interaction between therapeutic procedures and patient characteristics. Beutler, Moleiro and Talebi (2002) state that when comparing theory driven, manualized therapies applied to specific diagnostic groups "…there is very little evidence that the effects of different psychotherapy procedures are specific to the various symptoms that define a diagnosis" (p.139). For them it is unwise to think that effective methods are all part of one single theory and that a single diagnosis can capture the qualities that "constitute motivation, prognosis, and progress…"(p.139). These conclusions lead to the question of how classes of treatment procedures, rather than brand names, interact with qualities of patients. Castonguay and Beutler (2006a)

follow this line and report on therapeutic principles that work. Lambert and Ogles (2004) do not dismiss the effect of techniques and follow the idea of "…carefully matching techniques to client dispositions, personality traits, and other diagnostic differences" (p. 180). There are undoubtedly interpersonal, social and affective factors that are common across different therapies. Common factors and the Dodo-bird verdict (Wampold, 2001) must be taken into account but at the same time they are in need of being understood. What does it mean when a factor is classified and named as "common"?

> "The aim of common factors is to determine the core ingredients that different therapies share, with the eventual goal of creating more parsimonious and efficacious treatments based on those communalities "(Norcross, 1999, p. xviii).

Common factors are differentiated from specific ingredients, with the term "specific" defined as "a term ubiquitously used to refer to theoretically derived actions…"(Wampold, 2001, p. 5). Common factors are also referred to as incidental, meaning that they are not characteristic of a theory. One possible misunderstanding that can arise is that common factors may be understood as "general" in opposition to "specific" meaning concrete and delimited. Common factors are just as concrete and delimited as specific factors, for instance the communication of respect is just as concrete as a psycho-dynamically oriented relational interpretation, but is not related to theory in the same manner. Strupp (1986) states that; "…interpersonal variables such as empathy, warmth, and caring should be regarded as specific as traditional techniques" (p.513). In the same manner incidental does not mean haphazard but rather not systematically connected to a specific theory, although haphazard events may also be common factors. Not being haphazard means that common factors as used by therapists are connected to some beliefs, assumptions or model about therapy and change without necessarily being identified as related to a specific, delimited theory. Perhaps one should talk about "theory specific factors" and "common specific factors" instead of specific and common factors to underline the concreteness of both types of factors.

Building on and extending Lambert's (1992) four therapeutic factors – extratherapeutic, common factors, expectancy or placebo, and techniques -- Hubble, Duncan and Miller (1999b) suggest four groups of common factors: extra-therapeutic factors, relationship factors, placebo, hope and expectancy and model/technique

factors. With this classification the possibility emerges that there may be factors concerning the client and his or her life context, the relationship between client and therapist, the hopes and expectancies of the participants and the model and techniques used that cut across all efficacious and effective therapies. This means that whether theory specific or not, models and techniques must be investigated and taken into account.

Holan and Beck (2004) find strong support for cognitive behaviour therapies and Elliott, Greenberg and Lietaer (2004) for experiential therapies, but again the problem is to establish strong support for differential effects. Elliott et al (2004) found that when allegiance effects were taken into account small differences between CBT and experiential therapies disappeared and treatment equivalence was concluded.

Emmelkamp (2004) states that it is "becoming increasingly clear that the quality of the therapeutic relationship may be influential in determining the success or failure of behavioural therapies, although well-controlled studies in this area are rare" (p.431). Within the cognitive therapies, Gilbert and Leahy (2007) state that the therapeutic relationship do become important for several reasons. The importance of feeling safe for the patient through a "containing relationship" is one aspect, but also we know that relationships can influence psychological and physiological processes in a powerful manner, and can be an arena both for problems and amelioration. The relationship is also an arena for thinking and reflection upon the participants' lives and experiences.

Lambert and Ogles (2004) conclude that "there are probably some specific technique effects as well as large common effects across treatments…" (p.180). It therefore seems a sound strategy to keep in mind both common factor and specific effects while not feeling obliged to choose a specific theory driven method. An eclectic orientation seems just as viable when combining both common and specific factors.

3.4. Children, adolescents, parents and family therapy

The review and conclusions presented above are mostly taken from research with adults in individual therapy. What about children, adolescents and their parents, especially in a family therapy context?

Burns, Hoagwood, and Mrazek (1999) report strong evidence for five forms of services and treatments for children and adolescents: "…home-based services,

therapeutic foster-care, some forms of case-management and both pharmaceutical and psychosocial treatments, for specific syndromes" (p.238). Within psychosocial treatments they report a strong evidence base for those who focus on parent management training, problem-solving strategies, and parent-child interpersonal skills…"(p. 238). They also conclude that the effectiveness of the service does not have as much to do with the type of service as with how, when, and why families are engaged. "Family engagement is a key component not only of participation in care, but also in the effective implementation of it" (p. 238). Coupled with this is the underlining of a trend in which one is moving away from a hierarchical, top-down manner of service delivery towards service delivery with a much closer and collaborative relationship between caregivers and therapists (Burns, et al., 1999).

Shirk and Russell (1996) underline the lack of connection between research and child psychotherapy concerning research on development and change processes in childhood and on the processes and outcome of psychotherapy. Giving a chronological review of research on psychotherapy with children and adolescents they show a history that in many ways mirrors the history of adult psychotherapy but with a clear conclusion that the methodological qualities of the studies with children and adolescents seem more problematic than those with adults. Research on children and adolescents was reported to lag behind in methodological quality. In addition, they strongly point out "…that the problem with the traditional approach, that is, matching treatment brands with diagnostic entities, is that it fails to conceptualize both treatment and disorders in terms of component psychological processes" (Shirk & Russell, 1996, p. 88). Their view is that the task at hand is to identify the psychological processes "…that constitute both therapeutic interventions and variations in childhood maladjustment" (p. 88).

Kazdin (2004) seems to have a slightly more optimistic view of the methodological situation. In a review of meta-analysis he follows Shirk and Russell (1996) in concluding that psychotherapy appears to be better than no treatment, and that "…the magnitude of the effects with children and adolescents closely parallels the magnitude obtained with adults" (Kazdin, 2004, p. 551). Less consistently, other conclusions from the field are that when differences in effect are detected these favour behavioural techniques, the effects are maintained from post treatment to follow up, treatments are more effective with adolescents than with children,

individual therapy is more effective than group therapy and treatment is equally effective for externalising and internalising problems (Kazdin,2004).

Miller, Wampold, and Varhely (2008) conducted a meta-analysis in order to determine whether there were differences in efficacy among treatments applied to youth. Their conclusion was that differential effects found were explained by allegiance effects:

> "Controlling for allegiance of the researcher to the treatment approach under investigation removed all variability among the effects. In other words, allegiance explained all the observed systematic differences among treatments…the results are generally consistent with the dodo bird verdict, when allegiance is controlled for" (Miller, et al., 2008, p. 7).)

Shirk and Russell (1996) give close attention to the therapeutic relationship and the working alliance. Kazdin (2004) explicitly recognizes the parallel development of research on adults and children, and Kazdin and Nock (2003) recommend that formal evaluation of the alliance be included in research on change in child and adolescent therapy. Green (2006) acknowledges that research on the therapeutic alliance has been a neglected area within child mental health treatment studies. In Kazdin, Whitley, and Marciano (2006) full focus is directed towards the therapeutic alliance in evidence-based treatment for children and the authors conclude that both child-therapist and parent-therapist alliance predicted outcome. Shirk and Russell (1996) raise the discussion about how to look upon and understand the therapeutic relationship. They point to different ways of viewing this relationship; either as a means to and end or as an end in itself.

There are clear conclusions about the importance of the therapeutic alliance in working therapeutically with children and adolescents. Shirk and Karver (2003) found a small but reliable relationship with outcome, and Karver, Handelsman, Fields and Bickman (2006) showed a small to moderate relationship with treatment outcome. Karver, Shirk, Handelsman, Fields, Crisp, Gudmundsen, et al., (2008) found a strong association between the therapeutic alliance and client involvement and that involvement was "…differently related to treatment outcome, depending on treatment type" (p.23). In their conclusions they underline that "(t)herapist lapses, such as failure to attend to and acknowledge adolescent emotional expressions, appear to have a deleterious effect on alliance formation across types of treatment"

(p.25). At the same time their results indicate that "…common factors may not be common across all types of treatments and that there may be variations in effective relationship factors depending on the specific therapeutic techniques or orientation of the therapist" (p. 25). Concerning the question of whether one should have a focus on empirically supported techniques or relationship factors, their conclusion is that "…further research should look at how empirically supported relationship techniques and relationship factors both may influence effectiveness in different approaches to treating mental health problems" (p. 25).

Sexton, Alexander, and Mease (2004) focus on mechanisms of change. They conclude that the ability to help families redefine their problem mediated treatment effects together with changing the families' manner of problem solving when meeting impasses, reducing negativity and improving communication. In addition, the therapeutic alliance and early structuring of treatment sessions were important mediators of outcome (Sexton, Alexander, and Mease, 2004). Again the therapeutic alliance emerges as an important part of the therapeutic work and process. Friedlander, Escudero, and Hetherington (2006) introduce a trans-theoretical model for the therapeutic alliance in conjoint therapy and state that "…(i)n virtually every account of common factors and principles of change, the working alliance between therapist and the client takes center stage" (p. 4). So far in this investigation of therapeutic factors related to all age groups, the therapeutic alliance appears central.

3.5. Patient focused research

Howard, Moras, Brill, Martinovich and Lutz (1996) state that there are "…three fundamental questions that can be asked about any treatment (intervention): (a) Does it work under special experimental conditions? (b) does it work in practice? and (c) is it working for this patient?" (p.1059). For the clinician facing an actual patient, it is the third question that is crucial and in need of immediate answer. This means that "…one critically important task of research is to provide valid methods for systematically evaluating a patient's condition in terms of the ongoing response of that condition over course of treatment" (p.1060). This is the basis for patient-focused research (Howard, et al., 1996). This means systematically monitoring patient responses to treatment during the course of therapy and making this information available to the therapist. This requires regular measurement of outcome (Johnson and Shaha, 1996) through the use of a standardized measure continuously

throughout the therapeutic work (Lambert and Brown, 1996). Compared with questions (a) and (b) above this involves going beyond pre- and post-treatment assessment of the treatment (Kadera, Lambert & Andrews, 1996).

A series of experiments have investigated the effects of continuous monitoring and the use of such information as feedback (Harmon, Lambert, Smart, Hawkins, Nielsen, Slade and Lutz, 2007; Hawkins, Lambert, Vermeersch, Slade and Tuttle, 2004; Lambert, Whipple, Smart, Vermeersch, Nielsen and Hawkins, 2001; Lambert, Whipple, Vermeersch, Smart, Hawkins, Nielsen, et al., 2002; Whipple, Lambert, Vermeersch, Smart, Nielsen and Hawkins, 2003). In Lambert et al. (2001) the question under study was whether feedback on patient progress improved outcome. This was studied by "…supplying therapists with feedback about patient improvement through the use of progress graphs, as well as warnings for patients who were failing to make the expected degree of progress" (Lambert et al, 2001, p.. 51). A clinical trial was set up in which the feedback to the experimental group was formulated as progress graphs, coloured dots, and a statement that corresponded to each dot. Red, yellow, white or green corresponded to deterioration, no change, progress and recovery respectively (Lambert et al., 2001). Four treatment conditions were set up: (1) patients with green or white dots with therapists receiving feedback, (2) patients without therapists receiving feedback, (3) those with yellow or red with therapists receiving feedback, and (4) those without therapists receiving feedback. The patients in the two latter conditions were labelled not-on-track cases (NOT) (Lambert et al., 2001). NOT cases are connected to the fact that 5-10 % of the participants in psychotherapy deteriorate during treatment (Lambert & Ogles, 2004).

The results confirmed that the average outcome for not-on-track cases whose therapists received feedback was better than the average outcome for not-on-track cases receiving no such feedback. Also, fewer of the not-on-track cases with feedback "…were rated as deteriorated at the end of therapy, while more were rated as having reliable or clinically significant improvement" (Lambert et al, 2001, p. 63). The study also shows that the average outcome for most not-on-track cases with feedback was classified as "no change" or "deteriorated" which means that a large number of cases did not attain a clinically significant change. The authors suggest a "need to increase the strength of the feedback manipulation or to link feedback more closely to other quality improvement efforts in future research" (p. 64). In later

studies this was tested through the introduction of clinical support tools (CST) (Whipple et al. 2003).

A study by Whipple et al., (2003) investigated whether more not-on-track cases could have an enhanced outcome by linking feedback to the use of CST. These tools helped the therapists assess "…the quality of the therapeutic relationship, client motivation to change and its match to treatment tactics, the client's social support network, accuracy of the diagnostic formulation, and the appropriateness of a referral for medication" (Whipple et al., 2003, p. 60). The results supported the conclusion that the use of CSTs enhanced improvement of similar clients whose therapists received feedback but did not use CSTs.

A study by Hawkins et al (2004) investigated whether there was difference in outcome when providing information on progress to both therapists and patients in contrast to treatment as usual (TAU). Patients in the feedback condition were significantly more improved at termination than those in a treatment as usual condition, and a large percentage of patients in the patient-therapist feedback group met clinically significant criteria.

The above research points to the use of feedback, at least to the therapist, as helpful, and suggests that reviewing feedback about NOT cases and the use and implementation of CST enhance the outcome. Practice built on this research opens up for the possibility of evaluating the practice of each therapist. However … "(e)valuations in this context are much more threatening than studies that focus on comparison between theory-based interventions"(Lambert, et al, 2004, p. 813). This means that for the psychotherapy professions, an important change is about to take place. The effects of one's own professional practice and skills becomes a central target area for both research and practice.

3.6. The therapeutic relationship and the alliance

Running through the above review of research is the therapeutic relationship and the therapeutic alliance. Patient focused research adds to the significance of therapists having to take feedback seriously and change their focus in therapy in order to both strengthen the alliance and change their practice. In their review of the concept of the alliance, Horvath and Bedi (2002) argue that collaboration and consensus are the most important and distinguishing features of the therapeutic alliance. Bordin's (1979) formulation of the therapeutic alliance consists of three elements; agreement

on goals, consensus on tasks and a bond between the client and therapists. These become central elements in a "…modern alliance theory emphasizing the active collaboration between the participants" (Horvath & Bedi, 2002, p. 39). Their definition is as follows:

> "The alliance refers to the quality and strength of the collaborative relationship between client and therapist in therapy" (Horvath & Bedi, 2002, p. 41).

Positive affective bonds between client and therapist, consensus and active commitment to goals and means, a sense of partnership and of the alliance as a conscious and purposeful aspect of the relation between client and therapist are specifications of this definition. This represents a move away from underlining the unconscious aspects of the relationship toward a more equal and cognitively oriented perspective on the alliance.

Tryon and Winograd (2002) reviewed research on goal consensus: "the therapist-patient agreement on therapy goals and expectations" (p. 109), and collaborative involvement;" the mutual involvement of patient and therapist in a helping relationship" (p. 109) in relation to engagement; "the initial involvement of patient and therapist in the therapeutic process" (p. 109), and outcome. Six of nine studies showed a positive association between goal consensus and engagement, and in 19 of 24 studies collaborative involvement was positively associated with engagement. In relation to outcome, the research tended to support the positive influence of goal consensus and collaborative involvement. In particular, collaborative involvement is underlined as enhancing outcome while the positive relationship between goal consensus and outcome was not as strong, possibly due to the fact that although there was a sharing of goals, the manner of talking about them was different and as such difficult to assess. The clinical suggestions of Tryon and Winograd (2002) point to the fact that patients assessed as easy to collaborate with are easier to engage and establish both goal consensus and collaboration with. The mirror image of this would be that therapists who are able to collaborate with their patients are potentially more helpful. Tryon and Winograd state that when therapists attend to patient problems, help patients to clarify concerns, address topics of importance to their patients and resonate to patients' attributions of blame regarding their problems, patient engagement increases and therapeutic collaboration arises.

Goal consensus and collaboration are identified here as clear therapist responsibilities and part of what therapists must establish skills and knowledge in. This is supported by the study by Baldwin, Wampold and Imel's (2007) cited above which concluded that the therapist must have interpersonal skills facilitating the establishment of shared decision making with frequent discussions of goals. Where clients do not match the collaborative invitations of the therapists this is a clinical problem best solved by looking at the therapist rather than patient characteristics.

Testing out a theoretical model, Karver, et al. (2006) also found alliance to be a robust predictor of treatment outcome, but pointed to a more complicated picture concerning youth and families. A moderate to large relationship with treatment outcome was found for therapist direct-influence skills and the therapeutic relationship with youth. Counsellor interpersonal skills, parent willingness to participate in treatment, youth willingness to participate in treatment, client participation in treatment, and parent participation in treatment were only moderately related to treatment outcome. In addition, the therapeutic alliance with the family, therapeutic alliance with youth, relationship with parents, and autonomy demonstrated a small to moderate relationship with outcome. Their model suggests interaction effects between the different relationship constructs. They give the following example:

> …therapist characteristics and behaviours influencing client's cognitive, affective, and behavioural reactions to the therapist and therapy and client's cognitive and affective reactions to the therapist and therapy influencing actual participation in treatment" (p. 60).

Here a complex picture emerges in which the relationship between constructs such as therapeutic relationship, alliance and collaboration and outcome is related to interactions between aspects of the therapist, the client, and techniques used. In family therapy, this complexity increases because of the possibility of multiple alliance constellations between each family member and the therapist(s) (Friedlander et al., 2006) and within the family where "split" alliance between family members is related to outcome (Friedlander, Lambert, Escudero, and Cragun, 2008). The concept of tailoring treatment (Norcross, 2002b) becomes a particularly relevant metaphor for this complex interaction. This raises the question of whether such tailoring actually is realized. So far, in this presentation of research, the focus has been on efficacy and effectiveness research documenting results at the group level. When tailoring

treatment becomes the agenda, a need for knowledge about the individual level becomes visible: “Can I tailor the treatment to this client sitting in front of me?” No group level research can answer this question. This is the concern of the patient focused research presented above.

3.7. Concluding remarks concerning psychotherapy research

Interpreting the reviewed literature leads first of all to a confirmation of the importance of the therapeutic relationship and especially the therapeutic alliance. An emotional bond characterized by respect, empathy and listening is central. Agreement on goals, goal consensus, and method and manner of working together; that is collaboration between service users or therapist, is a necessary ingredient. How the therapist is in the relationship also matters. When there are ruptures or difficulties in establishing an alliance achieving one is the responsibility of the therapist. What characterises the client also matters, especially in how the therapist meets and organizes the therapeutic work. High severity and functional impairment speak to how much therapy is needed and when there are complicating factors like personality disorder, a low confrontational style with high flexibility is clearly indicated. The big question seems to be how much it matters what therapists do. What part does technique and manners of working play in the outcome of psychotherapy? Theory driven methods are deemed efficacious, but it is not understood if this points to specific factors or common factors. At the same time there are clear indications that therapy should be tailored to individual clients and thus a conclusion would be that it matters what is being done. Tailoring means that different clients profit from different manners of working and also that therapists may need to be in different modes when relating to different clients. The intertwining of being and doing becomes important. Perhaps any “doing” may fit the client and not specific ingredients based on specific theories. These conclusions also seem to hold for children, adolescents and families although with possible modifications of the alliance concerning children and adolescents. A main point that can be drawn from these conclusions is that the therapeutic work needs to be continuously monitored. The results must be fed back to at least the therapists and changes must be initiated by the therapist as a response to this feedback.

4.0 Method and Material

The aim of this study was to explicate the thinking of families and therapists about therapeutic practice, both in general and specifically concerning the use of process and outcome monitoring through the use of two measures, the Session Rating Scale and the Outcome Rating Scale (Duncan, Miller, Sparks, Claud, Reynolds, Brown et al., 2003). This meant application of a method that was specifically directed at accessing and using the verbal report and descriptions of family members and therapists. Part of this project also was to investigate the possibilities and problems around studying one's own practice. In this study this meant that one of the therapists (the author) took the role of "the researching clinician" who is concerned with clinical issues and problems as "…he/ she sees it from a practically constrained research position" (Bjørkly, 1996, p. 343, *my translation*). In contrast to this position there is "the clinical researcher" who traditionally has been the one setting the research agenda in the clinical domain. There does not have to be an opposition between these two positions but there remain concerns about the researcher-clinician gap and that research based knowledge does not easily spread to clinicians (Weisz & Addis, 2006). The notion of the researching clinician can be seen as an attempt to bridge this gap. For this particular study, this involved making specific demands of the method used. It should be applicable to verbal material and it should be useable by only one researcher. This lead the attention of this researcher towards qualitative research and Grounded Theory (Glaser, & Strauss, 1968) and applications of this method within psychology, especially the work of David Rennie (1994a, 1994b, 1998, 2000, 2006, 2007; Rennie and Brewer, 1987; Rennie, Philips and Quartaro, 1988).

4.1. Methodical hermeneutics

As will be shown below the method used for analyzing the data of this study is a mixture of elements from methodical hermeneutics (Rennie, 2000) and consensual qualitative research (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005, Hill, Thompson, & Williams, 1997), although the former has the main focus. Rennie (2000) uses the following definition of hermeneutics as a "theory of the operation of understanding in its relation to the interpretation of texts" (Ricoeur, 1978, p. 141). The operation of understanding can be seen to involve processes of inquiry and meaning making. Inquiry and meaning making are recognized as being done from

different perspectives and as such involve interpretation (Rennie, 2000). Rennie (2007) locates methodical hermeneutics within an epistemology that accommodates both realism and relativism. He points out that natural science ends up reducing the person downwards; that is, to categories from another descriptive level than the personal, while within the human sciences, such as in constructionist positions, the tendency is one of an upward reduction of the person to "language, culture, and/or tradition…" (Rennie, 2007, p. 10). By keeping the person in the centre, realism and relativism is both included and balanced. On the one hand realism is accommodated by grounding the categories created in the data generated, and on the other hand the interpretation of these data is acknowledged as part of the researcher's perspective. Two operations are central here: first, the operation of constant comparison, and second, the operation of reflexivity. The purpose of constant comparison is to "discourage the analyst from making subjective the understanding of the text by importing a priori, rationally derived understandings" (Rennie, 2000, p. 485). It "grounds" or keeps the analysis connected to the data and as such the meaning generated is not haphazard or simply constructed by the analyst. It is realistically connected to the material produced by the investigated person. At the same time, the researcher or analyst is not kept out of the material. He or she works "with their own experience when attempting to understand the experience of others…(Rennie, 2000, p. 487). Rennie (1995) suggests *a plausible constructionism* characterized by a rigor that "…rests on the extent to which the human scientist manages to address adequately the construction of two components—the realism of the object under study and the relativism of the researcher's subjectivity" (Rennie, 1995, p. 46). The last entails a reflexivity that implies a subjective involvement "…in the object and representing the returns from that activity" (p. 47). This reflexivity means to show and clarify the position and perspectives of the researcher while acknowledging that these cannot be kept out in the classical sense of bracketing (Giorgi & Giorgi, 2003). Instead, one could talk about a co-construction between researcher and person or object under investigation where the presuppositions and perspectives of the researcher help draw out and direct attention to specific parts or aspects of the data under analysis. Central here is that the researcher makes the conscientious effort to be self-reflective and to express the returns from the reflexivity (Rennie, 1995). In the following, this will be done by following the recommendations of Elliott, Fischer

and Rennie (1999) for increasing the quality of qualitative research (Appendix 1, table 8).

4.2. The researching clinician

Following methodical hermeneutics (Rennie 2000, 1998) and the recommendation of Elliott, Fischer and Rennie (1999), perspectives and presuppositions of the author and researcher of this study will be presented.

First of all, I am very comfortable with the designation "researching clinician" (Bjørkly, 1996). I identify myself primarily as a clinician and I want to do research from this position. This means that when I cross the bridge over the clinician-researcher gap I bring with me loyalties, perspectives, ideas and understandings formed through 25 years of working as a clinical psychologist within mental health of children, adolescents and adults. These loyalties have primarily been to the field of family therapy both as a practice of treatment and as a theoretical, philosophical and research based field.

I started out as a student by criticizing the scientific fundament of family therapy (Sundet, 1983) and found that working with this critique gradually brought me closer to the field and eventually engulfed me and my interests. I have been interested in the aspect of family therapy history connected to the work of Gregory Bateson. In the eighties, I was very influenced by the epistemology-debate as it was brought forth by authors like Allman (1982), Dell (1982) and Keeney (1982). Ideas from the cybernetics of cybernetics or second order cybernetics (von Foerster, 1977) and structure determinism (Maturana and Varela, 1980) became particularly influential because they led to a connection with postmodern and poststructuralist ideas. At the same time, within my clinical practice I experienced that the help these ideas gave me was only partial and sometimes experienced as completely irrelevant to the tasks I met in my clinic. As the family therapy field began to be drawn to ideas about language and "the linguistic turn" in philosophy (Flaskas, 2002), I was working with children and adolescents in a team focused on emergency cases. Here I came in contact with boys ages 12 to 18 with at least one common trait. They were not fond of talking about problems, they were often assessed as unmotivated and today they probably would easily be diagnosed as having problems with reflective functioning and mentalization (Fonagy, Gergely, Jurist, & Target, 2004), or at least they were experienced as not using language in the reflective manner in which the field of

family therapy was more and more interested. I experienced that with these boys "doing" was more important than "talking", closeness more important than distance and mutual participation and sharing of activities a more important agenda in the therapy room than talking and meaning making. These experiences led to an interest in developmental psychology and using the formulations of Daniel Stern (1985) as metaphors for psychotherapy with children and adolescents (Sundet, 2004a).

Stern gives an elaborate description of the relationship and nonverbal turn taking between child and care taker through concepts of regulation, agency and intersubjectivity. These concepts and formulations give an opportunity to downgrade the importance of language in psychotherapy and upgrade interaction and mutual participation. Clinically, this leads to a practice fuelled by the idea that the therapist can do anything, within ethical boundaries, to establish turn taking with clients. Turn taking becomes the foundation and start point for therapeutic work which can be nonverbal and action oriented just as much as language and conversation oriented, and results in the perspective that psychotherapy consists of two sets of processes; one called *participation*, the other *reflection* (Sundet, 2004, a, b. c.). The importance for this study is that I entered this project with an affinity for participatory, nonverbally oriented clinical work within an eclectic orientation, and in order to establish such turn taking, following the client was a necessary principle. This led me to seek employment at the Family Unit because I knew that this was a common clinical platform we shared and that I wanted to develop and investigate further. The above description of history and clinical preferences and interests provides important insight into how the data have been read and attended to by the researching clinician in this study. This process of interpretation will be given further explication below.

4.3. The Context

The physical context of this study is a combined day treatment and outpatient unit, the Family Unit, within Child and Adolescent Mental Health in Norway. It has existed for 12 years and at time of writing, six therapists service the practice. The therapist group consists of highly experienced therapists with backgrounds in diverse areas of practice within mental health and social welfare, and with varied professional backgrounds[ii] in different therapeutic methods.

In addition to its physical and organisational location within the hospital, the Family Unit is located within historical traditions of mental health care and

psychotherapy, especially family therapy. The inspirational sources presented above are representative of this context. In addition, the Family Unit became inspired by the work of the Institute for the Study of Therapeutic Change (Duncan & Miller, 2000a; Hubble, Duncan, & Miller, 1999a; Miller, Duncan, & Hubble, 1997) and decided in 2001 to implement a practice for increasing accountability and quality assurance by incorporating the use of two measures for monitoring process and outcome, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) (Duncan, 2003; Miller, Duncan, Brown, Sparks, & Claud, 2003). In line with the inspirational sources of family therapy, this practice was seen to fit with the general idea of "following the client", a founding idea for this unit (Sundet & Øritsland, 2006; Øritsland, 2003).

4.4. The Study

A research project was initiated in 2004 in order to explore characteristics of the practice and experiences of the participants (both therapists and service users) within the practice of the Family Unit.

The research questions investigated are as follows:

1. What are the ingredients families and their therapists identify as essential for a helpful therapeutic practice?
2. How do families and their therapists describe and evaluate the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work?

In addition to the above specified research questions there was the pragmatic aim of obtaining experience and knowledge about doing research on a practice of which the researcher clinician himself was a part. In order to bridge the gap between research and the clinic, the presupposition of this study was that the clinician must achieve first hand knowledge about what research means and at the same time be alert in looking for the distinctive features of the practice under investigation.

4.5. The participants

Four therapists (appendix 1, table 1) and ten families, ten mothers, six fathers and eleven children in total thirty persons, were interviewed (Appendix 1, table 2). In addition to written information the therapists received personal information about the development of the project through the ordinary meeting points of the unit. This

provided potential participants with opportunities for giving responses to the themes, method and aims of the study.

The families were recruited by the therapists and were given both written and oral information about the study (appendix 2). All the families asked except one, who could not find a suitable time, said yes to participation in the project. When a positive response was given to the therapists, the researcher contacted the family and an appointment for the interview was made. The following criteria were used for selecting families for the project:

1. Both families that were in active treatment and families that had finished the treatment.
2. Both single-parent and two-parent families.
3. Both families that the therapists experienced and assessed as being helped at the moment of contact and families that were not being helped.

The last criterion was a subjective assessment undertaken by the therapists. After the analysis the researcher made an assessment based on statements in the interviews of whether the family was being helped and experiencing the treatment as useful or not, and whether or not the family was uncertain or ambivalent on this question (appendix 1, table 3). 7 families were evaluated by the researcher as having been helped and experienced the treatment as useful. For two families, this was not the case. One family reported an uncertain result with ambivalence towards how much the family was helped. Here it was reported that both helpful and non-helpful aspects were present.

Concerning SRS and ORS both families that were assessed by their therapists to experience these measures as useful and families who did not was sought included (appendix 1, table 3). Again, seven families were assessed by the researcher to report that the SRS and ORS were helpful and useful. One family stated that the measures were not helpful and they had refused to use them. Two families were ambivalent with regard to their usefulness. They had again experienced both useful and not useful aspects of these measures.

In addition to the above mentioned criteria of selection, when the families were contacted on the phone by the researcher, the parents were given the choice of an individual interview or an interview as a family. In addition, they were asked if they wanted their children present, and if so, the parents asked them to join. Most of the families chose a family interview except one in which only the mother wanted to

participate, not the father and child. In one family, circumstances prohibited the participation of the children, and one mother did not want her child to participate. In seven of the families, the children were present. The participation of the children varied from active participation in the interview to commenting only when feeling for it and leaving the main part of the interview to their parents.

4.6. Data collection

When they met up for the interview the family members were given a declaration of consent to sign (Appendix 3). The participants were then interviewed for 1½ hours. Interview guides were prepared for both the therapists, parents and children/adolescents (appendix 4). These guides functioned as thematic guidelines for the interviews which were conducted using open-ended questions (Kvale, 1996) as starting points for conversations. These conversations were focused on the two main areas of the investigation; what is helpful therapy and how do families describe and evaluate the use of the SRS and ORS, at the same time allowing both therapists and family members to follow the associations and thoughts evoked by these conversations. As such, the interview guides functioned as a memory tool for the interviewer in helping him assess whether all aspects of the investigated questions had been covered. The interviews were audio taped and transcribed by a professional transcriber and analyzed by the author.

4.7. The analysis

When confronted with choice of method, the researcher identified two extensions of grounded theory as particularly relevant: methodological hermeneutics (Rennie, 2000; Rennie et al. 1988) and consensual qualitative research (Hill et al, 1997). Different aspects of both these groups' thinking and descriptions were appealing to this researcher. Rennie (1994a) states:

> "The framework of grounded analysis allows for the development of particular procedures according to the preferences and circumstances of the individual researcher p. 236).

Taking this as an invitation to tailor the research method to the particular study, the researcher made the decision to use elements from both these methods in producing a method that fit this project. In the following presentation, the choices of different methodological elements and their stated reasons will be clarified:

1. Grounded theory (Glaser & Strauss, 1968) employs theoretical sampling, what Rennie et al. (1988) name theory-based data selection. This involves the selection of new data sources on the basis of the emerging theory produced by the analysis. CQR researchers on the other hand, first define their sample and " …then collect all the data using the same protocol to ensure constancy of response within a homogeneous sample of participants rather than alternating between data gathering and data analysis as in grounded theory" (Hill, et al. 1997, p. 521). The project under presentation had a clearly defined target group: four therapists from the Family Unit and families that the therapists assessed as having been helped and that had not been helped, families about whom therapists were uncertain regarding the result of therapy and that had expressed either positive or negative experiences using the SRS and ORS. The researcher wanted to know the experiences of such a pre-defined group and therefore chose to follow CQR and to not use theoretical sampling.

2. Rennie (1992) advocates the use of one researcher as a viable position. Giorgi (1985) follows this and states that "consensus among researchers is not an intrinsic demand of the method" (p. 13). CQR on the other hand, argues for the use of a team to arrive at consensus judgements and also to use auditors to check all the work. This researcher sees the advantages and disadvantages of both these positions but the aim and agenda of this project was to look into the possibilities, advantages and disadvantages of using one researcher throughout the project. In a small team with high productivity demands it is unrealistic to use more than one person at a time for research purposes. Rennie and Giorgi's position was therefore followed.

3. One problem experienced when reviewing different qualitative methods is that the actual steps of the analysis are very often formulated unclearly. Hill et al. (1997) comments on this experience and states that "determining how to do qualitative study has been difficult because the steps are described only vaguely in the literature …" (Hill et al. 1997, p. 518). A comparison of Rennie et al. (1988) and Hill et al. (1997) lead to the following assessment: Rennie et al. begin by dividing the interview protocols into meaning units. Then they describe a two level condensation process which for this reader was not as detailed as that of Hill et al. (1997). Haavind (2001) describes qualitative research as transformation of data through different steps or levels towards greater abstraction. Conversations are transformed into audio

recordings which are transformed to text which is again transformed into meaning units. From this point on Hill e t al. (1997) describe the transformational process as one of three levels. The first is the organization or coding of text (meaning units in this project) into domains (i.e. topic areas). The next step is abstraction of core ideas (i.e. the "essence" of what the person said) in each domain. Then the data are compared systematically across cases and categories are created. The methodological nomenclature (domains, core ideas, categories) and descriptions given by Hill et al (1997) were judged to provide better guidance because the different transformational steps here are better differentiated and were therefore selected for the study.

4. In Rennie et al. (1988), lower order categories are seen as specifications and properties of higher order categories in which the analysis ends with a top level category called a core category. In the study presented here, lower order categories are seen as specifications of higher order categories but a choice was made not to formulate a top level core category. This is because therapy is seen as an intertwining of several processes; in this study, three main categories are each in turn specified by subcategories. In line with a perspective underlining the importance of tailoring treatment the main categories and subcategories in the models presented here can be mixed and intertwined in different manners and all are not required to describe good therapy.

On two central aspects of the analytical process, methodological hermeneutics (MH) and consensual qualitative research (CQR) follow each other. The first is in the use of constant comparison. Rennie (1994b) writes:

> "The text of a given protocol is broken into units of analysis (meaning units) and summarized. The MU summaries (…) are compared within and between protocols in the search for communalities of meaning,… The communalities are given labels, referred to as categories. The categories are compared within and between protocols in further searches for communalities. Communalities among categories are conceptualized as higher order categories. This conceptualization gives rise to a hierarchical structure, with the categories at each level serving as the properties of the category subsuming g them" **(**p.429).

Although the nomenclature for the analytical steps is different between MH and CQR (see above) the process of constant comparison is given equal weight in these two methods and retained in the same manner in this study.

The second aspect is the question of saturation (Rennie et al 1988). Hill et al. again uses another name, stability of findings, and gives a more elaborate description than Rennie et al. (1988). Saturation or stability of findings is reached if "…new cases do not change the results " (Hill et al, 1997, p. 552). Hill et al (1997) describe a process in which a number of cases are collected (12-15) and a preliminary analysis of a subset of these cases (8-12) is performed, and "…if the remaining cases do not change the results substantially, the findings can be considered to be stable" (p. 553). In the analysis of the therapist interviews the number of interviewees was fixed (no others to interview) so the question of saturation did not apply. In the family interviews a preliminary analysis was performed with 8 families. The two successive interviews did not supply new categories and saturation or stability of findings was concluded.

Rennie (1994a) states that the size of the meaning units varies and in the beginning, and describes looking for fragments of text ranging in length from a single sentence to a few lines of text. He continues:

> **"**As the analysis proceeded I came to prefer to work with larger blocks of text – text that encompassed mini-themes in the client's reported experience. These blocks were usually several lines in length but sometimes covered a page or two of transcript. Naturally these larger meaning units contained comparatively more meaning than the smaller units, necessitating more categorization pr. Unit. (p. 236)

My experience in this study is similar to that of Rennie. Appendix 1, table 4 and table 5 give an overview of the number of meaning units for each therapist and family. A total of 484 meaning units constitute the total material of the analysis.

Due to the use of constant comparison during all the steps of the analysis, the number of domains in use varied but the following domains came to organise the material that was turned into core ideas. In relation to the first research question concerning the perspectives of the families and the therapist on what constituted "good therapy" the following domains were used: manner of therapeutic work, effects of therapeutic work and understanding of therapeutic work. The second question concerning the use of and experience with the SRS and ORS utilised the following:

instructions, manners of use, and evaluations. Lastly, a domain for themes not related to the research questions was established.

In line with Rennie's statement that bigger meaning units contain more meaning than smaller units, the number of core ideas increased. Appendix 1, table 6 and table 7 give an overview of numbers of core ideas connected to each therapist and each family. A total of 1201 core ideas were formulated. Using constant comparison on this set of core ideas, categories were extracted and formed. In order to keep track of each idea and keep ideas connected and grounded in the data from the interviews, each idea was formulated in a short hand version based on the idea of a "web address". Rennie et al. (1988) describe using index cards for recording the condensation of meaning units. In this study this was achieved by using Word for Windows and the index card was substituted with a sequence of concepts fashioned after the idea of a "web address". The main reason for formulating these web addresses was ease of manipulation of abbreviated versions of core ideas. Working within Word for Windows using the copy and paste function, the researcher clinician was able to try out the addresses in different clusters whereas addresses retained their specified place within the different interviews. This process allowed maintenance of the close contact between the core ideas and meaning units.
An example is given below:

MU20F1 (meaning unit 20, Family no. 1)

(I=interviewer, M=mother, F=father, S=son)

I: The one we call SRS that evaluates how we have worked together, there is a question about whether the therapist has managed to listen to you, and whether we have worked on what we should work on in the manner we had decided.

M: The measure shows this clearly. I gave signals to therapist A, I scored low, that I did not think that day had given answers that I wanted. I had not been given the opportunity to talk about what I wanted.

I: When you used the measure for this did you experience yourself as heard and did the therapist take this into consideration later, the next session for instance?

M: Yes, I think he did.

F: Yes.

M: I don't know what S means about this?

I: Did you use the measure S and were there times when you were not heard?

S: Yes, I used the scale and I was heard.

Theme:

How the therapist worked; listening, working with what one should in the manner one should, and if the scales were used to give feedback on this issue.

Domains:

Therapeutic work

Core idea: Therapeutic work/manner of working/listens to (MU20F1)

Manner of use

Core Idea ("web address"):

Measure/manners of use/feedback tool/tell the therapists (MU20F1)

Measure/manners of use/feedback tool/evaluation/was heard by the therapists (MU20F1)

Categories were created by clustering core ideas together (see below). This was done by using the method of constant comparison. As stated above, two levels were chosen to express categories. The sub categories constitute the properties defining a main category. For instance in the example above the core idea; Therapeutic work/manner of working/listens to (MU20F1) is grouped together with the following core ideas:

Therapeutic work/manners of work/listens to (MU20F1)

Therapeutic work/manners of work/they listen when I tell, they don't deny it (MU127F5)

Therapeutic work/conversation/listen to everybody without regard to age (MU176F6)

Therapeutic work/manners of work/conversation/give everybody room (MU169F6)

In the analysis these became part of the sub categories asking questions, giving time and structuring the work which again were properties of the main category; "the helpful conversation". The common feature in these examples is "to listen" which provides room and time. Time is another common aspect found in other core ideas clustered together with the above subcategories in the analysis.

4.8. Reflections on method

Elliott et al (1999) suggest guidelines for improving the quality of qualitative research. These are divided into guidelines shared by qualitative and quantitative research and those especially pertinent to qualitative research. The study presented in this dissertation has tried to follow these guidelines. Guidelines shared by both qualitative and quantitative approaches will be attended to first (appendix 1, table 8):

1. Explicit scientific context and purpose

Descriptions of both the inspirational sources and relevant findings from the field of psychotherapy research have been presented and the research questions have been clarified. In the following the relationship between the research questions and the research field will be given a brief explication. The primary goal of both efficacy and effectiveness studies within psychotherapy has been to establish the actual outcome of psychotherapy (Lambert and Ogles, 2004). Process oriented research has had as its central agenda linking process aspects, factors and events to the actual outcome of psychotherapy (Orlinsky, Rønnestad and Willutzki, 2004). Quantitative methods, in particular randomised clinical trials, are the primary methods used in establishing these relationships. Hill (2006) points to some of the advantages of qualitative research in understanding the felt experience from the individual's perspective. It is discovery oriented, suited to examine complicated phenomena and useful to

clinicians. An important issue is that the participants can tell their story without the constraints that quantitative research can impose.

In this study the word "helpful" points to the experiences of the participants chosen for investigation. In a sense, "helpful" points to the inner and subjective experience of some of the same phenomena as the word "outcome" in quantitative research. Thus the comparison below between the findings of this study and the findings within psychotherapy research can illuminate aspects not touched upon in this study nor the research field in general. One such aspect is what is happening within the clinical sessions when feedback is used and asked for within patient focused research (Aveline, 2006). The two research questions of this study are related to each other in the sense that their answers may shed light on whether and how monitoring of process and outcome and the use of feedback are embedded in a broader description of helpful therapy and how this is related to the field of psychotherapy research. The discussion below will touch upon these relationships and connections.

2. Appropriate methods

An adequate method for answering the research questions has been chosen and presented.

3. Respect for participants

The researcher has demonstrated transparency in relation to all intentions and aspects of the research, has fully informed the participants and followed established ethical standards and procedures[iii].

4. Specification of methods

Specifying the method in this study involves making transparent which elements have been used from Methodological Hermeneutics and Consensual Qualitative Research respectively (see above).

5. Appropriate discussion

A discussion of the implication of the research data and understandings will be given below.

6. Clarity of presentation

When transforming this study into three written manuscripts, clarity of writing has been a main goal for the author through exposing the material to the scrutiny of the supervisor of the dissertation, several colleagues and a professional language consultant.

7. Contribution to knowledge

In the discussion and suggestions for future research below, arguments are given for how this study contributes to knowledge production within mental health and psychotherapy.

Next, guidelines especially pertinent to qualitative research (appendix 1, table 8) will be attended to (Elliott et al, 1999):

1. Owning one's perspective

This concerns the specification of the researcher's theoretical orientations and personal expectations, both those known in advance and those that arise during the research (Elliott, et al. 1999, p. 21). Theoretical and clinical preferences and perspectives have been made transparent in *3.2. The Researching Clinician*. In the following some ideas concerning language are elaborated on in order to clarify the epistemological and ontological position of the researching clinician.

As a clinician working in the intellectual atmosphere of the eighties and nineties within family therapy with its focus on postmodern and poststructuralist ideas, my personal perspective on language grew out of the meeting points between clinical work and theoretical studies. Let me briefly give a description of this view of language and underline that this is a heuristic description intended to be helpful to the clinician and not to answer philosophical and theoretical questions about language. At the same time these heuristics are definitely connected to philosophical ideas that have consequences for the perspective of science inherent in this dissertation. Some of these connections will be made explicit.

The persons who enter therapy are suffering. This suffering is real, just as real as the rocks, tables, computers and persons that exist around us. Suffering speaks to existence and the real. Therefore to deny the real is to question suffering and its ground. Central to therapy is to affirm what is real. Affirmation is at least partly a verbal process. One aspect of language is to affirm the real. How does language do

this? In my view, it does this by being a pointer. Language, words, are used as tools for pointing to that which is real. Traditionally, language has been seen as representational; language mirrors the real. To me, there is a difference between mirroring the real and pointing to the real. This means that by talking about the real and realism one does not mean a mirroring or doubling of that which is pointed to. Rather, the real is pointed out, that is; affirmed. Language is a rich and heterogeneous field. The real can be pointed to in different ways. This means that the real can be brought forth in different manners. Stated differently, the real can be constructed in different ways. These two functions of language can be called *the referential* and *generative* function of language.

Language is connected to two central areas. Firstly, it is realised through the nervous system. The nervous system and the constitution of the human body make language possible. The other area concerns language as a coordinated phenomenon. Language is intrinsically social in the sense that the meaning of words is always embedded in coordinated activity between humans. The meanings of words are established within a community of language users. The meanings of words are always connected to their use. These two areas of human functioning point toward two other functions of language in addition to the affirming and generative aspects. The communal and coordinated aspects or functions of language point to language as *communication*. The embodiment of language, its embeddedness in the body and nervous system also makes language *expressive* of the states of this body and nervous system. Language then is a heterogeneous phenomenon that exists in and is made possible through four interdependent functions: reference to and construction of the real, processes of communication and through bodily expression. Therapy must work within all these functions. Through language we seek to affirm the real, bring it forth in ways that fit with or are helpful to users through communication and expression of bodily states such as feelings, thoughts, intentions, preferences, hopes and other human phenomena.

The question of epistemology in family therapy has usually been viewed as one of the distinction between realism and constructionism (Flaskas, 2002; Hoffman, 2002). The above heuristic description of four different functions realised when language is used speaks to a position on epistemology that could be called *constructionist realism.* In this study this perspective has been found to have a close

kinship with methodical hermeneutics (Rennie, 2000) and the points described above provide an explication of why this method has had a dominant place in this study.

Both within science in general and the field of family therapy one of the major challenges of how to view language has come from social constructionism (Gergen, 1994). The above heuristics are closely related to social constructionism. First, what is named a generative function connects to the idea that the real is constructed through social processes and that one cannot escape language; "Once we attempt to articulate 'what there is',…,we enter the world of discourse" (Gergen, 1994, p. 72). At the same time the clinical situation and experience of the researching clinician is that the word "real" is of immense importance to the participants of psychotherapy. In this project this is pointed to by both the families and therapist through the importance accorded to being believed in (See article 1). Gergen describes social constructionism as "ontologically mute" (Gergen, 1994, p. 72) and therefore as not affirming the real in an ontological sense. In the clinical situation, especially through the importance of believing the other, affirmation of what is real becomes central to the therapeutic endeavour. Affirmation of the real, meaning that which is pointed out through the words used, involves acknowledging what is talked about as something that actually does exist independent of any description, while it is accessible only through some kind of description. The heuristics above seek to express that language both points to what is real and what is real exists independent of words, and that meaning is generated or constructed in different ways dependent on the language used. Following social constructionism, this construction or meaning making is again dependent on social processes, on communal coordination, and on communication. In addition, this construction is not only connected to social processes, but also to internal psychological and biological processes. Lakoff and Johnson (1999) show how the meaning of words and the metaphors we use are directly connected to the experience of bodily processes and postures in the world. Meaning making then is not only dependent on the language we use and the social and cultural processes of which we are a part. It is also dependent upon our inner experiences, feelings, emotions and bodily states. Their expression also colours the meaning we make.

2. Situating the sample

"Authors describe the research participants and their life circumstances to aid the reader in judging the range of persons and situations to which the findings might be relevant"(Elliott et al., 1999, p.221). *3.5. The participants* addresses this point.

3. Grounding in examples

Throughout the presentation of results examples are used to exemplify and specify the categories and understandings of them developed through the analysis.

4. Providing credibility checks

Elliott et al (1999) identify four strategies for checking the credibility of the categories developed in a study: (a) checking the understanding of the categories with the original informants or others similar to them; b) "using multiple qualitative analysts, an additional 'auditor' or the original analyst for a 'verification step' or reviewing the data for discrepancies, overstatements, or errors (c) comparing two or more varied qualitative perspectives; or (d) …triangulation with external factors (e.g. outcome or recovery) or quantitative data" (p. 222). The primary strategies chosen in this study were (a) and (d). These were implemented in the following manner:

In relation to the therapists, strategy (a) was implemented first by presenting and discussing the categories in the traditional meeting points of the Unit. Secondly, the therapists were present when the researching clinician presented the material to other therapists external to the unit in a teaching context, and thirdly, the researcher clinician was interviewed regarding the categories in a second teaching context and the interviewed therapists functioned as a reflecting team in this interview. Through this meaningfulness of the categories that constituted the therapist perspective was confirmed.

In relation to the families, the ideal situation would have been to do a check with at least some of the interviewed families. Due to practical constraints and circumstances this was not possible. Another strategy was therefore chosen. The therapists asked families that had been through treatment on the unit if they were willing to meet the researcher clinician and together look at the meaningfulness of the categories. Two families were asked and said yes. In both these families the mother and one child were present in the interview. One of the families was a single parent family. In the other the father could not be present. The researching clinician gave

first a short lecture presenting the categories concerning both the therapeutic work of the unit and the specific use of the SRS and ORS. Both mothers reported great meaningfulness of the categories presenting the treatment of the unit. One of the mothers, after the lecture, exclaimed spontaneously that she was annoyed with the researcher because he must have talked with her therapist beforehand about what had happened in her family's treatment. The description "revealed" this cheating through its precision. The researching clinician underlined that he had not talked with her therapist about what had happened but that this was the model created through interviewing the ten families. The meaningfulness of the categories produced concerning the SRS and ORS was confirmed through such conversations.

Both families interviewed agreed on the meaningfulness but put weight on different aspects as most important. The first family underlined the importance of the transparency of the therapists about their professional knowledge and the importance of structure. The other family underlined the importance of being listened to and that the therapists took part in opposing the violation they had been subjected to by a public agency.

The second strategy (d) was implemented through both reporting findings from the field of psychotherapy research (3.0) and relating these to the findings of the study. This last part is presented below in 5.0 Discussion.

5. Coherence

The recommendation of the method employed is that categories and understandings are represented in ways that "…achieve coherence and integration while preserving nuances in the data. The overall understanding fits together to form a data-based story/narrative, 'map', framework, or underlying structure for the phenomenon or domain" (Elliott et al., 1999, p. 223). Here the researcher has tried to remain close to the nuances in the data but at the same time has been reluctant to formulate a model or theory that specifies too much about the connections between the different categories developed. The aim has been to identify descriptions through naming categories and pointing to the fact that they are interrelated; however, it has not been the aim of this project to create theories about these relationships. This has also to do with a belief held by the researching clinician that theory very easily become determinate for practice. The attitude in this study is that theory in the research context primarily should function as a source for hypothesis testing and investigation,

and in the clinical domain as a source of suggestions for actions and ways of being with clients. The effects of these ways of being together should not be clarified through theorizing but through actual investigation in the clinical domain. The SRS and ORS have been investigated in this study, and this investigation has lead to suggestions for further practice.

6. Accomplishing general vs. specific research tasks

The distinction attended to here is between a general understanding of a phenomenon and the understanding of a specific case. Central to both concerns is a statement of the limitations of the research project. First of all, this study is a study of a specific case; the work of and within the Family Unit. Second, through interviews on this practice categories concerning what ten families and their therapists described as helpful therapy were generated. The family perspective points beyond the Family Unit in the sense that these families could be met in ways that reflect the content of these categories in another context; however, the family perspective described here can not necessarily be applied directly to families other than these ten. This is one main limitation of this study. The therapist perspective describes a preferred and intended practice but whether this practice is actually realized has not been investigated. The overlap between therapist and family categories suggests that the therapists follow their intended practice, but gives no evidence to support this. Questions of outcome, causation and correlation between categories are far beyond the scope of this study. In *5.0 Discussion* the developed categories will be discussed in relation to the field of psychotherapy research. The fit of the categories with the results of research in this field will be important in evaluating their usefulness in other treatment contexts.

7. Resonating with readers

The last point of Elliott et al (1999) concerns whether or not "(t)he manuscript stimulates resonance in readers/reviewers, meaning that the material is presented in such a way that readers/reviewers, taking all other guidelines into account, judge it to have represented accurately the subject matter or to have clarified or expanded their appreciation and understanding of it" (op. cit. p. 224). The researching clinician as writer seeks to fulfil these guidelines by clarifying what has been done; however, the final assessment is in the hands of the reader, just as in monitoring therapeutic

practice; the therapists are in the hands of clients and family members.

In addition to the above this researcher has had as an important concern the fact that he is part of the practice studied. Two concerns have been important here. First, how to use this insider position in a constructive manner, and second, how to increase the possibility of seeing and discovering something new and not only "rediscover" what is already known within this insider perspective. Constructive here means to balance the realist and relativist aspects of the method of analysis, to use the subjectivity of the researcher to bring out the distinctions inherent in the material and to use the knowledge and insider perspective of the researcher as a guide to discover, point out and reveal the various distinctions, aspects and categories that exist in the material. This implies a reading strategy for the interviews in which the researcher uses his insider knowledge and general knowledge to point out the possible categories existing in the material. It is the material that constrains the categories created but they are co-constructed given that it is the knowledge and position of the researcher that allows them to be discovered. This does not mean to bracket the position of the researcher but instead to use it actively as a tool for making distinctions and defining possible categories. Two aspects of the subjectivity of the researcher are particularly relevant here. First, his experience of the known, and second, his experience of the not known. The first is the use of familiarity as a reaction that reveals distinctions. The other the use of non-familiarity and the reaction of surprise as a tool for identifying the new and not-yet-thought of.

As an example, when reviewing the categories it becomes clear to this researcher that the sub category "asking questions, giving time and structuring the work" (Article 1) was evoked by statements that fell within the familiar about questions and time. At the same time "structuring the work" incorporated statements that were more connected to the unfamiliar in that these therapists, including the researcher, in accord with their inspirational sources, were reluctant to work with preplanned or manualized structures. Statements that concerned participation in the form of activities and doing things with the families fell into the domain of the familiar. At the same time, the presentation of statements of expectation for therapists to have knowledge and participate with this knowledge could be seen to break with the ideal of the inspirational sources of not taking an expert position. The feelings generated in the researcher when meeting such statements highlighted the issue of therapists' knowledge use as an important aspect of helpful participation.

On the other hand, the sub category "nuancing the nuances" is based on part of an interview that evoked feelings of surprise and lack of understanding which in turn led to the interpretation of this event as an example of the non-pathological gaze. The sub category of generosity evoked feelings traditional in Norwegian culture articulated through "the Law of Jante: "one should not believe too much in oneself". This reaction led to the realization and interpretation that for this Unit, generosity is a central value and part of this involves acknowledging that the evaluation of acts as generous is always done by the one these acts is directed at. Other examples of how knowledge of psychotherapy research led to sensitization towards specific statements concerns the subcategory of "giving of oneself". When the mother in family 2 makes the following statement "They are giving much of themselves. You feel it", this directs the researcher directly to research findings about self-disclosure (Hill & Knox, 2002) and the sub category "giving of oneself" becomes a way of connecting to these findings in this particular project.

This reading strategy can also be found as part of the actual interviews. Consider the following:

> *Therapist B.: Lately I've thought about it a lot and I've wondered how we can do it because several have mentioned it as a problem. If we are to measure whether there has been a change or not, they don't remember where they placed themselves the last time, and I have said, say how you think the last week has been and if it feels a bit better, or a bit worse and then mark that without thinking about whether you remember the last score or not. But I see that at least some don't find it that easy.*
>
> *Interviewer: No.*
>
> *Therapist B: Some sit for a very long time with it.*
>
> *Interviewer: What I do believe we must look at is the aspect of measuring and I'm used to the fact that when you are to measure something like this you will never be fully finished.*
>
> *Therapist B: But you're sitting there with the ruler and measuring, aren't you?*
>
> *Interviewer: Yes, I do that when they have finished marking the scales, but I'm saying that I think I downgrade the measuring aspect of it, and it has more to do with me being given an opportunity to ask the question, " what does this mean?".*

When the interviewee raises a question around the difficulties experienced when family members become caught up in questions of "correct" measurement, the interviewer certainly can been seen here to leave the role of interviewer and to become an adviser giving guidance about downgrading the measuring aspect and upgrading the opportunity for asking questions. In the interviews, especially in the interviews with the therapists, there are sequences in which the interviewer can be seen to leave the role of interviewer and instead become a participant with opinions and views like the persons he is interviewing. In this way, embedded within the interview there exists another interview in which the interviewer responds to his own questions or the answers of the interviewees. I have called this metaphorically "the N+1- interview". There are four interviews with the therapists. Embedded in this is a "4+1=5"; a fifth interview, revealing aspects of the ideas, perspectives and preferences of the interviewer. The example above shows how the interviewer, in a clinical situation in which the family members are caught up in questions of correct measurement, might downplay this concern and instead use the family's response as an opportunity for questions. This again reveals that this interviewer is especially responsive to answers identifying the SRS and ORS as opportunities for question asking. In addition, the responses of the interviewer can again be used as invitations for the interviewee to comment upon which can again illicit the hidden or implicit knowledge of the interviewee.

"The N+1-interview" is a strategy applied in order to keep in contact with and acknowledge how ideas, perspectives and preferences of the interviewer/researching clinician are definitely an aspect of the categories. This does not mean that their place in the study is determined solely by the researching clinician but that when they are revealed in the material they are more easily picked up by this researching clinician. The presuppositions of the interviewer contribute to creation of something distinct, both through the interview and the analysis, while other aspects and experiences are marginalized. The best test of whether the interview has managed to convey the informants' thinking and practices is that they recognize themselves in the product.

4.9. Ethical considerations

Following Kvale (1996), qualitative research on human beings imposes three ethical demands on the researcher; informed consent, confidentiality, and responsibility for consequences of the research. Informed consent was grounded in this study both in written and oral information and responding to questions from the informants throughout the whole study. Confidentiality has been maintained. Private and other identification information applying to the families has been omitted from the study. Concerning the therapists, the specific context and size of the Family Unit can in some instances make it possible for people who are familiar with the unit to identify individual therapists. The rule was therefore that any information that assessed as posing possible ethical or personal dilemmas for the interviewee was omitted from the study. This is also related to Kvale's third demand of responsibility for consequences. Any response or statement from the interviewee that could be assessed as harmful for this person or others was omitted. This is related to the specific context of this study. The position of the researcher is, as stated above, an insider position. In relation to the therapists this meant he was a colleague of the interviewees. In relation to the families, "insider" meant the researcher was inside the practice studied while outside the position of the family. Concerning the therapist-researcher relation, this meant a dual role as researcher and colleague for the researcher with possible ethical and collegial consequences for both parties involved. In this study, the researcher has attempted to deal with this through monitoring effects of the research process in the existing professional meeting points of the Family Unit and relationship have been attended to by the researcher through the use of monitoring questions for his colleagues/interviewees. In relation to the families, it was decided that the therapist should not interview families he was currently working or had worked with. In one family, the researcher had participated in some meetings but had not had treatment responsibility. This was discussed with the family who stated that this was not hindering them in participating in the study. In addition, for all the families but particularly this family, it was underlined that the interview could be terminated at any point and its results would be disqualified and taken out of the study on their request.

4.10. Concluding remarks concerning method

Kvale (1996) formulates the concept of validity within a postmodern frame. He distinguishes three approaches to validity: validity as quality of craftsmanship, communicative validity and pragmatic validity. The above explication of criteria by Elliott et al (1999) seeks to implement Kvale's first approach. By applying a qualitative method that underlines rigor, grounding the analysis in data and the use of reflexivity (Rennie, 2000, 1995), and seeking to realize these processes to one's best ability, the ideals of validity as quality of craftsmanship have been sought to be met.

Communicative validity "...involves testing the validity of knowledge claims in a dialogue" (Kvale, 1996, p. 244). This has been attempted through the different credibility checks described above. In addition, the discussion (below) can be read as a dialogue between the research findings from the general field of psychotherapy and the findings of this specific project. In this discussion both points of similarity and points of difference between these two foci are discussed. In addition this researcher has presented the findings at a series of conferences and teaching contexts, receiving responses that speak to the meaningfulness of the categories of the project.

Pragmatic validity deals with "whatever assists us to take actions that produce the desired results" (Kvale 1996, p. 248). For most of the period of this project, the researcher has been working in the Family Unit participating in the practice described in the project. This has had the consequence that parts of the researching clinician's practice have been given support, such as always keeping heightened attention on the "helpful relationship". Aspects that previously were not given as much attention, such as the use of technical and psychological expertise, have gained increased attention and there is heightened awareness of the importance of violations caused by social welfare and health care systems, of the experience of client vulnerability and of how therapists can be potential pathological influences. In addition, reports from colleagues underline the pragmatic utility of these categories.

Reliability concerns how consistent the results are (Kvale, 1996). One aspect of this is the issue of leading questions. Stated differently, "Can the interview results not be due to leading questions?" (Kvale, 1996, p. 157). Although documenting and accepting that the wording of a question can shape the content of an answer, Kvale continues: "…it is often overlooked that leading questions are also necessary parts of many questioning procedures; their use depends on topic and purpose of the investigation" (Kvale, 1996, p. 158). In this study, the metaphor of the "N+ 1"

interview tries to catch the fact that the interviewer is using his inside knowledge to bring out hidden or unexplicated knowledge on the part of the interviewee. In addition to this, the interview has followed Kvale's (1996) description of employing leading questions to check the reliability of the interviewee's answers and to verify interpretations and understandings of the interviewer.

5.0. Results

5.1. Summary of article 1

Collaboration: Family and therapist perspectives of helpful therapy

The aim of the article is to examine how four therapists and ten families from a family therapy unit in Norwegian Child and Adolescent Mental Health describe helpful therapy. In addition, the article concerns the differences and similarities between the perspectives of the families and therapists, and what happens to guiding ideas from postmodern language oriented family therapy in this context?

A qualitative interview study was carried out with four therapists and ten families. Data was analysed using a modification of grounded theory. Theoretical sampling was not employed as the target group was pre-defined. Saturation did not apply to the therapist interviews, and was reached after ten families were interviewed. A participant check was done in order to secure the different voices and the variety of perspectives in the material.

Two sets of categories, one for therapists and one for the families, each specified by sub categories, was generated and constitutes the therapist and family perspectives of helpful therapy. By attending to the similarities between the two sets, three concepts have been defined. These are; conversation, participation and relationship. Support for these findings is found in psychotherapy research. Both perspectives point towards expansion of the original guiding sources of the unit. It is suggested that this is connected to the particular focus on behavioural problems in the context of the unit. It is concluded that the language oriented models must be expanded to include action oriented forms of therapeutic practice and that the professional knowledge and skills of therapists do not stand in opposition to the non-expert and not-knowing position of these models when therapy is seen and implemented as a collaborative venture between families and their therapists. The imperatives here for therapists concerning both research and training are to generate and access as many skills and knowledges as possible and to do this within the areas highlighted by the concepts of conversation, participation and relationship.

5.2. Summary of article 2

Collaboration: Working with process and outcome

The aim of this article is to explicate how families and their therapists evaluate and describe the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work. The practice studied was a local practice of a family therapy unit in Child and Adolescent Mental Health and was guided by the work of the Therapeutic Institute for the Study of Therapeutic Change, patient-focused research and ideas from postmodern language oriented family therapy. The central research questions were: What are the important ingredients that families and their therapists identify when monitoring process and outcome in a therapeutic practice?, How is this practice evaluated?, and How is it related to the inspirational sources of this unit?

A qualitative interview study was carried out with four therapists and ten families. Data was analysed using a modification of grounded theory. Theoretical sampling was not used as the target group was pre-defined. Saturation did not apply to the therapist interviews and was reached after ten interviewed families. A participant check was performed in order to secure the different voices and the variety of perspectives in the material.

Categories were generated both for the questions of evaluation and of how these measures were used. Both perspectives concluded that these measures are feasible and should be used but that there are possible disturbances and difficulties that should be attended to. In the analysis of the therapist data, six conversational types were identified, and in the analysis of the family data four conversational processes were identified. The evaluation measures were regarded as tools with therapeutic functions as conversational aids. This is in addition to their intended function as tools for monitoring process and outcome and supplying feedback to therapists. Working with process and outcome in this manner means to establish and strengthen collaboration between service users and therapists. It is concluded that the findings of this study support the centrality of collaboration and the role of the measures in expanding and securing such collaboration. Further, through monitoring practice, research based therapy and post modern language oriented forms of therapy are brought into a productive contact.

5.3. Summary of article 3

Therapeutic collaboration and formalized feedback: Using perspectives from Vygotsky and Bakhtin to shed light on practices in a family therapy unit.

The aim is to reflect upon the findings of our study through concepts and perspectives from the work of Vygotsky and Bakhtin. The family therapies that have inspired the practices reported on are sceptical towards the technical aspects of therapy, fearing objectification of the service users. The aim here is to show that the use of tools can be an opening for collaboration between families and their therapists.

Vygotsky's concept of mediation concerns reaching a goal through indirect means. The study reported on uses standardized measures as tools to supply feedback on process and outcome and for setting up conversation types and processes. These mediate new actions and understanding and become important aspects of therapy as a collaborative venture. For Vygotsky, tools are used in interaction with the social environment in a cultural and historical situation. The interaction is internalized and becomes mental phenomena. Bakhtin's concepts of dialogicality supplement this perspective. In dialogicality, when a person speaks an utterance, at least two voices are present simultaneously, the voice of the one speaking, and the voice of the one being addressed. The voice of the other is implied in the original spoken voice. This underlines the idea that there are multiple ways of representing reality leading to an acceptance of heterogeneity in how reality can be described and that privileging one voice over another is an act of power.

The work of the Family unit rests partially on the idea of reality as heterogeneously described and the reluctance to privilege descriptions outside preferences of the service users. Therapists and families create new options and possibilities through collaborative actions. A special event is when there is a situation of no-change and lack of development. The concepts of the zone of proximal development and the metaphor of scaffolding illustrate how a collaborative situation can be set up to create new developments for both families and therapists. It is concluded that therapeutic practice must be monitored in each single case and that feedback can be implemented within a practice guided by post-modern, language oriented family therapies. Further, it is concluded that it is the responsibility of therapists to have access to methods and techniques that can function as such tools.

6.0. Discussion

In the following discussion, five areas will be touched upon. First, the findings of this study will be compared with those discussed in the review of the field of psychotherapy research. Second, the use of the SRS and ORS and the practices associated with these measures will be attended to. Third, the clinical practice that the findings and comparisons speak to will be specified. Fourth, this discussion will converge on the question of what is psychotherapy, with a suggested definition that fits the findings of the study. Lastly, areas for future research will be pointed out.

6.1. Comparing the findings of this study to others in the field of psychotherapy

The APA (2006) suggests that the individual therapist, the patient, the therapeutic relationship, the question of theory specific ingredients versus common factors, and the monitoring of outcome as central research topics of psychotherapy research. The presentation above attends in addition to the same issues in relation to children, adolescents and families. The results of the study presented in this dissertation are communicated as categories representing the perspective of the families and the perspective of their therapists. Article 1 extracts three concepts: conversation, participation and relationship, expressing the overarching similarities between these descriptions. These and the specific ingredients of the two perspectives will be used in the following comparison.

Psychotherapy research (Lambert, 2004) confirms the importance of the therapeutic relationship, especially the therapeutic alliance, with a heightened attention to collaboration between service users and therapists (Horwath and Bedi, 2002). "The helpful relationship" parallels these findings, and in both perspectives the emotional bond is connected to a suggested inseparable trinity; listening, taking seriously and believing the client. The sub category "generating collaboration" includes, in addition to the alliance, proper conduct in which sincerity combined with lack of prejudice towards the family are of utmost importance. This means to behave towards the family as an ordinary person and the refusal to establish oneself in a top down position. This is in line with the recommendations of Burns et al (1999) for how therapists should relate to the parents of their clients. In the therapist perspective, this is expressed within the main category "to be where people are". Here "generosity" supplements "the helpful relationship" in expressing the

importance of always valuing, including and accepting that which the service users present.

Both these perspectives receive confirmation from the research on self-disclosure, which is seen as a promising element of the therapeutic relationship (Hill & Knox, 2002). "Giving of oneself" and "blurring the differences" point to the importance of the therapist making him or herself visible as a person, and that events and stories from personal life are used in shedding light on the life of the family members.

The work of division 29 of the American Psychological Association (Norcross, 2002a) states the importance of tailoring treatment to the individual client. Within the presented study, tailoring implies fitting therapy to the whole family. "To be where people are", "being flexible" and "having many possibilities" all point to the necessity and importance of tailoring treatment to the needs and potentials of the family. This goes beyond fitting a specific method to the client and towards fitting the whole therapeutic context to the family; that is, where, with whom, when, how and in what quantity therapeutic ingredients must be fitted to the family. Psychotherapy research concludes that both therapist and patient characteristics have impact on outcome (Beutler et al., 2004; Clarkin and Levy, 2004). The results of our study highlight two important features of this conclusion. First of all, that these characteristics must be matched, that is; the therapy must be tailored to the patient characteristics and preferences. Second, this tailoring is the responsibility of the therapist. In article 2 this is underlined through the necessity of taking feedback seriously and especially when alliance ruptures or detrimental development is identified. Baldwin et al (2007) also state that these therapeutic issues actualize therapist change.

In "the helpful relationship" one aspect appears to be particularly strong in our study. This is the fact that the helping system and its labourers are potentially toxic factors for some families through behaviour that violates the families and creates disparagement and degradation. That therapy can have detrimental effects is well documented within patient- focused research (Lambert, 2007) and there are reports on the importance of client advocacy within qualitative research (Gehart & Lucas, 2007). These reports give clear support for the importance of the sub category of "fighting violation, disparagement and degradation". It seems safe to conclude that there exists

good support within psychotherapy research for "the helpful relationship" and the related therapist category "to be where people are".

One of the big questions within psychotherapy research is how much it matters what therapists do and what part techniques and manners of working play in the outcome of psychotherapy (Ogles, Anderson, and Lunnen, 1999; Lambert and Ogles, 2004). As stated in the above review, theory driven methods are deemed efficacious, but it is an open question whether or not this points to specific factors or common factors. Psychotherapy has traditionally been "the talking cure". The generated perspectives of this study focus on "the helpful conversation" and "the lingering conversation and the big tool box". The use of questions combined with allowing enough time to linger on questions and answers is central for both families and therapists. Cooper (2008), reviewing the research on questions, cites Williams (2002) in concluding that open questions are rated as moderately helpful while closed questions are given a low helpfulness rating. It is also concluded that questions can be challenging in that they can be opportunities for deepening of experiences, but that it is important not to use questions too much. In the results from this study, questions and the opportunity to linger on what the question elicits are underlined as very important, but it is made clear that sooner or later this lingering must lead to specific manners of structuring the work. For the families the questions must lead somewhere and they must be asked within "the helpful relationship". For the therapists "the lingering conversation" also must lead somewhere in the sense of specifying and helping the therapist choose ways of working from their "big tool box".

Talking in therapy thus is both an open ended lingering process and a targeting and structuring process. "Giving and receiving feedback" are important for the families, especially receiving feedback. One of the recommendations from some of the families in this study is that the Family Unit can work more on giving negative feedback to the families. They want help in identifying what could or should be changed. When receiving feedback it is of the utmost importance that therapists take this process seriously and change according to the feedback. This result reflects and is given strong support in patient-focused research. The evaluation of the SRS and ORS by both families and therapists confirms this.

The families also underline the importance of "reformulation". This concerns both reformulation of specific events and perspectives, but can also be interpreted as an underlining of the importance of creating new meaning. If defined as a form of

interpretation, reformulation is supported by research when connected to relational matters on condition that one avoids high levels of transference interpretations. Within brief therapies "interpretations should primarily focus on the central interpersonal themes for each patient, namely, the quality or accuracy of such interpretations" (Crits-Cristoph & Gibbons, 2002, p. 298). Cooper, again referring to Williams (2002), shows how the use of interpretations, broadly understood as processes of discovering new connections, perspectives and understandings has compelling evidence to support it. This is what the families underline within the sub category of "reformulation". Seen together with the therapist perspective that underlines the lingering conversation and the use of questions, the above is seen as supportive of conversation as an overarching concept.

Connolly Gibbons, Crits-Cristoph, Barber and Shamberger (2007) conclude that the quality or accuracy of interpretations might be more important than frequency of interpretations. Consistency with the formulations of the patient is an important part of quality. In the findings of our study, high quality interpretations are defined as fitting with the perspectives and theory of change of the service users. An important question becomes what helps the therapists in making adequate interpretations or reformulations? In our study the "the helpful participation" and "to get a taste of it" point to possible answers to this. The therapist perspective, underlining "sharing experiences", "participating", attaining mutual definitions" and "blurring the differences", can be seen to point to the fact that understanding the family is grounded in the therapists having similar experiences as those of the families. This is achieved by actively participating in the life of the families. It means to participate in problem solving trials, in doing oneself what one recommends the family do, and through this being allowed to experience successes, impasses and failures. It is from this platform of understanding grounded in similar experiences that new manners of understanding and acting can originate and be investigated. Reformulations as new manners of understanding joint experiences can thus be presented as supplementing the original understanding from the perspective of an insider. The reformulation is grounded in the acknowledgement from both parties of a similar experience.

Empathy is a concept that traditionally has pointed to the therapists' experience of the other and it is empirically well established as related to outcome (Bohart, Elliott, Greenberg, and Watson, 2002). The above points towards empathy but can be interpreted to go beyond empathy towards descriptions based on

developmental concepts (Stern, 1985, 2004, 2008). Daniel Stern (2004) has described and suggested the clinical relevance of the present moment. He relates this to the concept of implicit relational knowing and to the fact that nonspecific factors have a central place within psychotherapy research (Stern, 2008). This triad of the present moment; what happens here and now, implicit relational knowing; "…representations of how to proceed, to do things…" (Boston Change Process Study Group, 2008, p. 128), and the above documented non specific therapy factors points to the overarching concept of participation of this dissertation.

The concept of participation with its weight on sharing experiences, getting a taste and blurring the boundaries between service users and therapists can be seen to point to the present moment and, for the therapists, to give themselves over to what happens in these moments. This means to give oneself over to one's implicit relational knowledge and, as such, the concept of participation means an increased attention to the personal involvement of the therapist in therapeutic activities. This dissertation concludes that it is by immersing themselves in the life of the families through personal participation, involvement and giving of oneself that therapists can increase the possibility of putting these mutual experiences into words in the form of high quality reformulations by having such first hand experience of the life contingencies of the family.

Seen from the family perspective the concept of participation involves more than this sharing of experiences. It means not only a personal, experiential involvement but also oneself with all of one's professional knowledge and authority. This means using skills and techniques, to be transparent about one's rationale and perspectives that are relevant for the family. The therapists participate with their entire knowledge base, both in actual action and making strategies available for families to use. It also means to participate with reports and specialist declarations where these are needed in order to help the family. The expectation of the families is that the therapists have skills and knowledges that they apply in collaborative efforts together with the family. This means that although the research is ambiguous on the role of techniques and methods, these families confirm their importance within the collaborative relationship between families and their therapists. The question of specific vs. common factors then is not one of either- or. One possible conclusion from this, also following Stern (2008), is that techniques and models are avenues and opportunities to establish a helpful relationship. Cooper (2008) is clear that it is an

unsettled question within the field of psychotherapy research whether techniques lead to a good therapeutic relationship or if the therapeutic relationship is a fundament for techniques to work. By using her or his technical skills and theoretical and research based knowledge with the families in a collaborative manner, a relationship is created that implies new relational learning for the family which again can give rise to new verbal formulations and understandings.

6.2. Use of the SRS & ORS

The importance of feedback is underlined in both the family and the therapist perspective. The families state this explicitly while the therapists communicate it through the choice of using the SRS and ORS. Although the families are most concerned about getting feedback from the therapists, they confirm both the feasibility and importance of the use of these measures and especially the importance of the therapists taking seriously and follow the feedback. Both perspectives support the conclusions of patient focused research and the clinical specification given by the Institute for the Study of Therapeutic Change (Lambert, 2007; Miller, Duncan, & Hubble, 2004).

Articles 1 and 2 in this study can be seen as a specification of a therapeutic practice in which monitoring process and outcome and the use of feedback is embedded. The practice used in this unit differs from the classical experimental situation of patient focused research in that both service users and their therapists continually are exposed to the feedback and it is continuously implemented within the therapeutic practice. The SRS and ORS are used as conversational tools and are a central part of the therapeutic practice. A central difference in relation to patient focused research is that both on-track and not-on-track cases are exposed to conversations around process and outcome. The results points to the fact that the use of the SRS and ORS goes beyond the simple use of feedback. The family perspective identifies three conversational processes in addition to obtaining feedback. Focusing, structuring and exploring are suggested as important conversational processes that are facilitated by the use of the SRS and ORS. The therapist perspective supports this finding by specifying types of conversations that are also facilitated. Further research is needed on such processes and types of conversations. This points to the possibility that the use of such measures not only decreases the development of being not-on-track, but may serve other functions as well. For instance, results reported by Anker,

Duncan and Sparks (in press) point to the possibility that using these measures in this specific manner prevents not-on-track developments from occurring within on-track cases.

Lastly, the use of the SRS and ORS is supportive of ideas about following the preferences of clients, and therapists managing to change in order to re-establish collaborative relationships when confronted with impasses and detrimental development. It is essential to identify such developments and for this the SRS and ORS are invaluable. Reviews of research (Duncan & Miller, 2000a) point to the fact that therapists are in danger of doing poor evaluations of the therapeutic relationship and alliance. A supplementary perspective provided by the service users through the use of standardized measures reduces the danger of missing out on such situations.

6.3. What kind of therapeutic practice do these findings speak to?

Denzin and Lincoln (2005) introduce the concept of *bricolage* and the *bricoleur.* These metaphors speak to the epistemological position of this project. They write: "The researcher may,…, be seen as a *bricoleur*, as a maker of quilts, or, as in filmmaking, a person who assembles images into montage" (Denzin and Lincoln 2005, p. 4). This points to processes of mixing things together, blending, taking odds and ends and bringing about "..a pieced-together set of representations that is fitted to the specifics of a complex situation" (Denzin and Lincoln 2005, p. 4). With reference to filmmaking they introduce *montage.* This process creates "..the sense that images, sounds, and understandings are blending together, overlapping, forming a composite, a new creation." (Denzin and Lincoln, 2005, p. 4). The result of this is an emotional, gestalt effect (Denzin and Lincoln 2005).

Through the analysis of the interviews in this project, the metaphors of bricolage and montage can be seen as leading images. Central to the epistemological suppositions here is that this montage points towards something outside itself. As such it could be called a representation, but within the epistemology of this study it is considered constructionist realism. At the same time the concept of bricolage in this study can be seen to point beyond an epistemological position to describe an important aspect of the findings of the study. This concerns the fact that the relationship between the overarching concepts and the categories and sub categories they build upon seems to conform to a form of intertwining and braiding as seen in a

bricolage. The reviewed research points also to such a braiding of aspects, attributes and processes.

The review of psychotherapy research (3.1) gave ambiguous answers to the question of whether therapists affect the outcome of psychotherapy (Elkin et al., 2006; Kim et al., 2006). Beutler et al (2004) concludes that the effect of therapists' traits must be investigated in relation to aspects of patient functioning. The key phrase is patient-therapist compatibility. We know that some therapists matter but some matter more than others (Lambert & Barley, 2002; Miller, Hubble & Duncan, 2007) but the question is how this comes about. The interplay and braiding of different aspects of different factors involving the therapist and the patient is indicated as important. The same goes for the relationship between patient and method. Again, the match between them is crucial (Beutler, et al., 2004). Evidence also points to the fact that therapist attributes such as flexibility, honesty and others influence the therapeutic alliance (Ackerman and Hilsenroth, 2003), and that repair of alliance ruptures through the therapist acknowledging and pointing out his or her contribution to and part in the rupture event is correlated with outcome. Shifting the focus to patient characteristics and client variables, the same question arises in the form of which client and therapist characteristics interact most saliently to produce outcome. Concepts such as severity of symptoms and functional impairment are related to outcome as well as social and cognitive dysfunction, expectation of improvement, endogenous depression, duration of the current and personality disorders (Clarkin and Levy, 2004).

Again a recurring theme is the match between patient and therapist. Persons suffering from personality disorder have problems with personal relationships. To match such interpersonal problems, friendliness, flexibility and responding in ways that reduces behaviours that could be classified as "resistance" is of the utmost importance (Beutler et al, 2002). The central theme of collaboration in this dissertation underlines this. Horvath and Bedi (2002) argue for collaboration and consensus as the most important and distinguishing features of the therapeutic alliance (Bordin, 1979). Tryon and Winograd (2002) document the same together with the importance of the mutual involvement of patient and therapist in a helping relationship. Baldwin et al (2007) conclude that the therapist must have interpersonal skills that can facilitate the establishment of shared decision making with frequent discussions of goals. Again we meet the fact that when clients do not match the

collaborative invitations of the therapists, a clinical problem arises that is best solved by looking at the therapist rather than exclusively patient characteristics. This leads directly to situations in which the therapist should look for help and support in solving his or her clinical problem. The solution chosen by the more traditionally oriented evidence-based practices is to increase the search for knowledge through intensifying assessment and diagnostics and identifying the best available research (Norcross et al. 2008). This dissertation does not disqualify or stand in opposition to the importance of assessment, diagnostics and best available research, but it raises questions on their place in the singular case; how is the knowledge generated to be used? It is the assertion of our study that the use of assessments, the stated diagnosis and the best knowledge available must be subordinated to the actual responses of clients and families. This places continuous monitoring of the actual course of therapy at the centre of therapy. Psychotherapy research results (Castonguay & Beutler 2006; Goodheart, Kazdin, & Sternberg, 2006; Norcross, 2002a), and those of our study point towards the importance of flexibility and the ability to move and change in accordance with the responses of the other. The description of the work of the Family Unit exemplifies a specification of what a practice inspired by a bricolage can look like and it is not primarily constrained by theoretical or generalised knowledge, but by the actual responses and feedback from those most concerned with this work, the patients and their families. This perspective founds therapy on the family. The client's theory of change (Duncan and Miller, 2000b), with the use of the SRS and ORS, is an invaluable conceptual tool for the therapists in this work. To follow and to found therapy on the family means to construct the form and content of therapy from the ideas, preferences, aims, and principles of the family. It is to take seriously the concept of the theory of change of the family and let this direct the form and content of therapy. It does not mean that the therapist is a passive non-participant in the building of this therapy. Rather, the therapist becomes an active consultant and contributor to the construction and development of a therapy tailored to the family (Norcross, 2002a, 2002b). Central to this contribution is the knowledge base that any therapist represents. This knowledge is a central ingredient of helpful therapy together with the knowledge of the family. In addition, a need for learning arises when the preferences of the family do not match the knowledge base of the therapist. This leads to a constant knowledge-seeking process within the unit.

This way of working has a fundamental effect on how to think about lack of progress and development towards the preferred state and situation of the service user. Traditionally, lack of change has given rise to conceptualizations primarily connected to the client and family members. Concepts such as resistance, lack of motivation, and treatment incompatibility all point towards the client and the service user (Beutler et al., 2002). Confronted with a situation characterized by lack of change, therapists have applied these concepts to clients and their families. Within the perspective of this study, lack of change points towards the therapist and his or her way of working. Stated differently, resistance is not an aspect or characteristic of the client and his or her family. It is an aspect of the method used, and as such, lack of change points towards change in the therapist and his or her way of working.

This therapeutic work is governed by the idea that the family and the therapist use what they need or prefer in order to reach their goals, solve the problems, or live their dilemmas (Sundet, 2004d). This means that all knowledge and every skill—whether research-based, theory-based, or based in the participant's personal and professional experiences—will be used. As such, the material or practice described in this dissertation does not represent a therapeutic model or method. It is based on all available knowledge, and could be called a perspective or a position. Viewed in this manner, the position adhered to in this study is an eclectic position, and it can be named *a radical eclectic* position. The word eclectic is etymologically connected to *gather, to assemble, to choose, to pick out.* The dictionary definition is "borrowing freely from various sources" (Hornby, Gatenby, & Wakefield, 1963). It points to the importance of being free to choose, mix, and blend all possible elements from the knowledge bases of the participants. Etymologically, two meanings of radical are also of special interest here; first, to grow out from, to form branches, to branch out, to create a network or rhizome (Deleuze & Guattari, 1988; Partridge 1966). Branching could also imply an end point of the branch, an extremity or margin. Second, the meaning is that of pertaining to roots, having roots, or being deeply rooted. Semantically there is a root-branch alternation here (Partridge, 1963) that implies that to be radical could be seen as both being rooted in something and as branching out from this, forming a network. To be eclectic is to pick and choose without these choices being dictated or constrained by demands for logical or theoretical coherence. Here there is high tolerance for fragmentation and parts, and upholding a reciprocal agreement or understanding within a coherent system is not

decisive for the choices. What, then, is decisive for the choice of a radical eclectic position? A radical eclectic position lets the choice of method, action, statement, or question be rooted in, and branching out from the service user. As stated above it involves subordinating theoretical and research-based knowledge and clinical experience to the perspectives of and feedback from the service users.

Cooper draws the conclusion that "at the heart of most successful therapies, is a client who is willing and able to become involved in making changes to her or his life" (Cooper, 2008, p. 157). Client willingness and ability to use what the therapist provides become the key predictors and factors in this perspective. Unfortunately, this can be seen as a punctuation making the client the primary cause of both change and no-change. The above conclusions about therapeutic practice raise questions about this punctuation. Change is a collaborative venture where both therapist and client matter, but in situations of no-change, following Baldwin et al (2007), the primary responsibility for change is with the therapist. No-change does not testify to lack of willingness and ability, only that what is brought forth does not fit. This makes situations of no change a context for discovery; a place for creating or generating a process of exploration that can lead to the discovery of tasks, perspectives and actions fitting the client's specific willingness and abilities. The danger of concluding lack of willingness and ability on the part of clients is that this process of exploration is not started and that instead a process of exclusion is instigated with the potential result that the client is judged not fit for treatment. The conclusions of this study are that when a process of exploration concerning what is effective therapy for this client is set in motion, the "unwilling" becomes willing, and "lack of ability" is discovered to be different abilities. This process of exploration includes both the professional knowledge base of the therapists and the knowledge base of the client through his or her history of change and life perspectives. Searching within these different knowledge bases and experimenting with what is found, eventually may lead the therapist to new options and change. Article 3 employs the concept of the zone of proximal development and the metaphor of scaffolding as ways of explicating how both families and therapists are in need of such processes of discovery and that this is a central part of the professionality of the therapists. Therefore the weight is on therapist, and not following Cooper, who, truth be said, expressed the equivocal state of both the research and clinical situation through the old joke:

'How many therapists does it take to change a lightbulb?' 'One, but the lightbulb has really got to want to change' (Cooper, 2008, p.157). It can hardly be called therapeutic craftsmanship to need a willing lightbulb to see the light.

6.4. What is psychotherapy?

The above acknowledges that there always is a possible tension between the therapist's perspective and the family perspective on what one should do. It is the conclusion of this study and the review of the research that therapy must be seen as a joint and collaborative venture where contributions of both families and therapists are needed. The inspirational sources (Andersen, 1991; Anderson & Goolishian, 1988; White, 2007) of the Family Unit all underline collaboration, privileging the client voice and the importance of conversations and dialogue. The above discussion and the research review confirms the importance of collaboration and relationship aspects as strong emotional bonds developed through listening to and taking seriously the service user, establishing goal and task consensus, accessing the client's voice through feedback procedures and creating new meaning through reformulations. At the same time, these sources must be expanded to include action oriented practices, active use of professional knowledge and authority and seeking to create and uphold an adequate structure of the therapeutic work. This means that in our study the interviewed families invite a stronger participation of the therapists both concerning their personal participation and the use of their professional knowledge. This again connects to the fact that although there is no clear cut evidence for strong relations between techniques and outcome, the research review points to the importance of braiding together both personal attributes and professional skills of the therapists with attributes of the service users within a collaborative relationship. In this perspective, therapeutic outcome becomes a result of interactions and intertwining of several processes and attributes of the participants and their ways of working and being. Further, such outcomes must be seen as individualized results of creating manners of working tailored to and fitting with the single service user and family. Implemented therapy must ultimately be created with the individual client and family. This speaks to what psychotherapy is. With reference to Hubble, Duncan & Miller (1999a), Grenness (2000) suggests the following definition of psychotherapy.

> "(P)sychotherapy constitutes an idiosyncratic, process-determined synthesis of ideas of the client and therapist that culminates in a new local theory with

> explanative and predictive validity for the specific client's situation. Therapy constitutes a co-evolution between client and therapist towards an emergent reality consisting of the following main factors; 1) to create space for the client's use of his or her own *resources* (….), 2) to secure the client's positive experience of the *alliance* with the therapist and 3) to strengthen the client's frame of reference or *theory of change* " (Grenness, 2000, p. 42, my translation).

This study conforms to this definition. In addition to underlining client resources, the alliance and the theory of change of the client, it brings forth therapy as a process of co-evolution and collaboration and it confirms it as a process through which the responsibility of the therapists is to make space for, secure and strengthen both the family and the relationship with them. In the end this must be decided by and together with the service users. Research and evidence based knowledge together with knowledge based on clinical experience must be put to use for and subsumed under such an individualized and singular practice.

6.5. Future research

This study has pointed to a need for more understanding of the participatory aspects of therapy, especially concerning experiential sharing. Further, the role of questions and ways of talking together need to be investigated more. Thirdly, the possibility of therapists being toxic through violation and disparagement needs to be investigated. One aspect of this is that the sub category "nuancing the nuances" from the therapist perspective invites a nonpathological view of families. This points to a need to further investigate whether the thinking of the therapists, especially the use of a pathological gaze on the family; that is, the family as cause of suffering, has a possible role in detrimental development in therapy. Lastly, three overarching concepts; conversation, participation and relationship have been suggested as important aspects of psychotherapy and their importance for the single service user and family lies in how they are intertwined and braided. This then identifies intertwining and braiding as a target for research. This is seen as especially resonant with the research findings concerning the concept of tailoring therapy (Norcross, 2002).

The main focus of our study has been on what the therapist can do in order to be experienced as helpful. In terms of the above perspective on psychotherapy as co-

evolution, the intertwining of different therapeutic processes and collaboration between the participants there is a need for the Family Unit to shift focus from the therapist towards the client and his or her family members. What is it that families do that is helpful for them? How do they use what therapists bring to therapy? What is the part played by the client and the family in the co-evolutionary process called psychotherapy? In the field of psychotherapy this has been investigated by Bohart and Tallman (1999). Still, in order to fulfil the project of the Family Unit in explicating all the parts of a helpful therapy the natural continuation will be to go back and interview both families and therapists on these questions. Hopefully, such a local project, when viewed in relation to the field of psychotherapy research, can make further contributions to the field of psychotherapy.

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Appendix 1: Tables

Table 1 Therapists

Therapist	Gender	Age	Experience	Profession
Therapist A	Male	49	20 years	Clinical psychologist
Therapist B	Female	63	27 years	Clinical pedagogue
Therapist C	Male	56	29 years	Social worker
Therapist D	Female	47	Second year diploma student	Student therapist
Researcher/author	Male	54	25 years	Clinical psychologist

Table 2 Families

Families	Family size	Mother	Father	Children	Interviewed	Status	Therapists
Family 1	3	1	1	1	All	Active	A & B
Family 2	3	1		2	Mother, 1 child	Active	C & D
Family 3	5	1	1	3	All	Terminated	B & D
Family 4	3	1		2	All	Active	A & B
Family 5	2	1		1	Mother	Active	A & B
Family 6	2	1		1	All	Terminated	A & X[iv]
Family 7	4	1	1	2	Mother, father	Terminated	A & B
Family 8	3	1	1	1	Mother	Terminated	A & B
Family 9	4	1	1	2	Mother, father, 1 child	Terminated	C & D
Family 10	4	1	1	2	All	Active	A & B
Total	33	10	6	17	10 mothers, 5 fathers, 11 children	5 active, 5 terminated	

Table 3. Assessment of outcome and use of SRS and ORS

	Therapy	SRS/ORS	Total
Helped/useful	Family nr. 1,2,3,4,6,9,10	Family nr. 1,3,4,6,8,9,10	7/7
Not helped/not useful	Family nr. 7,8	Family nr. 2	2/1
Uncertain/ambivalent	Family nr. 5	Family nr. 5,7	1/2
Total	10	10	10

Table 4. The therapists: Number of meaning units

Therapist A	Therapist B	Therapist C	Therapist D	Total
83	61	39	26	209

Table 5. The families: Number of meaning units

F1	F2	F3	F4	F5	F6	F7	F8	F9	F10	Total
49	27	26	19	23	35	19	21	32	25	276

Table 6. Therapists: Number of core ideas

Therapist	Therapist A	Therapist B	Therapist C	Therapist D	Total
Therapy	49	27	17	17	110
SRS/ORS	84	69	37	21	211
Total	133	96	54	38	320

Table 7. Families: Number of core ideas

Families	F1	F2	F3	F4	F5	F6	F7	F8	F9	F10	Total
Therapy	40	52	47	33	51	86	35	48	94	91	577
SRS/ORS	62	36	51	28	58	8	15	14	18	14	304
Total	102	88	98	61	109	94	50	62	112	105	881

Table 8. Evolving Guidelines for Publication of Qualitative Research Studies in Psychology and Related Fields (Elliott, Fischer & Rennie, 1999, p. 220)

A. Publishability Guidelines Shared by Both Qualitative and Quantitative Approaches

1. Explicit scientific context and purpose
2. Appropriate methods
3. Respect for participants
4. Specification of methods
5. Appropriate discussion
6. Clarity of presentation
7. Contribution to knowledge

B. Publishability Guidelines Especially Pertinent to Qualitative Research

1. Owning one's perspective
2. Situating the sample
3. Grounding in examples
4. Providing credibility checks
5. Coherence
6. Accomplishing general vs. specific tasks
7. Resonating with readers

Appendix 2: Information for participants

The therapists:

Letter of information for the therapists of the Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud, HF.

For 2 ½ years we have used the measures; Outcome Rating Scale (ORS), Child Outcome Rating Scale (CORS), Session Rating Scale (SRS) and Children Session Rating Scale (CSRS), as clinical aids and as tools for quality assurance of the work of our unit. This work has constituted the start point for the project: Client-directed, outcome-informed therapy in an intensive family therapy unit. The first part of this project is to interview therapists working in the unit. The superior aim of the project is to investigate the practice of using these measures in our unit. The research question to be investigated in this part of the project is: What experiences do individual therapists have with the use of these tools?

In our conversation I would like to focus on your experience of and with these measures. My goal is that this be a conversation in which you tell me as much as possible about your experiences, and from which I can acquire the best possible understanding of these. This means that I am asking permission to ask you questions, but also to bring forth the understanding that develops for me during our conversation so that I can check if this understanding is in accordance with yours. This means that I ask to be allowed to stop the conversation when I do not understand or where there is something that I need to explore more deeply in order to get a better understanding of it.

The focus of this conversation is the Family Unit's use of the measures. I am after the experiences that you have with these measures, that is; all that happens in connection to the concrete use of them in conversations with clients and the results of this use. What can you tell me about how it is to use/administer them and what do you experience when persons fill them out and you start a conversation about this? What do you experience as useful in the concrete conversations in which they are used? Further, I am interested in where this use leads you. Where does it lead in the

individual case? Do the measures have any significance beyond the individual case? Have you experienced something of value that can be transferred to other cases and your activity as a therapist in general? Over time, what do you experience as useful and if possible not useful? This means that I am interested in knowledge and understanding about all aspects that have significance or lack of significance concerning these measures and their use.

In addition I want to know as much as possible about how you experience the fit this use of the measures has with, or does not have with, your thinking about and understanding of the clinical practice of the Family Unit specifically and therapeutic work in general.

The next part of the project will be to interview a selection of our service users, i.e. mothers, fathers and patients, about their experiences with our practice with these measures. In connection with this it is important for me to get to know any question that you think will be important to ask our service users.

I am asking for 2 hours for our conversation. If it appears that we need more time, I ask for the possibility to have one or more further conversations with you.

All participation is voluntary and you can withdraw from this collaboration whenever you want without this having any consequences for you of any kind. I will not use any of the information you give without your permission. Information that I am not allowed to use will immediately be erased.

There is no compensation following participation in this project.

The information I receive will be made anonymous and be treated confidentially. I must have an overview of who I am interviewing, but I will see to it that only I can couple the interview material to each person through a coding system that is kept separate and secured.

I ask for permission to record the interview. The recordings will be kept until 6 months after the project is terminated, and they will be kept secured.

The project has been approved by the Regional Committee for Medical Ethics, South-Norway, and Norwegian Social Science Data Service. The project is financed by the University College of Buskerud.

If you have questions you can contact me in my regular work hours at the Family Unit, through the internal e-mail system of the unit, phone: 91706211 or e-mail; rosundet@online.no.

In advance, thanks for your help!

With friendly regards

Rolf Sundet
Research fellow/clinical psychologist

The parents:

To

Earlier and present service users of the Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud HF. Invitation to participate in a project of evaluation; Client directed, outcome informed therapy in an intensive family therapy unit.

You are/have been service users of the Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud HF. In our contact, we have used two measures. One sought to give us information about how each treatment session was or functioned for you, and has been a tool for us to find out if we managed to create a good collaborative relationship with you. The second measure sought to give us information about the outcome of our work, that is; if we actually were helpful to you.

We have called our project: Client directed, outcome informed therapy in an intensive family therapy unit. The use of the measures is part of the development of a practice in which each service user gets to direct how our help is organized and performed. Research shows that a high degree of service user participation through concrete feedback from each service user to therapists about how the collaboration functions and whether the therapists actually are helpful is decisive in getting a good treatment result. The interview that we are asking you to take part in will play a conclusive part in how we will develop this work further. Are we on the right track? Was there anything around the use of these measures that was useful/not useful? Is there something we should do differently?

We would now like to evaluate our work with special attention to these two measures, and ask, with this letter, whether it would be possible for the undersigned to interview you (mother, father, child/children) about your experiences with our work in relation to these two measures. It is important for us to get to know how you have experienced our work, if we were helpful and if the use of the measures contributed to us being helpful. We are concerned with gathering information that can help us

create a practice that supports good collaboration and increases the probability of our being helpful for children and their families. Specifically we would like to know more about the two measures and your experiences with their use. Further, we would like to have advice from you concerning this.

We ask for the opportunity to set aside two hours with each family for our conversation. If it should appear that we need more time, we ask for the opportunity to have another conversation with you. As a starting point we may want to talk to each of you separately. The reason for this is that it will be easier for me to keep an overview of each person's answers, but if you should want to have this conversation together this is fully possible.

All participation is voluntary and you can withdraw from this collaboration any time without this having any consequences for you of any kind. I will not use any of the already given information without your permission. Information that I am not allowed to use will immediately be erased

No form of remuneration follows participation in this project.

The information I receive will be made anonymous and treated confidentially. I must have an overview of those I have interviewed, but will see to it that only I can couple the data from the interviews to a particular person through a coding system that will be kept separate and locked up. I ask to be allowed to record the interview. The recordings will be kept half a year after the research project is finished, and they will be kept safely secured.

The project is approved by the Regional Committee for Medical Research Ethics and the Norwegian Data Service for Social Sciences.
The project is financed by the University Collage of Buskerud.

I will contact you by phone approximately one week after you have received this letter to inquire if you would like to participate in this, and, if you say yes, make an appointment for the interview.

If you have questions before this please contact me on my phone, 91706211 or by

E-mail: rosundet@online.no

Beforehand thanks for all help.

Yours sincerely

Rolf Sundet
Research fellow/Clinical psychologist

The children:

Information about the talks at the Family Unit about our cross-off forms

To

…….

You are having or have had a stay at the Family Unit. At the Unit we gave you some sheets or forms. One had questions about how you had been doing since the last time you filled it out. The other had questions about whether we listened to you, consulted you about what we should talk about, did this in a manner that you liked, and lastly, what you thought about what we did together overall. On both of these sheets you answered by putting a cross on a line for each question. We used these sheets to try to find out what you thought was helpful for you and your family, and if we did this in the way you thought we should.

Now we are wondering about what both those who are with us now and those who have been with us earlier, think about these sheets and the way we use them. We are very curious about whether those of you who have used them, think that there are some useful points in using them, whether you think they are not so useful, or maybe that you do not have any opinion at all about the sheets. Because all of us at the Family Unit are curious about this, I will be trying to find out what some of those who are or have been with us think about them and the way we use them. The reason for this is that we want to know as much as possible about how we can be helpful to the children and adults who stay with us. When we get to know this, we think that we might become even better at being helpful for new families that come to us.

As you are or have been with us and used the sheets, I wondered if I could have a conversation with you about what you think and mean about them and the way we used them. Usually, at the Family Unit, we have conversations in many different ways. One is that you just tell me what you think and mean. If you feel that is difficult, then another way is that I ask some questions about the sheets. But sometimes it is also difficult to answer questions, so we will see if there are other ways that we can have a conversation together. We may have to find this out together. What is important is that if you do not want to say something or want to finish the conversation, then you can do this whenever you want.

I will record the conversation. I do that because instead of trying to remember everything that is said, I can listen to the recording of what you have said. I can also copy it and read it afterwards. I will use this to write about what children and parents think about the sheets and our way of using them. Other people that work on helping children and parents can read this, and they can start to do it in the way that you and others describe. This means that I will write about what you are telling me, but no one will know that it is you that has told me this. Who has said what will be kept secret. When I have completed work on the recordings, I will erase them so that no one can listen to them after I have finished with them.

If there is something you wonder about, you can ask your mother or father to telephone me at 91706211 or send an e-mail to me. My address is: rosundet@online.no

With friendly greetings

Rolf Sundet
Research fellow/clinical psychologist

Appendix 3: Declarations of consent

Therapists:

Declaration of consent

I_____

____

Employed at the Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud today _____ have received information about the research project Client directed, outcome informed therapy in an intensive family therapy unit, led by Rolf Sundet.

I give my consent to be interviewed about my experiences with the use of the measures SRS/CSRS and ORS/CORS and the place and significance this use has in the treatment program of the unit.
I agree to be interviewed more than once if necessary.
I have understood that I can withdraw from further participation without having to give an account for the cause and that there will be no consequences for me if I choose to withdraw.
I have understood that participation in the project does not entail any form of compensation.
I have been informed that identifiable aspects of the material will be omitted and the material will be treated confidentially.
I have read through and understood the above.

Date and signature

Family members:

Declaration of consent

I, _____

have received information about the research project Client directed, outcome informed therapy in an intensive family therapy unit, lead by Rolf Sundet.
I give my consent to be interviewed about the Family Unit's use of SRS/CSRS and ORS/CORS and the experiences I have had with these, the way in which they were used and the place and significance of this manner of use within the treatment program of the unit.

I agree to be interviewed more than once if necessary.
I have understood that I can withdraw from further participation without having to give an account for the cause and that this withdrawal will have no consequences.
I have understood that participation in the project does not entail any form of compensation.
I have been informed that identifiable aspects of the material will be omitted and the material will be treated confidentially.
I have read through and understood the above.

Date and signature

Children

Declaration of consent

I……

have been told about the research project Client directed, outcome informed therapy in an intensive family therapy unit, led by Rolf Sundet.

I say yes to be interviewed about the scales that we used when I was at the Family Unit. This means that I say yes to talk about what I think about the scales, what we did with them and how they fitted together with the other things we did at the Family Unit.

I say yes to be interviewed more than once if necessary.

I understand that I can say no to being part of this at any time without having to tell why and that nobody can say anything about that afterwards.

I have understood that I can withdraw from further participation without having to give an account for the cause and that this will have no consequences.

I have understood that I will not get anything for being part of this.

I have been told and I understand that what I say will be kept secret.

I have read through and understood the above.

Date and signature

Appendix 4: Interview guides

Interview guide for the interviews with the therapists of the Family Unit.

Project: Client directed, outcome informed therapy in an intensive family therapy unit.

Project leader: Rolf Sundet

Interview start:

First I wonder if you had any questions about the information letter regarding the project?

The focus of this conversation is, as explained in that letter, your experiences with the use of SRS/CSRS and ORS/CORS, and the clinical practice connected with use of these measures. I am wondering if you could start by telling me something about what you are most engaged with at the moment concerning these measures so that I can understand more about your relationship with them.

Administration of the measures

How is using these measures?

-introduction?

-technical problems/difficulties/comprehensibility?

-special positive aspect of the use?

Discussion/interpretation of service users' completion of the measures

Can you describe what you do after the service users have answered the two measures?

How do you relate to SRS/CSR? How do you relate to ORS/CORS?

- dialogues that develop?
- your own focus/concerns?
- use of the graphs and how?

What are your experiences about where this leads?

- the service users' own reactions to their own answers?

- difficulties
- positive/usefulness
- especially important for you?

The effects of the use of the measures

Can you tell me a bit about what you think are the main effects of the use of these measures?

Where has the work with these measures brought you?

Have you noticed changes in the unit that can be ascribed to the use of these measures?

Do you have any stories concerning your use of the measures that have been significant for your further work with these, both specifically and with regard to therapy in general at the unit?

What is helpful in therapy?

We have now talked about the measures. I was wondering if you could tell a bit more about your experiences with what is helpful or effective in therapy more generally? What are your concerns? Is there something special that you seek to manage in your work? Is there something special that you have experienced as effective or useful?

Thoughts about therapy

One area I am interested in is whether or not the use of SRS/CSRS and ORS/CORS has influenced your manner of thinking about therapy?

Is there something that has been central for you concerning therapy that has been confirmed through the use of these measures?

Can you describe any changes in your manner of thinking about your practice as a consequence of your experiences with the measures?

The future work of the unit

Given the experiences that you have had with the measures and given what we have talked about today; do you have any thoughts that are important for the unit in the future?

Do you gave thoughts about how the work with the measures should/must/ideally could be developed further?

The understanding of the interviewer

Let me be allowed to recapitulate some of what you have said……..

Have I understood you correctly?

Is there something you think we should cover more thoroughly in order for me to create a good and adequate understanding of your experiences?

Questions concerning the interview of the service users

My next step will be to interview a group of our service users. Are there questions that you would like to have answered concerning their experiences with the use of the measures and our practice in general? Are there questions you would like me to pose?

Additional comments

Before I say thank you, I would like to end by asking if there is anything you would like me to add or other topics you think are important to talk about that will ensure that I have heard all the important experiences and that I have understood them?

Is there something that emerged during this conversation that has engaged you and that you have not spoken about?

Interview guide for the interviews with the parents

Project: Client directed, outcome informed therapy in an intensive family therapy unit.
Project leader: Rolf Sundet

Interview start:
First I wonder if you have any questions about the information letter about the project?
The focus of this conversation is, as explained in the letter, the experiences each you had with the work of the Family Unit and especially the use of SRS/CSRS and ORS/CORS (*show them the measures and explain/retell what they seek to tell about).*
Let me begin with the measure that we call ORS/CORS. Was a graph drawn with you? *(Show them the graph form and give an interpretation/understanding concerning results given a particular graph).*
Given my description of your graph, how different or similar is it with your experience of the work at the unit and the result of this work?
The use of the measures: administration and use
How is/was use of these measures?
- aspects of use (not clear, negative, incomprehensible, disturbing, difficulties)
Did you experience any problems concerning how they are constructed?
Do you think that there is something we could do to improve them and our use of them?
Effect of use
You have told me that you think these measures are useful/not useful and that they are helpful/not helpful.
Could you help me understand what it is about them and their use that was helpful/not helpful and/or significant/not significant?

What was it that happened that was helpful/not helpful? Was it something you yourself did or some of your family members? In that case what was it that was done and what words would you use that best would describe this?
If it was something done by the therapists, what was it and what words would you use that best describe this?
Effects of contact with and/or the stay at the Family Unit
Can you say anything about how you experienced the work of the family unit?

What was helpful/not helpful?

Did the work have any results and effects for you?

If you did not experience any results, could you tell what was missing in what the Family Unit had to offer?

Can you think about any of the changes or lack of change that you have told about and comment on whether or not our use of the measures had any significance for this?

Further development of the work of the unit

Do you believe it is important/not important that the unit uses the two measures?

Should we continue with this?

We have called our project; Client directed, outcome informed therapy in an intensive family therapy unit. Is this a good motto or a good vision for the work of our unit?

Are there problems that you experienced with this and if so which?

Is there something about the use of the measures that results in other important aspects, areas or themes being displaced or not coming into focus?

Are there areas that you think it is important for therapists to devote more attention than we have done up until now?

What do you miss the most?

Questions brought up in the interviews

(Make a guide after the interviews with the therapists).

The understanding of the interviewer

Let me be allowed to recapitulate some of what you have said……..

Have I understood you correctly?

Is there something you think should be covered more thoroughly in order for me to create a good and adequate understanding of your experiences?

Additional comments

Before I say thank you, I would like to end by asking if there is anything you would like to add or that you think is important to tell about that will ensure that I have gotten all the important experiences and that I have understood them?

Is there something that emerged during this conversation that has engaged you and that you have not spoken about?

Interview guide for the interviews with the children

Project: Client directed, outcome informed therapy in an intensive family therapy unit.

Project leader: Rolf Sundet

Interview start

First is there anything you would like to ask about the conversation we are about to have?

Do you know what we shall talk about and do you have any questions about it?

Do you remember the two scales with different lines on that we used to make marks on?

Effects of contact with and/or the stay at the Family Unit

Can you tell me what you especially remember about the scales?

Can you tell me what you think about filling them in?

What did you think about them then and what do you think today?

Was it helpful or not helpful to make marks on them?

The use of the measures: administration and use

Was it possible to understand these scales?

Do you think it was easy or difficult to fill them in?

Could we have made them different?

Effect of use

You have told me that you thought they were helpful/not helpful

Can you help me understand what it was about them and their use that was helpful/not helpful?

What was it that was helpful/not helpful? Was it something you did yourself or something your parents did? In that case what was it that was done? Do you think you could describe it for me?

If it was something the therapists did, what was it and do you think you could describe it for me?

Effects of contact with and/or the stay at the Family Unit

Did you like/not like being and working at the Family Unit?

What was helpful/not helpful?

What words would you use to tell me about what was useful/not useful?

What were the results of the stay and work at the family unit do you think?

Further development of the work of the unit

Do you think we should continue or stop using the two scales?

Is there something we should do instead of using them?

Was there something we should have done differently?

Did you miss something at the Family Unit and what do you miss the most?

Questions raised by the interviews

(Make a guide after the interviews with the therapists).

The understanding of the interviewer

Let me be allowed to retell some of what you have told me:……..

Have I understood you correctly?

Is there something you think we should talk more about in order for me to understand you better?

Additions and others

Before I say thank you, I would like to end by asking if there are other things that you think are important to tell about in order for me to be certain that I have gotten all the important experiences you had at the unit and that I have understood them.

Is there something that came to mind during this conversation that that you have not spoken about?

I

COLLABORATION: FAMILY AND THERAPIST PERSPECTIVES OF HELPFUL THERAPY

Rolf Sundet, Department of Health, University College of Buskerud, Norway.

Rolf Sundet, Clinical Psychologist, The Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud, Drammen & Research Fellow, Department of Health, University College of Buskerud, Drammen, Norway.

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Address correspondence to Rolf Sundet, Department of Health, University College of Buskerud, Grønnland 58, 3045, Drammen, Norway.

E-mail: rosundet@online.no

ABSTRACT

This qualitative study examined how a group of families and their therapists described helpful therapy. The qualitative analysis generated family and therapist perspectives. As a double description, the therapist- and family perspectives highlighted conversation, participation and relationship as three core areas of helpful therapy. These are specified by categories and subcategories that center upon activities of sharing experiences, contributing own knowledge and personal involvement, posing questions, reformulating and giving feedback, and specifying the therapeutic relationship as a relationship of collaboration. Discussion of similarities and differences between the perspectives provides a description of what constitutes good therapy for the families and therapists and points to expansion of the models that have guided the therapists.

Research has established psychotherapy as efficacious (Lambert and Ogles, 2004). Rennie (1992) underlines the importance of making the experience of clients within psychotherapy practices accessible, and The American Psychological Association (APA, 2006) argues for a multiple perspective on research methods. These perspectives suggest that an important question for investigation is that of what clients experience as helpful therapy. This is particularly important within practices that traditionally have not been evaluated by clinical trials. Reports about what is helpful are a step towards knowledge about such practices, although they do not answer questions of efficacy.

Three family therapy approaches are important to the work presented here. These are the collaborative language systems approach of Anderson and Goolishian (1988), the reflecting team and reflecting processes work of Andersen (1991), and the narrative practice of White (2007). Common to all three approaches is a focus on collaboration and language (Anderson & Gehart, 2007; Andersen, 1993; White, 2007), and an emphasis on privileging the perspectives of the service user (Andersen, 1991; Anderson, 1996; White, 2007). They can all be located as part of the turn towards postmodern and poststructuralist ideas connected to the linguistic turn in philosophy (Flaskas, 2002).

Bennett (2008) and Gehart, Ratliff & Lyle (2001) document the fact that mainly qualitative research has been performed on these methods. This is exemplified by the following studies: Smith, Yoshioka and Winton (1993) and Smith, Winton and Yoshioka (1992) who examined clients' and therapists' opinions of reflecting teams to better understand the benefits of this way of working. Sells, Smith, Coe, Yoshioka and Robbins (1994) and Smith, Sells and Clevenger (1994) continued this focus with an agenda of generating descriptive categories detailing latent meaning, beliefs and understandings of how the participants perceived reflecting team work. London, Ruiz and Gargollo (1998) presented three client accounts of their experience using the collaborative approach of Goolishian and Anderson, and Gehart-Brooks and Lyle (1999) investigated the process of change within this way of working through the experiences of clients and therapists. O'Connor, Meakes, Pickering and Schuman (1997) reported on helpful aspects and the meanings and perceptions of families participating in narrative practice. O'Connor, Davis, Meakes, Pickering and Schuman (2004) explored the experiences of therapists using narrative

practice. Common to all these qualitative studies is their focus on one specific method: the reflecting team, the collaborative method or the narrative method, with the exception of O'Connor et al (2004) who looked at the use of reflecting teams within a narrative practice. Lambert, Bergin and Garfield (2004) points to a "… growing trend for therapists to disavow allegiance to a single system for treatment in the form of a purely theoretically based approach" (p. 6). Within an eclectic position, ideas and procedures from different sources are used. This is in line with ideas from the postmodern family therapy field (McNamee, 2004). Guided by this field, the therapist must be ready to go beyond a single method. The main concern of this study was to explore this issue through investigating how a practice guided by three postmodern oriented methods was experienced and described as helpful by participants. In addition, the following two questions were attended to: What happens to the forms of practice based on these methods when they are put to use by families and therapists? And, what are the differences and similarities between the perspectives of the families and those of their therapists, and how do they supplement each other?

THE STUDY

Context

The context of this study is The Family Unit, a combined day treatment and outpatient family unit within the Department of Child and Adolescent Psychiatry in a Norwegian hospital. The unit receives referrals from general practitioners, school health and pedagogical services and child protection agencies. It is a publically funded mental health service of 5 therapists with a residential apartment at its disposal. As a combined day treatment and outpatient unit, it can offer traditional outpatient treatment and supplement this with a stay in the apartment for a maximum of three weeks. The treatment can be divided into three periods: a preparatory period with outpatient work which consists of discussions of needs, preferences and specific goals and culminates in a decision about how to continue the work together. If a stay in the apartment is judged appropriate at the conclusion of the preparatory period, a maximum of three weeks can be offered during which the family works together with two therapists from 9 a.m. until 3 p.m., Tuesday to Friday. After this period, the unit offers ordinary outpatient work in accordance with the needs and preferences of the

family. Within these constraints, a variety of ways of organizing contact between the family and therapists can be implemented.

The reason for referring a family to the Family Unit is either that the family has expressed the wish to work together as a family, or that the referring agency has recommended it. A diagnosis of a child or adolescent is required for admission to the service. Common admission diagnoses are conduct disorder, attention deficit /hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD) and developmental or emotional problems. Many families have tried other treatment programs without success. Usually, there are multiple contextual issues related to the family's problems, such as those arising from the interaction of the child or adolescent with his or her school or peer group. The concepts of multi-agency situation or complexity (Seikkula & Arnkil, 2006) describe this situation. The therapist group consists of highly experienced therapists with backgrounds in diverse areas of practice and varied therapeutic methods.

Participants

Four therapists (Table 1) and ten families, ten mothers, five fathers and eleven children (Table 2), in total thirty persons, were interviewed. Table 1 depicts gender, age, years of experience and profession of the therapists. Table 2 depicts family size, who was interviewed, their status at the time of interview and who the therapists were. All the families and therapists were ethnic Norwegians. The families were recruited by the therapists. The criteria for inclusion were both two parent and single parent families, and both active and terminated treatments. All families asked agreed to participate. The families were supplied with both verbal and written information about the study, and the researcher contacted the family after they had given their consent for participation.

Table 1 & 2 about here

The author/researcher contacted the consenting families by phone and the parents were given the choice of an individual interview or an interview as a family. In addition, they were asked if they wanted their children present. If so, the parents asked them to participate. All the families chose a family interview except one of which only the mother wanted to participate, not the father and child. In one family, circumstances prohibited the participation of the children, and one mother did not want her child to participate. In seven of the families, the children were present. The

participation of the children varied from full active participation in the interview to leaving the main part of the interview to their parents.

The author was the fifth therapist of the Family Unit and was part of the praxis on which the interviewees commented. This meant he had a participatory position that necessitated increased awareness of the subjective presuppositions of the researcher. Traditional research positions have marginalized the insider position in support of claims that one observes more and better from an outsider position. Schutz (1967, in Rennie, 2000, p. 484) suggests that "…when compared to an Other, the person having an experience is in a better position to know its meaning". Misunderstandings can arise as easily from an outsider as from an insider perspective; in both positions, researchers must explicate their subjectivity.

Data Collection

A grounded theory analysis was performed. Data was collected through one interview session with each therapist and family, lasting from1 hour to almost 2 hours depending on the time needed to collect the information. Interview guides were prepared and adapted for the therapists, parents and children/adolescents. These guides functioned as thematic guidelines for the interview (Kvale, 1996). Five thematic areas were covered by all the interviews: thoughts/perspectives on therapy, important and helpful/not helpful ingredients of therapy, effects/outcome of therapy, recommendations resulting from therapy and ideas and associations not previously asked about. Examples of questions asked the family include: How did you experience the work at the Family Unit? What thoughts do you have about the treatment? Was there something that was helpful/not helpful? Do you have any recommendations for us? And to the therapists, questions such as these were posed: What are your preferred means of working? What are the central ideas inspiring your work? Both were asked: Are there areas that we have not touched upon in this interview that you would like to mention? The interviews were audio taped, transcribed by a professional transcriber and analyzed by the author.

Analysis

This study employed modifications of grounded theory (Glaser and Strauss, 1968) by Rennie, Phillips and Quartaro (1988) and Hill, Thompson and Williams (1997). The interviews were organized into texts composed of statements that constituted blocks of data (Hill et al., 1997) or meaning units (Rennie et al., 1988).

The meaning units were organized into a preliminary structure according to common themes differentiating topic areas that formed different domains. The following domains formed an initial organization of the material: manner of therapeutic work, effects of therapeutic work, understandings of therapeutic work, and a domain for themes not related to the research question. The next step was to abstract core ideas (e.g. the "essence" of statements) within each domain (Hill et al., 1997). 110 core ideas were formulated from the therapist interviews and 577 from the family interviews. These core ideas were compared within and across cases to create categories. Two levels of categories were chosen: category and sub category (Nerdrum & Rønnestad, 2002). The following provides an example:
I: To confront something in the moment. It sounds as if you have experiences with that. Could you tell me more about how that was experienced?
F: It gave you the opportunity to have a real situation where you could be given supervision or you could be given affirmation that what you were doing was right in a difficult situation and at the same time the therapists were experiencing how difficult our daily life could be.

Three themes of the therapy process were identified in this sequence: opportunities for supervision by the therapist, for affirmation by the therapist and for the therapist to experience the difficulties of the family. These themes were all classified as belonging to the domain called "manner of therapeutic work", and were specified as three different core ideas: Opportunity (1) for supervision, (2) for affirmation and (3) for sharing experience. Through constant comparison of all the core ideas of the study (Glaser and Strauss, 1968), the first and third core ideas in the example above were seen to be part of "helpful participation" in the family perspective. The first core idea was included in "using professional knowledge", and the second was included in "understanding through participation". The second core idea was part of "the helpful relationship" in the family perspective, and was included in "generating collaboration".

The present study had a defined target group: Four therapists and families who fitted the selection criteria described above. Processes for identifying the experiences of such a pre-defined group as described by Hill et al. (1997) have been followed. Hill et al. (1997) did not use theoretical sampling (Glaser and Strauss, 1968). Instead they defined the sample and "… collect(ed) all the data using the same protocol to ensure constancy of response within a homogeneous sample of

participants rather than alternating between data gathering and data analysis…" (op. cit. p. 521).

Saturation (Glaser and Strauss, 1968) or stability of findings (Hill et al., 1997) is reached if "… new cases do not change the results" (Hill et al., 1997, p. 552). In a process in which 12 to 15 cases are collected, a preliminary analysis of 8 to 12 is completed, and "… if the remaining cases do not change the results substantially, the findings can be considered to be stable" (op.cit. 553). The therapist interviews were fixed (there were no others to interview) so the question of saturation did not apply. A preliminary analysis was completed with 8 families. The next two interviews did not supply new categories and saturation was assumed.

Hill et al. (1997) advocate the use of teams to establish consensus of analysis while Rennie (1992) argues for the use of one researcher as a viable position and maintains that consensus is no guarantee of objectivity. In this study, the author considered the concerns of Rennie as legitimate and this position was taken. At the same time, the use of external judges was seen as an important way of securing different voices and the variety of perspectives in the material. Therefore a participant check (Elliott, Fischer, & Rennie 1999) was performed. The author presented the results to the therapists and two families familiar with their practice. Both groups accepted the findings as valid descriptions of their experience.

RESULTS

The Therapists' Perspective

The analysis produced two descriptions: one based on therapists' views and one on the families' views. Main themes in both connected helpful therapy to conversations, mutual participation and the therapeutic relationship, although these themes were expressed through different metaphors and concepts. The following metaphors, "to get a taste of it", "the lingering conversation and the big tool box" and "to be where people are" (Tab. 3) explicated how therapists described the therapeutic practice they sought to realize at the unit.

"To get a taste of it" pointed to therapists' use of opportunities to have similar experiences as the service users. It was specified by the following sub categories: sharing experiences, participating, attaining mutual definitions and blurring the differences. Experiences of sharing concerned therapists being "…in their shoes…" and getting "…a little taste of it..." (T.A[v]). Through their close work with the

families, therapists described how they often experienced being in the same situation as the families in that they felt helpless in getting through to the children. The therapists also experienced that it was helpful for the families "to see other persons struggle with these problems…" (T.A). There was *"*...a mutual touching, you were touched yourself and they were not unaffected by the way they were being met by us*"* (T.A).

(Insert Tab. 3. about here)

Participation expressed an idea of mutuality. "If you don't have (mutual participation), it's easy for the therapist to see themselves as an expert, which can make family involvement more difficult" (T.C). "Instead…I do try to treat them as experts and elicit their expertise". For instance, in a role play the therapist "switched positions, and was the parent, the child and myself. I had to have help from them about how it had happened, what they had tried and then get their response to my ideas that we then tried out" (T.A). Doing things together lead to "other ways of dealing with the problem … and to co-determination of how to work" (T.C.).

Attaining mutual definitions is exemplified by the following utterance: "(T)hey answered, and I chose to take this seriously, and that again affected them. I think there was a process of definition that went on between us and them." (T.A). The agenda in this process of definition was, for instance, to find out about the problem: "What are we dealing with here?"(T.A.). Through participatory verbal and non verbal activities the family members were experienced as "gradually being woken up as people who had something to say and (the problem) was put into words and made more clear and explicit…" (T.A).This was "an exchange of ideas" (T.A) that gradually gave meaning to and defined the problem and its context.

The focus on mutuality of experience, participation and definition of meaning expressed similarities in the positions of family members and therapists. In the words of T.A:" When you exchanged ideas in this manner the differences became blurred concerning who was the expert and who was not and I like to erase these differences and (the family members) said that it was reassuring." A central characteristic of "getting a taste of it" was this blurring of the differences between families and their therapists. An important effect of the similarity of positions was that it implied obligation on the part of family members because "when you were part of a decision then you had to follow it through" (T.C.). Increased family involvement was the result of this blurring effect.

"The lingering conversation and the big toolbox" points to two intertwined processes. One concerned the use of language in questioning in a lingering way, and the other the use of tools and having access to many therapeutic tools. The starting point for work at the unit was "(t)o ask good questions that could make (the family) see other ways of thinking " (T.B). Questions started a process that opened up a path into the world of events and meanings of the family. Often this concerned aspects of their life "…that were difficult to put into words. It was difficult for them to make themselves understood and make others understand what they struggled with" (T.A). In this situation "asking questions created distance and led to a focus and (possibilities for) summing up and clarifying the situation" (T.A.). Lingering related to the manner in which questions were asked. The decisive aspect was "to be able to linger enough, not to hurry. Create long conversations, linger properly through listening a bit longer, a bit more…(then) what they needed to focus on came about gradually" (T.A).

At the same time the therapists wanted to have a variety of techniques to draw from. T.B. introduced "the big tool box" in the following manner:

> "The question of method, that is, how we work, we aren't so concerned about the distinctions between talk therapy, milieu therapy, play therapy, couple therapy, family therapy, individual therapy…We do all this and are very concerned about having a big toolbox with access to many things, many possibilities, so it's eclectic. We pick what fits with the family."

This practice had led this unit to collect various methods according to the needs of the family. When "we learned something new or sought consultation this came from a family that had told us that this was what they needed." (T.B). The process that led to choice of a particular method was closely connected to the lingering conversation that revealed "the point of view of the family" (T.B). This connection highlighted the importance of intertwining both conversation and the use of specific therapeutic methods or techniques by continuously alternating between talking, conversation and dialogue, and action, interaction and doing things.

Over several years, the therapists had developed a variety of techniques from which to draw. Typically mentioned in this study were: the flip chart and chart pens as tools for visualizing and memorizing material; the use of specific, more-or-less manualized forms of therapy like Barkley's parental training (1997) and narrative practice (White, 2007); tools used across specific methods such as the Genogram

(McGoldrick, Gerson & Shellenberger, 1999) and the Family Dialogue Set (Balmbra, 2006); role-play, puppet theatre, games, the making of videos, the use of photo albums and play were also part of this toolbox. Lastly, the Session Rating Scale and the Outcome Rating Scale (Miller & Duncan, 2004) were used to monitor process and outcome.

Traditionally, pathology has been the focus of mental health. This focus was suggested in the therapist's view of a service user as being "without nuance" or "lacking nuances". The following can be seen to express a different position: "I never declare that 'I'm going to show you how it should be done'. I try to treat them as experts on everything they have tried and to get nuances around their nuances" (T.A.). A pathologizing gaze viewed the service user as arriving "without nuance" for the expert therapist to assess what was wrong. Therapy thus provided an opportunity for correction. A different position was implied when family members were seen as arriving "with nuances". The problem was not seen as that of clients being without nuances, but rather that they had not been given the opportunity to further nuance their already nuance rich lives. Although this interpretation is based on a single statement, the centrality of a non pathological point of view in the practice of the Unit warranted its position as a central characteristic of the therapists' tool box.

"To be where people are" was the central idea of this unit, and meant "to work with what people want to work with" (T.C.) and to "...use the starting point of the family" (T.D). It was specified by listening, taking seriously and believing, by being flexible and by being generous. A central experience for these therapists was that "people actually experienced it as good to be heard. It was…being taken care of" (T.C.) and to "feel that they had been met on what was important to them" (T.B.). The therapists connected being listened to in a satisfactory manner with taking seriously and believing in what people presented. "It was central to take seriously the small signs that something was wrong. They mustn't be overlooked and they must be given words so that (the therapists) can take them into account" (T.A.). Part of the language of change of the unit was that "you must believe…" (T.A.). This meant both believing in the family and believing that "behind all that (the family) had tried out in distressing situations there were positive intentions" (T.A). Embedded here was also the belief that "people don't come to therapy if there isn't the desire for some change" (T.B.). Listening to, taking seriously and believing in people was considered fundamental in helping people to verbally formulate their lives. Very often, clients

had an opinion or a feeling not yet put into words. The therapists took seriously and believed in the signs and hints by which this "not yet said" material was expressed and the family was given the opportunity to formulate and explore their meanings.

Being flexible was specified in the following manner: "I think that we from the start were very preoccupied with listening to the wishes of the family and this word 'flexibility'. In later years we've started to talk about tailoring therapy" (T.B.). Connected to this was the central intention of the unit "of not getting rid of clients and on the contrary being concerned with how we can construct our treatment so that it can fit all families" (T.A.). Therefore choice of method and context of the therapeutic work was always contingent upon the preferences of the family. One question was about the arena of the treatment. "In the home, would we have seen or experienced something different there? I'm always curious about what can emerge there. It's in that arena that (the family) tries out things and sees what works" (T.C.). Work outside the unit, in the home, school and other contexts were therefore important for these therapists. Concerning method of treatment and manner of working, these therapists "picked from what we thought, believed, hoped, felt in relation to the family, and …over the years we have picked up different methods"(T.B.). This was related to "the big tool box" but here therapists emphasized that choice of method always was related to family preferences and goals. This meant that what the therapist saw as the correct path of treatment often had to be changed because "…things surfaced that made us see that it was not possible (for this family) to follow that path" (T.B.). Flexibility and tailoring treatment meant that willingness to give up or defer own therapeutic preferences and follow the family was a cornerstone of the work of this unit.

The source of the concept of generosity was the student therapist (T.D.). Characterizing her colleagues, she stated: "They show generosity. I see it in how they refer to the families, they don't pass judgment on them and they're attentive and ask for feedback". Although generosity was a word that would be difficult for these therapists to use about themselves, they certainly would agree that generosity would be an important value to pursue. "Now we have a superstructure in the concept of the client's own theory of change…that necessitates that we must develop and expand our repertoire continuously" (T.A.). One way of viewing this statement about the relationship to families was that it communicated generosity towards them.

The Families' Perspective

Helpful conversations, participation and relationship were the main elements of the family perspective. Helpful conversations were further specified by asking questions, giving time and structure, giving and receiving feedback, and reformulation. Helpful participation was characterized by using professional knowledge, having many possibilities and understanding through participation. Central to the helpful relationship was listening, taking seriously and believing, being flexible, and the therapists taking a stand against violation, disparagement and degradation.

Insert Tab. 4 here

All the families were represented with statements and meaning units in the three main categories. There was variation in the preferences and needs of the various families. In the following, "all families" means all ten families, "most families" means eight or nine of the ten families, and "some families" means six or seven of the ten families (Tab.4).

The word "effective" is part of the vocabulary of therapists and psychotherapy researchers but was not used by the interviewed families. In the interviews, "help" was the recurring word, as in such statements as "what we do wrong we must get help with" (F10). The ingredients of effective therapy, in the vocabulary of the families, include that which is "helpful".

In "the helpful conversation" all the families particularly mentioned the significance of therapists asking questions, giving time and structuring the work. "N.N. asked questions and dug his way into things…the therapy was very thorough…" (F1). Families connected thoroughness to being given time, not having to rush things, and being allowed to dwell on one's answers to questions. It was also important that these conversations led to structuring the work, especially concerning what to work on and how to do it. Key words and expressions describing this were to "direct", to "guide", to "focus", to "suggest" and "to stick to the plan".

Giving and receiving feedback were significant activities for most of the families, and although giving feedback to the therapists was confirmed as important, the main concern was to get feedback from the therapists: "(M)aybe what was missed was more feedback if I did it correctly…. Am I doing it right or could I have done it differently?" (F10). Some family members said that the therapist could have supplied more feedback about negative aspects of family interactions. Key words were

"state", "be direct" and "be concrete". The focus should be on errors, but in a friendly and non-degrading manner.

Reformulation was identified by some families. "They were good at making us reformulate (through repeating questions like) 'have I understood you correctly?', 'do you mean like this'?" (F7). Key words for the families were "affirmation", "giving different angles", "creating distance" and "getting up the details of the case". Reformulations led to changes in perspective and meaning: "…when I felt I'd failed in something, then they saw it from another angle… and turned it into something positive… and when you're constantly lifted like this, then you do a better job." (F2)

"The helpful participation" was based on the families' advice that therapists should participate actively in the work and supply opportunities for more than talk and conversations. It was important to be able "…to express oneself…by doing things…" (F1). The families invited the therapists to use professional knowledge to establish activities like play, games, competitions, art work, puppet theatre, role play, strolls and making video recordings. Both adults and children found it necessary to do something more than talking. This drew all parties more deeply into the work and increased possibilities for working with the here-and-now, as when "…we took things when they happened" (F3) and solved problems as they arose.

Professional knowledge helped both therapists and families see the situation of the family from the outside and gave the therapist a position of professional authority. Families viewed this authority as necessary in all aspects of family life; externally, in eliciting the necessary resources from helping agencies, especially in situations of conflict between the family and the "system". Here therapists represented the family: "The report from the therapist…was the trump card… that we could win with." (F3). Internally, this authority provided information and transparency for the family concerning the intentions, perspectives and thinking of the therapists. At the same time there were reports that more information could have been given. "We didn't receive so much in the beginning. How the day and work were organized could have been given to us" (F3).

Having many possibilities was important for all the families. This concerned where, when, how long, how and with whom to work. This family unit had the opportunity to go outside the traditional time span and treatment contexts, an element valued by all the families. To stay at the unit gave"…a kind of breathing space…" (F5). Families emphasized the opportunity for the participation of the extended

professional network and the extended family. To involve kin was "…healthy in most connections because they were touched by (the problem) also and they were a great part of the lives of the children" (F9). Organization of the therapeutic work also included separating the family into subgroups that allowed parents to work alone knowing that the children were attended to. The most important context outside the family was the school. Establishing good collaborative relations with the school was a central agenda for all the families.

Understanding through participation was valued by most of the families. Participation in situations similar to those of the family context was often characterized by experiences of failure, both on behalf of the service users and the therapists. The keyword was "sharing experiences": "You do not have to drown in order to be a life guard, but you must take in through your thinking what drowning involves (F5)." Participation did not mean to have exactly the same experience, but for therapists to put themselves in the place of the family. Families viewed understanding through therapist participation as happening in the immediacy of the moment, showing itself nonverbally on the part of the therapist and was received as an embodied experience by family members: " I only needed to look at him (the therapist), and (I knew) he just knew" (T6).

In "the helpful relationship" generating a collaborative relationship implied being listened to, being heard, being taken seriously and believed, and being allowed to follow preferred goals and methods. Therapists who showed they were taking what the person offered seriously were seen to respond to the client as a credible person: "It is frustrating not to feel a credible person…I think it is of the utmost importance (to feel credible)" (F6). When therapists followed the wishes, perspectives and preferences of the family, they were seen to affirm these experiences. When this did not happen, it was important for therapists to relate this failure back to themselves. When a therapist stated, for example, that the mother "…should not rule out the possibility that it was him…" (F6) that was at fault, this dissolved tension and became a step in the right direction in the working relationship.

The personal conduct of therapists was vital in generating a collaborative relationship. To be quiet, patient, friendly, and easy to talk with, non-judgmental, humane and above all, to have a sense of humor made therapists "…easy to collaborate with…" (F4). Sincerity combined with lack of prejudice towards the family was of utmost importance. Prejudice was connected to "knowing better than"

and taking a top down position towards the family :"(The therapists) apologized…and I was heard. I thought it was good that they admitted a mistake because… often we get the feeling…that authorities don't make mistakes. They came down to our level…" (F10).

For some of the families giving of oneself was important. This had to do with therapists telling something about themselves and using stories from their own lives: "That's why I managed to communicate with him because he referred to his own family and we used many images about him and his wife or his children…"(F5). This was experienced as strengthening the bond between the family and the therapist, which again increased collaboration.

Some families reported powerful experiences of violation, disparagement and degradation in their contact with schools, childcare and mental health services. Not being heard or being characterized in a negative manner combined with an emotional atmosphere of contempt defined these experiences. "I got the feeling from the doctor that I was over hysterical and over nervous, and that I was the one who needed help…" (F8). These events had been disruptive and destructive to contact and the possibility of further therapeutic work. They also became pathogenic factors in themselves as traumatic experiences. The families reported that in order to establish a helpful relationship, the therapists needed to take a clear stance against such practices; they should take an active role in fighting them and they should actively seek to ensure that the credibility of the family was re-established especially towards the party that had perpetrated such practices.

DISCUSSION

Getting the perspective of both therapists and clients is an example of a "double description" (Bateson 1980). Double description refers to enrichment of the perspectives of a phenomenon by letting the aspects of a duality supplement each other. Such descriptions are connected through their similarities and enriched by their differences. Among the similarities here, three concepts can be extracted from both descriptions. These are conversation, participation and relationship. These coincide with the helpful ingredients of therapy singled out in the family perspective. From the therapists' description, "to get a taste of it" comes under the concept of participation, and "to be where people are" comes under the concept of relationship. The dual metaphor of "the lingering conversation and the big tool box" taps into both

conversation and participation. In the following, the concepts of conversation, participation and relationship are developed by looking at both the similarities and differences of both perspectives.

Similarities of Perspectives

Among the similarities, the concept of conversation is underlined in both perspectives by the importance of questions and giving time. The concept of participation involves therapists being able to influence the problem and life situation of the family through their provision of expert knowledge (families) and through the idea of having a big tool box (therapists). There is an agreement here that the therapists should make their skills and knowledge available to families, they should be transparent about the thinking and action generated from their knowledge base and they should not disqualify the perspectives of the family; knowing more does not mean knowing best. In addition, the concept of participation points to having many possibilities (families) and being flexible (therapists), and to the idea of sharing experiences (families/therapists) with importance placed on the therapist experiencing something of what the family experiences.

The concept of relationship receives strong support in both perspectives. Both "To be where people are"(therapists) and generating collaboration (families) emphasize listening, taking seriously and believing, establishing and following the family's preferred goals and methods, and using therapists' knowledge within a collaborative venture. The value placed on generosity (therapists), giving of oneself (families) and willingness to blur the boundaries between therapists and families (therapists) strengthens the commitment to such a relationship.

Differences between Perspectives

The differences between these two perspectives enrich the three concepts. Conversation is enriched by the difference in focus concerning the use of feedback. The therapists were committed to the idea of monitoring their work and adjusting it according to feedback about process and outcome[vi]. The families acknowledged this, but gave a strong message that they needed more feedback from the therapists on negative aspects of their own interactions within the family. The therapists were experienced as supportive and this made their focus on such negative aspects safe and secure. Training within the language oriented therapies (Flaskas, 2002) emphasizes skepticism towards labelling the family as "problematic" and positive connotations are promoted (Selvini Palazzoli, 1978). The message from the families was that

therapists did not have to be afraid of focusing on the negative as long as this was within the boundaries of "the helpful relationship" depicted here. This obviously suggests that the families' previous experiences with social services were not perceived in a "helpful relationship" context.

Further enrichment of the concept of conversation was supplied by families underlining the importance of structure. Even though new ideas and ways of working during the course of therapy might be appreciated, they clearly wanted a treatment plan with goals and methods, and active participation of therapists who guided, steered, and influenced the therapeutic process according to the plan. Asking questions, giving time and structuring the work exemplified this. Questioning was a lingering process where each response was governed by the previous response. This was an exploratory process that was open-ended. After a time, however, a focus had to be established. When focusing on a particular aspect, questions about concrete actions usually arose, and a treatment structure was called for. Here the use of the flip chart was highly valued. Although structure could be interpreted as embedded in the therapists' perspective, it was made much clearer within the family perspective. Lastly, some families pointed to the importance of therapists' reformulation of events in and behaviours of the family. The reformulations were experienced as opening up new perspectives with new possibilities for action and experiences. The importance of reformulation confirms the focus of language oriented therapies on meaning making and the generation of new and alternative meanings (Anderson & Gehart, 2007).

The concept of participation was expanded by a difference concerning lack of information, especially at the beginning of contact. For instance, one family recommended the production of a brochure explaining the unit's practice. Because therapists' training had been in the "not-knowing" position (Anderson & Gehart, 2007) it was important for therapists to get to know each family as a unique group without imposing their own understandings. Even though the therapists did not deny their professional knowledge, they may have tended to under-communicate it. The response from the families made it clear that one did not have to be afraid of losing sight of the uniqueness of the family in relation to presenting generalized knowledge. Again "the helpful relationship" secured families' experience of uniqueness; the conclusion is that therapists should be as transparent as possible about their knowledge and experience.

The concept of relationship is enriched by the fact that some families reported experiences of violation, disparagement and degradation in the form of powerful stories about suffering inflicted by the education, health care and social services. This is a reminder that therapy and health care can develop into detrimental processes. When relationships between professionals and families turned into the opposite of "the helpful relationship", adequate problem solving and treatment were hindered. Additionally, the experiences themselves became pathogenic. Service users confirmed therapeutic elements such as "to be where people are" and "to get a taste of it", and underlined the importance of attending to such processes and events. The message to therapists was clear: participate on behalf of families and be their agents in the system. This supports findings of Gehart and Lucas' (2007) work on client advocacy.

In this study the different aspects of the concepts of *conversation*, *participation* and *relationship* have been seen to be intertwined and braided together into different helpful constellations according to the preferences and perspectives of the family. Additionally, the use of professional knowledge, the creation of structure and the supplying of feedback about problematic aspects of family interactions are embedded within and constrained by the helpful relationship. These concepts identify main areas of concern for clinical practice, research and training. These concerns will be discussed in the following.

Implications

The concept of *relationship* in this study parallels the findings of Norcross (2000), but also suggests some expansions that should be given attention in clinical work, training and research. It reflects the importance of the therapeutic alliance (Horwath & Bedi, 2002) and self disclosure (Hill & Knox, 2002) and highlights the importance of privileging and following the perspective of the client. One expansion of the concept of relationship is the role of the therapist in taking an active part in resolving conflicts between the family and other parts of the health care system, social services and school system in a manner that resurrects both the honour of the family and collaboration with these services. This implies the expansion of therapist training to include skills in conflict management and an active role for the therapist as supportive agent of the family. Research into what kinds of skills and knowledge are needed in such situations is therefore recommended. This issue also invites further

research into detrimental results of therapeutic activity and helping behaviours of the helping systems at large.

Embedded within the helpful relationship, more specifically oriented therapeutic activities can and must be implemented. The concept of *conversation* directs attention to all verbal process within the relationship but singles out two possibly opposing processes: a lingering and questioning process which is open-ended, and processes built on and adhering to a particular structure. This indicates training tasks involving management of such potentially oppositional processes. Reviewing existing research (Lambert & Ogles, 2004) gives the therapist much information about adherence to specified therapeutic structures, but there seems to be a lack of research both on the effects of a lingering process and its implementation with structured therapeutic work. Further research is therefore needed.

Research on feedback both to clients (Claiborne, Goodyear & Horner, 2002) and therapists (Lambert & Ogles, 2004) is emphasised within psychotherapy research, but there seems to be a lack of studies reporting the experiences of both the receivers and suppliers of feedback. Further knowledge could guide us in how to train therapists in using feedback, especially when one is continuously monitoring therapy.

Reformulation is probably part of all therapeutic endeavours, though presented through concepts such as redefinition, meaning making, interpretation and understanding, among others. In this study the importance of reformulation must be seen within the boundaries of the helpful relationship. The reformulation must fit the service users in a manner that privileges and upholds their perspectives. This is probably more easily said than done and indicates that a central task in training is the creation of skills that allows therapists to both present something new and support the positions and perspectives of the family.

Above there is identified a possibility of having to deal with aspects that might be experienced by therapists as oppositional. Potentially opposing processes are included within the concept of *participation*. The linguistically and collaboratively oriented therapies (Anderson & Gehart, 2007; White, 2007; Andersen, 1991) that have inspired this unit have a troublesome and sceptical relationship with technical aspects of therapy. Andersen stated: “Therapy is not a technique. It is a way for the ‘therapist’ to engage in client relationships” (1993, p. 305). The fear is that use of techniques and tools turns it into an instrumental relationship, where the family members become objects of scrutiny with the objectification of persons and

relationships as the result. The families in this study expected therapists to be skilful, have knowledge, and use it. What therapists might fear as detrimental to a helpful relationship was taken for granted by the families in this study. For them it was a matter of course that therapists used what they knew and that they shared it. To be able to do this is a necessary aim of training, and also invites research on the collaborative use of specialist knowledge within the therapeutic relationship.

Participation in this study also pointed to being together in joint situations, and doing and experiencing some of the same things. Being personal and allowing oneself to be involved are central skills in this regard and therapists should be allowed training situations that support such personal involvement. The concept of affect attunement (Stern, 1985) from developmental psychology emphasises human skills established long before the initiation of training as a therapist. Training should therefore be about getting to know how to use such innate or early established skills therapeutically and research on affect attunement should be seen as an important goal within psychotherapy research.

Context for changes

The changes that the ideas taken from the models had undergone were contingent upon the context of the Family Unit. Especially important were the problems that the families and therapists struggled with; ADHD, conduct problems, OCD and developmental problems raise specific challenges and are characterized by disrupted interpersonal relationships. What is evoked in the therapist in these disrupting interactions increases the therapist's awareness of the impact of the problem and identifies nonhelpful ways of working. Expanding the conversational perspective of useful sources for therapeutic practice to include action oriented forms of practice and actual participation of the therapist can be seen as a response to such experiences. When working with behavioural problems, the therapist needs tools other than talking; the choice to include, for instance, a token economy or role-play can thus be seen as a consequence of working with disruptive behavioural problems. Many of the families referred to the Unit had also tried therapeutic programs in other agencies with no result. The need for alternative forms of practice is therefore strengthened. Guided by the preferences and ideas of the family, changes and expansions in original guiding ideas and practices can therefore be expected to develop.

CONCLUSION

Conversation, participation and relationship are suggested in this study as three overarching concepts whose specification gives content to the notion of helpful therapy. The importance of the collaborative nature of the models that have guided this unit is confirmed but at the same time there is need for expansion of these models in two important directions. First, the language orientation of the guiding models must be expanded to include action oriented forms of therapeutic practice. Second, the professional knowledge and skills of the therapists do not stand in opposition to the non-expert and not-knowing position of these models. On the contrary, when embedded in a helpful relationship, the skills and knowledge base of the therapists become central tools for the families to access through the transparency and participation of the therapists. There is a clear imperative here for therapists concerning both research and training to generate and access as many skills and knowledges as possible and to do this within the areas highlighted by the concepts of conversation, participation and relationship.

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Table 1 Therapists

Therapist	Gender	Age	Experience	Profession
Therapist A	Male	49	20 years	Clinical psychologist
Therapist B	Female	63	27 years	Clinical pedagogue
Therapist C	Male	56	29 years	Social worker
Therapist D	Female	47	Second year diploma student	Student therapist
Researcher/author	Male	54	25 years	Clinical psychologist

Table 2 Families

Families	Family size	Mother	Father	Children	Interviewed	Status	Therapists
Family 1	3	1	1	1	All	Active	A & B
Family 2	3	1		2	Mother, 1 child	Active	C & D
Family 3	5	1	1	3	All	Terminated	B & D
Family 4	3	1		2	All	Active	A & B
Family 5	2	1		1	Mother	Active	A & B
Family 6	2	1		1	All	Terminated	A & X[vii]
Family 7	4	1	1	2	Mother, father	Terminated	A & B
Family 8	3	1	1	1	Mother	Terminated	A & B
Family 9	4	1	1	2	Mother, father, 1 child	Terminated	C & D
Family 10	4	1	1	2	All	Active	A & B
Total	33	10	6	17	10 mothers, 5 fathers, 11 children	5 active, 5 terminated	

Table 3. Therapeutic work: The therapist perspective

"To get a taste of it"	**"The lingering conversation and the big tool box"**	**"To be where people are"**
Sharing experiences	Questioning	Listening, taking seriously and believing
Participating	Lingering	Being flexible
Attaining mutual definitions	Content	Generosity
Blurring the differences	Nuancing the nuances	

Tab.4. Therapeutic work: The family perspective.

"The helpful conversation"	**"The helpful participation"**	**"The helpful relationship"**
Asking questions, giving time and structure the work (10 families)	Using professional knowledge (10 families)	Generating collaboration (10 families)
Giving and receiving feedback (8 families)	Having many possibilities (10 families)	Giving of oneself (6 families)
Reformulation (6 families)	Understanding through participation (8 families)	Fighting violation, disparagement and degradation (6 families)

II

COLLABORATION: WORKING WITH PROCESS AND OUTCOME

Rolf Sundet, Department of Health, University College of Buskerud, Norway.

Rolf Sundet, Clinical Psychologist, the Family Unit, Department of Child and Adolescent Psychiatry, Hospital of Buskerud, Drammen, & Research Fellow, Department of Health, University College of Buskerud, Drammen, Norway.

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Address correspondence to Rolf Sundet, Department of Health, University College of Buskerud, Gronnland 58, 3045, Drammen, Norway.

E-mail: rosundet@online.no

ABSTRACT

The aim of this study is to explicate how families and their therapists evaluate and describe the use of two measures, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) in order to monitor therapeutic work. The study is qualitative using a modified grounded theory approach. Results confirm the feasibility of these scales as conversational tools although some difficulties and disturbances were identified in relation to both. The family perspective identified four conversational processes and the therapist perspective identified six conversational types. A suggested generalization is that all the measurements and tools applied in clinical practice in principle can be seen as therapeutic tools especially useful for establishing conversations and strengthening collaboration between service users and therapists.

There are clear indications that processes of collaboration between clients and therapists lie at the heart of modern psychotherapy. Levin (2007) used the following definition of collaboration: "to work jointly with others or together especially in an intellectual endeavor" (p. 115). Gergen and Gergen (2007) maintained that collaboration "requires mutual adjustments" (p. 398). What does this mean in a therapeutic context? The following article explores this by reporting from a qualitative study investigating family and therapist experiences of a collaborative practice (Sundet, in press).

COLLABORATION AND PSYCHOTHERAPEUTIC PRACTICE

Collaboration and the therapeutic alliance

Collaboration was seen as a key feature of the therapeutic alliance by Horvath and Bedi (2002) who reported preliminary evidence indicating that collaboration is linked to better alliance and thus to better outcome. Tryon and Winograd (2002) reported the necessity for therapists to attend to patients' concerns and to clarify these through agreement on treatment goals. Friedlander, Escudero and Heatherington (2006), reporting on the therapeutic alliance within couple and family therapy, linked collaboration to increased engagement of the family and Gilbert & Leahy (2007) as central in cognitive and behavioral therapies. Collaboration was exemplified by Katzow and Safran (2007) as the establishment of "a sense of 'we-ness'" (p.102).

Collaboration and postmodern oriented family therapies

Within family therapy, an argument can be made for the postmodern, language oriented therapies as a special resource for development and implementation of a collaborative oriented practice (Flaskas, 2002). Anderson and Goolishian (1988), Andersen (1987) and White (2007) provided examples of therapies that have made collaboration a cornerstone. Researching the collaborative language orientation of Anderson and Goolishian, Gehart and Lyle (1999) reported that both clients and therapists identified "…therapist listening and the sense of being heard as a central aspect of the change process" (p.71) along with the generation of new perspectives. Smith, Winton and Yoshioka (1992), Smith, Yoshioka and Winton (1993) and Smith, Sells and Clevenger (1994) echoed these conclusions in their research on reflecting teams, and the latter underlined the importance of holding up different views to reflect "… the experience of multiple realities" (Smith et al., 1992, p. 430). Research on narrative practice by O'Connor, Meakes, Pickering, and Schuman (1997) reported

increased agency and empowerment of clients as a result of narrative practice. Young and Cooper (2008) reported that feedback from their informants pointed to the importance of "'being' with people in therapeutic conversations that most participants commented on as engaging, collaborative, and facilitative of learning/discovery" (p.79). These contributions connected collaboration with agreement on goals and methods (the alliance), listening to and hearing people, upholding different views, maintaining a sense of 'we-ness' and being with people, and increased engagement agency and empowerment of service users.

Collaboration and the use of feedback

Sundet (in press) reported on experiences of therapists using postmodern, language oriented therapies as guiding sources for their work, and experiences of families participating in this practice. Family and therapist reports on what constitutes helpful therapy reflected the findings discussed above regarding the centrality of collaboration. Dawes (1994) argued that clinical judgments are poor predictors and Horvath and Bedi (2002) stated that in general, clients' alliance rating was a better predictor of outcome than therapist ratings. Thus, although recognition of collaboration as central was useful to developing a helpful practice, the problem still was to judge if one actually had a collaborative relationship with service users; judgments made by therapists themselves were insufficient. Feedback from service users was necessary in order to conclude that collaboration was taking place. This relationship between collaboration and feedback was confirmed by Sundet (in press).

Patient focused research

Investigating the effect of supplying feedback to therapists was the agenda of patient focused research (Howard, Moras, Brill, Martinovich & Lutz, 1996) which proposed the systematic monitoring of patient responses to treatment during the course of therapy and making this information available to the therapist. This required regular measurement of process and outcome (Johnson and Shaha, 1996). Lambert and Brown (1996) made the case for monitoring practice through the continuous use of standardized scales throughout the therapeutic work (Kadera, Lambert & Andrews, 1996). A first step in this process was to operationalize clinically significant change (Jacobson, Follette & Revenstorf, 1984).

The next step in developing a monitoring system was to create expected recovery curves. Using the OQ45 (Lambert, Lunnen, Umphress, Hansen &

Burlingham, 1994) as measurement, two variables—initial level of distress and early response to treatment—were found to account for the majority of the variance (Brown & Lambert, 1998) and were used in computing expected recovery curves in relation to the initial score or severity. A sufficiently large deviation from the expected score and curve represented either clinically significant change or treatment deterioration (Jacobsen et al., 1984). This was graphically expressed by curves in which the direction of this deviation, either above or below the expected recovery curve, expressed these two positions[viii]. The final step was to use this information to monitor the treatment and as feedback for therapists (Lambert, Whipple, Vermeersch, Smart, Hawkins, Nielsen & Goates, 2002; Lambert, Whipple, Smart, Vermeersch, Nielsen & Hawkins, 2001). The results pointed clearly toward the use of feedback as a systematic way of improving outcome where no gains or detrimental results were reported.

Duncan, Miller, Sparks, Claus, Reynolds, Brown and Johnson (2003) and Miller Duncan, Brown, Sparks and Claud (2003) investigated the feasibility, reliability, and validity of two such tools: the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS). Their psychometric properties were found to support the conclusion that these tools yield measurements that fulfill the aim of supplying reliable and valid conclusions concerning the therapeutic alliance (SRS) and the outcome of psychotherapy (ORS). As they were designed specifically as clinical tools, a reduction in their psychometric properties compared with the accepted research tools against which they were measured was viewed as a necessary trade-off (Duncan et al., 2003; Miller et al., 2003). Although the utility of these scales as research tools is not the focus of this paper, the standard of their psychometric properties was still seen as important and valuable within the clinical context. Feedback about the therapeutic alliance and outcome were based on trust in the psychometric properties of these tools. Psychometric properties therefore cannot be excluded from the clinical context.

THE STUDY

Context

The context of this study was the Family Unit, a combined day treatment and outpatient family unit within the Department of Child and Adolescent Psychiatry in a

Norwegian hospital. The unit receives referrals from general practitioners, school health and pedagogical services and child protection agencies. It is a publically funded mental health service of 5 therapists with a residential apartment at its disposal. As a combined day treatment and outpatient unit, it can offer traditional outpatient treatment and supplement this with a stay in the apartment for a maximum of three weeks. A diagnosis of a child or adolescent is required for admission to the service. Common admission diagnoses are conduct disorder, attention deficit /hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD) and developmental or emotional problems. The therapist group consisted of highly experienced therapists with backgrounds in diverse areas of practice and varied therapeutic methods who employed postmodern, language oriented family therapy methods as their main source of inspiration and guidance (Sundet, in press).

Participants

Four therapists (Table 1) and ten families, ten mothers, five fathers and eleven children (Table 2), in total thirty persons, were interviewed. The fifth therapist was the researcher. Table 1 depicts gender, age, years of experience and profession of the therapists. Table 2 depicts family size, who was interviewed, their status at the time of interview and who the therapists were. All the families and therapists were ethnic Norwegians. The families were recruited by the therapists. Both two parent and single parent families, and families in both active and terminated treatments were recruited. The families were recruited by their therapists who were the participating therapists in the study. The researcher secured confidentiality by contacting the family after they had consented to participate and assigning a code to each family to which only the researcher had access. All families asked agreed to participate.

Tables 1 & 2 about here

Data Collection

Data was collected through single interview sessions. The parents were given the choice of an individual interview or an interview as a family. In addition, they were asked if they wanted their children present. If so, the parents asked them to participate. All the families chose a family interview except one of which only the mother wanted to participate (not the father or child). In one family, circumstances prohibited the participation of the children, and one mother did not want her child to participate. Children were present in interviews with seven of the families.

Method

The study employed modifications of grounded theory (Glaser & Strauss, 1968) by Rennie, Phillips and Quartaro (1988) and Hill, Thompson and Williams (1997). The interviews were organized into texts composed of statements that constituted blocks of data (Hill et al., 1997) or meaning units (Rennie et al., 1988). The meaning units were organized into different domains from which core ideas (e.g. the "essence" of statements) were abstracted. These core ideas were compared within and across cases using constant comparison (Glaser & Strauss, 1968) to create categories.

Rennie (1992) argued for the viability of the single researcher and maintained that consensus is no guarantee of objectivity. In this study, the author adhered to Rennie's position, though the use of external judges was seen as an important way of securing different voices and a variety of perspectives in the material. Therefore a participant check (Elliott, Fischer & Rennie, 1999) was performed. The author presented study results to the therapists and two families familiar with their practice. Both groups accepted the findings as valid descriptions of their experience.

RESULTS

The analysis resulted in two sets of categories of responses to the two scales. The first concerned the evaluation of the scales and the second the function of the scales within therapeutic work. In the presentation of the family perspective "all the families" means all ten families, "most families" means eight or nine of the ten families and "some families" means six or seven of the ten families.

Family evaluations

Most families gave confirmation that evaluation using the scales was feasible (Table 3): "Yes, I thought it was OK to use those scales, because they gave an impression of what we were doing, and where I stood" (F1[ix]). One family did not remember much about the scales and remarked that they had not thought much about them but recalled their having been used in an appropriate manner. Another family rejected their use but stated that they understood the significance and feasibility for others. They had rejected them because they looked upon themselves as a verbal family that preferred to give feedback verbally rather than through the scales. One family was ambivalent but recognized different aspects of the scales as significant. The remainder of the families confirmed the feasibility of the scales.

(Insert Table 3 about here)

Feasibility was expressed through expressions such as, "good to use", "clear", "helpful", and "functioned well". Two families reported that the SRS was easier to use than the ORS. It was easier to say something directly to therapists than to indicate where one was on the ORS. Six of the families made evaluative comments about the sub categories in the model for the scales (see below) calling them feasible and useful.

The second main category, difficulties, was specified by three sub categories. Difficulties concerning information about and administration of the scales indicated that more information and instruction could have been given. This concerned especially whom to score on the ORS (e.g. children or parents). It was important that one allowed sufficient time both when filling the scales out and talking about the scores afterwards. This pointed to the importance of opportunities for learning to use them: "Put purely and simply, one must be allowed to learn to use (the scales)" (F1). It was pointed out that the behavior of therapists could vary during a session and that this variation could be difficult to capture with the SRS.

Difficulties concerning the shape of the scales came next. Problems concerning indicating where one was and what one had experienced were described. Making comparisons between sessions and expressing a variety of experience on the sub scales of both the SRS and ORS was sometimes described as difficult: "…maybe I didn't think (the therapists) listened enough, at the same time…(in a way)… they did… so sometimes I wonder which of these two to score" (F2).

The last subcategory was difficulties concerning special situations and relationships. One such situation was filling out the scales for a person diagnosed with dyslexia and reading difficulties. Another parent struggling with ADHD reported that:"…it was too much. I wasn't able to answer clearly because the questions became similar, the questions could have been shorter and limited to two questions" (F5). The question was raised about whether use of the scales could threaten aspects of the relationship with other family members, especially one's children: could they, through discussing the scores, be exposed to material too difficult to handle?:"…it became difficult when the therapists through questioning touched on delicate themes while (my child) was sitting there, and I had to (protect her) by dodging the subject…" (F5).

In connection with all these difficulties there were suggestions on how to overcome them, including making it clearer whom to score, when to score, why the scales were used and suggestions about changing the shape of the scales. The main conclusion of the evaluation was that the scales were useful and should be used; however, when they do not seem appropriate, families should feel free to choose not to use them. When difficulties with their use arose, one required time and opportunity to work with the scales in the manner that best suited the family. It was important to give the opportunity for conversations about their use.

Therapist evaluations

Evaluations of the scales and their application were divided into two main categories, feasibility and disturbances (Table 4). Confirmation of feasibility was provided by all the therapists. Expressions such as, "useful", "fairly useful", "good", "good tools", "satisfactory", and "significant" indicated the feasibility of the scales, and there were few complaints about their use. They were described as useful both within a single session and across sessions, as fun and exciting, and as increasing feelings of safety for therapists. Feelings of safety were connected to service users' acknowledgement of the usefulness of the scales. Overall, there were agreements on continuing with them in the practice of the unit.

(Insert Table 4 about here)

Although there were no concerns about feasibility of the scales, there were reports that they might contribute to disturbances in the therapeutic work:" Having a measure come between (client and therapist), I think that might be difficult… it might be too schematic… it becomes a disturbance in a way" (Therapist B). These disturbances were grouped into three subcategories. The first was disturbances concerning deflection; the scales could become an occasion for deflecting attention and focus away from the central agenda of the therapy towards aspects of the scales. Scale wordings such as "all in all," "generally," and "last week" could lead to a discussion about semantics that therapists experienced as irrelevant to their therapeutic work. Both work and friendships were included in one of the visual analogue scales. This could create feelings of conflict and contradiction, because the relationships between these two areas have potentially different emotional connotations for the service user. The same might happen with reference to the family:"(I)t was the four lines, for example 'interpersonal or the family', then they

can say that …with mum I'm OK, but with dad it's not good" (Therapist B). This generality complicated the making of appropriate distinctions in such matters. Focus on the scoring process as a process of measurement could raise questions about exactness of measurement. Lastly, there were reports about service users declining to use the extreme points of the scales, leading to discussion of their use. All this could lead to deflection of attention away from therapeutic concerns.

Disturbances concerning special situations had to do with aspects of these situations influencing the use of the scales. This was often connected to issues of power and autonomy. Being referred by other agencies for assessment of parental care or treatment was a situation characterized by feelings of vulnerability and failure. Meetings with Child Care Services were specially mentioned. Service users in this situation were sometimes seen to give high scores in order to communicate that everything was in order. Particular problems arose when therapists met people with different cultural and ethnic backgrounds:" (I)n relation to people with a different language background, I think both that the scales are difficult and possibly that they're not used to thinking so much about this" (Therapist C). A different language background and low skills in the Norwegian language could complicate understanding subtleties of meaning of scale items. Another aspect had to do with expectations about Norwegian culture. A high score might be understood as a sign that service users would have to end contact with the helping agency whereas a low score might be produced in order to secure continued contact with the unit. When the service user felt uncertainty in meeting therapists because they were seen as representatives of the official health care system, high scores might have been a way of communicating that everything was okay, or that it was important to focus on those aspects of one's life that functioned well.

Lastly, there were disturbances concerning the scores of children and adolescents. One difficulty was how to understand their scores. Children who varied their scores could be understood as thinking through the questions before scoring. At the same time, there were many children and adolescents who had stable high scores, often above 25, which is the non-clinical area of the ORS. A frequent question for the therapist, then, was whether a high score was a way of emphasizing that which was good although other aspects of life on the scored dimension were not good. Did they choose to give high scores until they felt safe? Was there an agenda to please the therapists? Was a high score a way of avoiding questions? Very often, both

children and adolescents expressed feeling safe in the Unit. This was both stated verbally and demonstrated through their behavior and participation in the work. The high scores might have been a way of expressing this. Lastly, it was acknowledged that the score of the child or adolescent was dependent on their level of maturation. In conclusion, researchers and clinicians need more information about the experiences of children and adolescents with the use of these scales.

Scale function: *The family perspective*

The analysis of the ten family interviews concerning the functioning of the SRS and ORS resulted in four main categories, each specified by two sub categories (Table 5). To communicate, included processes that made it possible for each family member to express and tell; to step forward as a person: "…and be allowed to be oneself and tell it straight from the heart" (F10). Especially important were the opportunities the scales gave for expression of and talk about the problem. They represented a simple means:"…of telling how you are" (F9). They also gave opportunities for non verbal self expression:"Those who did not want to speak, could mark it on the scale instead…," (F4); and:"…it was a plain way of expressing feelings" (F3).

(Insert Table 5 about here)

The second, to state areas of acceptance and change, included feedback about therapeutic processes and the outcomes of these. Using the SRS and the ORS to give feedback to the therapists was acknowledged as: "…helping (them) help us" (F9); "It would be difficult to correct things without feedback" (F10); "…and feedback to the therapists made them understand whether they had hit the target or not" (F7). To be able to signify when one did not feel heard, when one was dissatisfied with the therapeutic method and when the therapists represented a disturbance were reported as important areas of use for the scales. When a mistake was made: "...it was very good that (the therapists) apologized. They're only human and they don't have to pretend to be different or put themselves above the families" (F10).
When the families had given their feedback it was of utmost importance that the therapists took this seriously, believed it and responded according to the message received: "…then the scales functioned as they should" (F10).

Next was to focus. The scales helped direct attention towards what to look into: "…what we should work on" (F2). In the first sub category, to

visualize:"…things showed themselves through the scales" (F1). Often the service user had merely a sense of what he or she wanted to express, and:"…the trajectory, the visual image of the scale…helped…" (F3). By marking the visual analogue scales, what was sensed was made visual:"…to see it in written form…in black and white…" (F5); and thus …detach it a bit from the dialogue…" (F7). This made it possible to develop words to describe the initial, immediate sensation: "When I see things about myself, they become more distinct" (F5). Making sensations distinct through conversation was an important step made possible by using the scales:"The therapists were thorough …they didn't stop until they got an answer…and it became a good way of getting to know where one stood" (F1). The visual aid made it possible to see other family members and made more distinct what one held as important. One could gain a new perspective by seeing an aspect on paper rather than merely talking about it. One important effect of this was that:"…one became much more conscious of where the other (family members) were in their experience of daily life" (F3). Other important effects of the scales were that they gave an "overview" (F9), and helped in "ranking" (F7) themes to work on, which again was an important part of making distinct and differentiating where, how and on what to work. This was connected to the next main category, <u>to structure</u>.

Different options regarding where and how to proceed gave direction to the work. Through the overview generated and the concrete scores on the SRS and the ORS it became possible to decide where one should start and this was often indicated by the lowest score.

The scales state broad areas or directions in which to move. The person, family or network is the agenda of the ORS whereas aspects of the alliance are indicated by the SRS. Conversations based on the scales could again open up new directions in which to move: "(The therapists) …could ask if something was missing … and we could find what would make things easier for us" (F9). This meant that within the chosen direction, one followed a thematic content. If, for instance, the direction of the work was the family, a series of themes could be attended to such as child rearing practices, the state of the child, his or her needs, et cetera. Another important theme highlighted in this way was the relationship of the family to the school and the situation of the child in this context.

To discover and to deepen specified the last main category, <u>to explore</u>:"All you had to do was mark the scale and then we had a conversation that allowed us to find

out what was not functioning" (F4). This involved therapists being thorough in asking questions, always being able to ask another question, and setting up conversational processes of exploration through which the client could discover new aspects of his or her life, self or relationships: "There were a lot of questions about why we had scored the way we had so one got more than what the reason for the score was, so the questions afterwards were essential" (F3). Discoveries could be about oneself or other family members. For parents especially, themes concerning the children were naturally central:"It was good to see that we followed each other, there was agreement, and we got affirmation that we know our children" (F10).

Having made a discovery, one's knowledge about this could be deepened through further thorough conversations:"We went through and talked about why we didn't score at the top, why we scored so low, and then you touched on things… and you could go deeper into things" (F3). The thoroughness of the therapists was revealed in the use of questions:"They went very thoroughly into it, because they saw our low score … and they didn't stop before they got an answer" (F1). This process brought the families closer to important aspects of their lives and relationships:"One question we've had often is 'how are you?', and when we say 'good' then you have to say good in relation to what and then you come closer to the reality"(F6).

Scale function: The therapist perspective

All the therapists saw the scales as tools for conversation through the opportunity they afforded for posing questions to the service user. They provided openings into conversations that led in different directions. Six openings for conversations (Table 6) creating six conversational types have been differentiated.

(Insert Table 6 about here)

The scales were introduced into the Family Unit in order to secure feedback, and were confirmed as openings to conversations about feedback, progression and change. An ideal was the goal of changing ways of working in accordance with feedback. Receiving feedback and working with it created feelings of safety and excitement in the therapists. Detecting a decreasing curve was especially important, as this created an opportunity for stopping processes of no change or maltreatment. The feeling of safety was also connected to clarifying useful ways of working. Some therapists found it difficult to talk about negative developments. Here the scales

provided an opening for service users to voice their frustrations about the therapeutic work, and legitimized talk about frustrations. Therapist D commented: "A teenager who did not want to be here scored at the bottom on everything except on being seen and understood which was almost all the way up, and I saw that he was actually seen and understood. This was honest feedback". But frustration and lack of change were not the only themes. A rising curve could reflect recovery and without the scales, recovery and change could have been overlooked. Following each other's curves gave family members insight into the processes of change that other family members were going through.

The scales were experienced as openings for creating routine and structure. They were "reminders", helping the therapist remember themes and agreements between family members about how to work. Each component of the scales gave opportunities for creating a structure that fitted the family. Structure did not imply rigidity and it was always the response of the family that became decisive for the successive response of the therapist. Therapist A observed: "They were not unaffected by the manner in which we met them, and when they were given a scale, then they responded, and I chose to take seriously what they scored, and then that in turn affected them". Following the structure suggested by these measures, especially in situations where there was great uncertainty about what to do and how to do it had the effect of increasing feelings of safety.

The scales were also experienced as openings for conversations that expressed experiences, meanings, and perspectives about the therapeutic work. The families expressed how things were developing for them, what they wanted to happen, and their views and perspectives on all relevant aspects of their lives. The SRS indicated whether the service users felt heard, if the work incorporated their goals, if it was being done in a preferred manner and what they felt about it in general. The ORS invited service users to communicate how they felt about themselves, towards their family, towards the social network and about how they were doing generally in life. Conversation within these areas was identified as important. One important issue was how parents used the scales to communicate about their children and explore how to best care for them. Children and adolescents used the scales to ask for breaks, to establish when to finish the work, and to pose other questions about regulating how much work one was required to do and which conversations to enter into or not.

Therapist B recalled finding entry into both humor and mastery in an unlikely place:"A small boy …got the scale with faces to draw on, and he was hardly able to draw, but he demanded the 'lales' every day".[x]

The scales were important as openings for conversations characterized by the not-knowing position (Anderson, 1990). After being instructed in the use of each scale, the therapist measured out the scores, computed the total score for the ORS, inserted the score, and drew the curve. The score and the curve were then an opening for questions from a not-knowing position such as: "What do you think, seeing this?"; "What does this tell you?" There could be clear answers to these questions, but just as likely the answering process brought forth new thoughts for the user. A dialogical process was set up in which new ideas were brought forth, nuances created and knowledge generated. Questions about the scales exemplified this:"It is clear that if … (the score) comes down, then this is at once a foundation for asking questions about it. Difference is interesting even if it's small… it's a basis for asking questions …about the background for scoring as they have done" (Therapist A). In this process, new knowledge could arise for the family as well as the therapist.

The scales allowed for externalizing conversations (White, 2007), particularly through making distinctions between persons and problems. An important issue in this respect was that persons and relationships are not the problem, the problem is the problem. Externalization was an explicit aspect of this Unit's conversational style. Therapist A described this mode:"The next day we were joking about how today was going to be, and then it became just as much a question about how much the problem was exposing itself in the here and now, as a question about what we were doing." The separation of problems and persons is embedded in this way of talking. Therapist B talked about this as working "at a remove." One literally placed the development on the table in the form of scores and curves. As visualizations, these became a focus of joint attention for the participants:"… you can talk about it as something down here (knocks on the table), not as something inside you" (Therapist D).This created distance and one could then relate the questions and conversation towards what the scores and curves represented. Here, we saw that externalization was generally directed towards making distinctions between persons and aspects of relationship and therapy. The development of therapy was depicted through the ORS and the SRS and placed outside the person. This increased the possibility for the

person to view and relate to these developments in new ways. Viewing the scales in an externalizing manner became an additional avenue to new knowledge for the families and their therapists.

The scales as openings to conversations that bring forth a product or result led directly into what the family wanted to achieve. Parents tuned in to their children, scored them, and stated that they would not be content until their children felt okay. These conversations often resulted in concrete results. Therapist A notes:"I got it confirmed that seeing the rise of the curve became dangerous because it was at the end of our contact and it became an underlining of having achieved something but at the same time seeing that it was fragile. So the thought of being alone made them afraid… (This led) to a conversation about… what to do for the continuation." Service providers in the local health care system had been experienced by the family as unwilling to provide support; however, the result of these conversations was that providers became more engaged. The therapists entered into the lives of service users to achieve concrete results such as placing necessary help in the home to counteract a problem, and attended meetings and lobbied for the rights of the family. Taking the scores seriously helped therapists emphasize their position as persons who actively took a stand with the family.

DISCUSSION

The conclusion of this study is that the SRS and the ORS function as conversational tools. In addition to their intended function to supply feedback on process and outcome this study identifies a surplus value in these scales concerning both conversational processes and types. Other researchers have come to similar conclusions concerning tools for monitoring practice (Sapyta, Riemer & Bickman, 2005; Stratton, McGovern, Wetherell & Farrington, 2006). Sapyta et al. (2005) introduce the possibility of supplementing the feedback with interventions. Harmon, Hawkins, Lambert, Slade & Whipple (2005) describe a set of clinical support tools activated with feedback about no change or detrimental development. The Family Unit has not had resources such as computer based systems nor systematically developed manuals for formal assessments and suggestions for interventions. Instead, the Unit uses a pencil and paper format (Henkelman & Paulson, 2006) and has developed conversational ways of responding to feedback. Both perspectives in this

study give strong support to the view that these scales function as conversational tools. The conclusion is that this can maximize their value in therapy.

Suggestions for in-session practices

Within both the therapist and family perspectives the scales are seen as creating opportunities for conversations through inviting the asking of questions. The conversational types within the therapist perspective emphasize concerns, in addition to feedback, such as "structure", "meaning", "discovery", "separation between persons and problems" and "getting results". By asking questions about the scores on the SRS and the ORS conversations within all these areas are enhanced. In the family perspective, central issues are movement from general meaning making to specific feedback, from sensation to verbalization, from chosen direction to thematic content, and exploration leading to discovery and deepened knowledge. These conversational processes are all made possible and enhanced by the use of the scales.

The surplus value here concerns the experience that although these conversational processes and types can be invited and created from many different therapeutic positions and manners of working, the experience in this study is that especially in situations of no change the use of these standardized tools makes available new options in the session. This has changed the focus regarding other standardized tools such as tests and questionnaires. All such standardized tools can, in principle, be seen as therapeutic tools especially useful for establishing conversations and strengthening collaboration between service users and therapists. This implies that all measurements, questionnaires and manuals have the potential for being tools for conversations. This point reflects a distinction between information gathering and therapeutic models of assessment (Finn & Tonsager, 1992, 1997) in which therapeutic assessment is a collaborative venture between clients and their therapists: "The tests and methods used are an opportunity for the client to communicate with the assessor, and responses reflect the quality of the developing relationship" (Tharinger & Finn, 2007, p.297). Hilsenroth, Peters and Ackerman (2004) report that a working alliance developed during psychological assessment conducted using a collaborative therapeutic model of assessment (Finn & Tonsager, 1997) was transferred to formal psychotherapy and was significantly greater than for patients receiving psychological testing from a traditional information-gathering position.

This has possible consequences for how to view assessment. For the therapists in this study working with the SRS and the ORS as conversational tools, these processes were not separate from therapeutic work but integrated as processes of such work. Early change and therapeutic alliance are among the best predictors of outcome (Haas, Hill, Lambert & Morrell, 2002). This fact points to the fact that therapeutic work begins with the first contact with the family in contrast to the traditional way of considering assessment, diagnosis and treatment as separate stages of a linear process. In the perspective argued for in this article, assessment and diagnostics including treatment plans grow out of the therapeutic work as integrated elements. This is not an argument against assessment and diagnostics however, but rather promotion of a perspective in which one always begins with treatment, assessment and diagnostics are integral processes of treatment and treatment is dependent on the results of communication, monitoring processes and feedback. This perspective supports a view of therapeutic change in line with Wampold's (2007): "…communication is not simply a necessary condition for the remediation of a dysfunction but is the primary mechanism of change" (p.861).

Patient focused research argues that whenever therapy is formally assessed to be working and helpful, the chosen method or manner of working should be continued (Hawkins et al. 2004; Okishii et al. 2006); there is no reason to change a winning team. When there is no change or detrimental development the situation is different. Here the therapist's method is ineffective and there is a lack of treatment options. The families report the experience of two such situations in previous therapeutic encounters. In one, "everything" had been tried and there were no options for further action. Here, increased exploration of experiences, previous solutions, hints and ideas within the family appeared to lead to new possibilities. In the other situation, therapists had not followed the hints, suggestions, ideas or theory of change of the family (Duncan & Miller, 2000). These families had had experiences of not being heard, or of being regarded as uncooperative and difficult because their ideas about change differed from those of their therapists. Also, some of these families had experienced violation, disparagement and degradation in relation the social welfare and health care systems (Sundet, in press).

As stated above, therapeutic collaboration is a central avenue to healing and problem solving (Saggese, 2005) and the establishment of such collaboration is particularly pertinent with these families. For the therapists, feedback on process and

outcome is essential in this respect. In addition, this feedback and the other conversations generated through the use of the scales contribute to the creation of a therapy that fits and works for the family. Pinsof and Wynne (2000) argue for an idiographic couple and family therapy "organized in regard to individual and specific cases" (Pinsof & Wynne, 2000, p.4). This is not to disparage knowledge of efficacy and effectiveness, but to underscore the fact that it is the response of the family to the response of the therapist that is most decisive for the therapist in his or her choice of approach. This is seen as an integral part of being flexible and follows the American Psychological Association's recommendation that "…psychological services are most likely to be effective when they are responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences." (APA Presidential Task Force on Evidence Based Practice, 2006, p.278).

A central agenda for therapists in this study is to follow the lead of the family and this is seen as dependent upon receiving feedback from the family (Sundet, in press). The question of whether the therapist actually responds in an adequate manner to the family and follows its theory of change can only be answered by service users themselves; informal clinical assessments of these questions is insufficient (Hatfield & Ogles 2004). At the same time, the families in this study underlined that an important aspect of the collaborative venture was to seek solutions and manners of working within the professional knowledge base of the therapists (Sundet, in press). In this perspective, therapeutic work can be described as a continuous learning process (Pinsof & Wynne, 2000) in which the responsibility of therapists is to make their knowledge base transparent and accessible to the families.

Enhancing contact with research and professional manners of thinking

Patient focused research is considered to lessen the gap between research and clinical work (Lutz, et al., 2006). The results of this study agree with this conclusion, and it is argued that patient focused research also may lead towards a conceptualization of psychotherapy as an egalitarian and mutual relationship characterized by collaboration. This study questions how this kind of relationship might affect the perception of traditional psychotherapeutic concepts such as motivation, resistance and transference. Perhaps the central question of psychotherapy is not whether the client is motivated for change, but what his or her intentions are when they come to the clinic (White, 2007). Perhaps the problem is not unmotivated clients but the fact

that clients and therapists often are motivated to do different things. Perhaps in situations of no change, exploration of therapist intentions and motivations is a more profitable avenue than increased use of psychological explanations of the lack of change in clients (Baldwin, Wampold and Imel, 2007).

Lastly, the use of scales like the SRS and ORS as tools for conversations along the lines presented above turn formal and standardized monitoring of process and outcome into integral parts of family therapy as a collaborative venture between family members and therapists. Sundet (in press) connects this venture to the language oriented therapies and suggests how these manners of working are expanded through a family perspective. The evaluations of the SRS and the ORS by families and therapists support the centrality of collaboration and the role of scales in expanding and securing such collaboration. For this author this means that through formal and standardized monitoring of practice, classical research based therapy and post modern language oriented forms of therapy are brought into a productive contact.

Limitations and future research

This study exemplifies how research can be applied in a naturalistic clinical setting using one of the participating therapists as a researcher. This internal position of the researcher can be seen as both a strength, in the sense that the researcher has a first hand, insider knowledge of the practice under study, and at the same time as the main weakness of the study. One main problem here is the ability to see something new in a familiar situation and make sure that that which is foreign to the researcher is included in the study. The conclusions of this study must therefore be corroborated by other studies performed from other positions. More research is especially needed on the efficacy, effectiveness and effects of conversational processes and types similar to those described in this study.

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Table 1 Therapists

Therapist	Gender	Age	Experience	Profession
Therapist A	Male	49	20 years	Clinical psychologist
Therapist B	Female	63	27 years	Clinical pedagogue
Therapist C	Male	56	29 years	Social worker
Therapist D	Female	47	Second year diploma student	Student therapist
Researcher/author	Male	54	25 years	Clinical psychologist

Table 2 Families

Families	Family size	Mother	Father	Children	Interviewed	Status	Therapists
Family 1	3	1	1	1	All	Active	A & B
Family 2	3	1		2	Mother, 1 child	Active	C & D
Family 3	5	1	1	3	All	Terminated	B & D
Family 4	3	1		2	All	Active	A & B
Family 5	2	1		1	Mother	Active	A & B
Family 6	2	1		1	All	Terminated	A & X[xi]
Family 7	4	1	1	2	Mother, father	Terminated	A & B
Family 8	3	1	1	1	Mother	Terminated	A & B
Family 9	4	1	1	2	Mother, father, 1 child	Terminated	C & D
Family 10	4	1	1	2	All	Active	A & B
Total	33	10	6	17	10 mothers, 5 fathers, 11 children	5 active, 5 terminated	

Table 3. Family evaluations

Feasibility	Difficulties
Confirmation	…concerning information about and the administration of the scales
Confirmation of functions	…concerning the shape of the scales
	…concerning special situations and relationships

Table 4. Therapist evaluations

Feasibility	Disturbances
Confirmation	…concerning deflection
	…concerning special situations
	…the score of children and adolescents

Table 5. The scale function: The family perspective

1.0.To communicate	2.0. To focus	3.0. To structure	4.0. To explore
1.1. To express and tell	2.1. To visualize	3.1. To give direction to the work	4.1. To discover
1.2. To state areas of acceptance and change	2.2. To make distinct	3.2. To state thematic content	4.2. To deepen

Table 6. The scale function: The therapist perspective

The scales as openings;
…for conversations about feedback, progression and change.
…for conversations that create routine and structure.
… for conversations that express experiences, meanings, and perspectives about the therapeutic work.
…for conversations characterized by the not-knowing position.
…for externalizing conversations.
…for conversations that bring forth a product or result.

III

Therapeutic collaboration and formalized feedback: Using perspectives from Vygotsky and Bakhtin to shed light on practices in a family therapy unit.

Rolf Sundet
Buskerud Hospital and University College of Buskerud, Norway

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ROLF SUNDET is a clinical psychologist working at the Family Unit, Department of Child and Adolescent Psychiatry, Buskerud Hospital, Drammen, and as a lecturer at the Department of Health, University College of Buskerud, Drammen, Norway.
CONTACT: Rolf Sundet, Haugveien 5, 3340 Åmot, Norway. [E-mail: rosundet@online.no]

ABSTRACT

Patient-focused research points to the necessity of continuously monitoring process and outcome in psychotherapy, supplying service users and their therapists with feedback as a way of avoiding no-change and detrimental development. At the Department of Child and Adolescent Mental Health, monitoring is implemented in an intensive family therapy unit inspired by postmodern and language oriented forms of family therapy using two scales, the Session Rating Scale and the Outcome Rating Scale. Research-generated descriptions of users' experiences of these scales as conversational tools are reflected upon through concepts from the work of Vygotsky and Bakhtin. Mediation, dialogicality, voice, the zone of proximal development and the metaphor of scaffolding are offered as conceptualisations that expand the inspirational sources of the unit by creating and enhancing further possibilities for collaboration between families and their therapists.

KEYWORDS

patient-focused research, feedback, conversational and conceptual tools, collaboration

Within the field of psychotherapy, different theoretical positions have served as a platform for the development of knowledge and practice. Research into the positions and practices of psychotherapy has become increasingly important in recent decades. At center stage of this development is the concept of evidence-based practice (Goodheart, Kazdin and Sternberg, 2006; Norcross, Hogan & Koocher, 2008). Laboratory research through the use of randomized clinical trials has established the efficacy of psychotherapy at the group level (Dawes, 1993; Lambert, 2004). We now know that for a specified group of patients, a particular method will be helpful for a certain proportion of patients within this group. It is also well established, although controversial, that this efficacy level is constant across different theory driven methods and that one interpretation of this is that the effective ingredients in psychotherapy are common among different methods (Hubble, Duncan & Miller, 1999; Wampold, 2001). This supplies the clinician with many potentially helpful options as well as with a central problem. We may know that a method or a manner of being together is helpful at the group level but we do not know if it is helpful for the next patient that enters the office. We only know that there is a heightened probability of the approach being helpful. Further, we know through research that there are patients who do not get help from evidence-based methods and that there are those who become worse (Lambert, 2007). Again randomized trials do not supply an answer to the question of who these patients are. This is the concern and starting point for patient-focused research (Howard, Moras, Brill, Martinovich and Lutz, 1996; Lambert, 2007) which aims to systematically monitor patient responses to treatment during the course of therapy and make this information available to the therapist with the assumption that this practice enhances the results of therapy (Howard et al., 1996). Michael Lambert and co-workers (Finch, Lambert, & Schaalje, 2001; Harmon, Hawkins, Lambert, Slade & Whipple, 2005; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005; Lambert, Whipple, Smart, Vermeersch, Nielsen & Hawkins, 2001; Lambert,

Whipple, Vermeersch, Smart, Hawkins, Nielsen, et al., 2002;Okiishi, Lambert, Eggett, Lielsen, Dayton, & Vermeersch, 2006) have extensively and systematically investigated this perspective. The results point clearly towards the use of feedback on process and outcome as a systematic way of improving results in cases where no gain or detrimental results have been reported. This has been called "a revolution in progress" (Aveline, 2006, p.233).

There exist many different outcome management systems, all based on the idea of continuously monitoring the outcome of therapy and feeding this back to therapists, especially in therapies where there is lack of development and change or detrimental developments (Grissom, Lyons, & Lutz, 2002; Kordy & Bauer, 2002; Lambert, 2007; Lutz, Martinovich, Howard, Leon, 2002;

Miller, Duncan, & Hubble, 2004; Pinsof, Mann & Lebov, 2000). Within the different outcome management systems, the aim has been to develop clinical practice guidelines, appropriate practice standards and the benchmarking of therapy outcomes through access to outcome data from actual practices (Audin et al., 2001). One focus has been for management to increase the potential for control and overview of the production of health care within an organization. Thus patient-focused research has been concerned with both management and organizational issues and on securing change in individual cases where there are no or detrimental effects; that is, not-on-track cases.

Although we know a lot about the effects of feedback, we do not know much about what happens within therapy sessions when such feedback is made available to therapists and their patients. Even if we know that clinicians increasingly accept the use of formalized feedback as part of their clinical practice (Hatfield & Ogles 2004), we do not know much about how they use such feedback. What in-session behaviors characterize the work with process and outcome feedback? Aveline states: "I would like to see a qualitative investigation of what the measure means to patients and how much they use it as a means to communicate with therapists and clinical services"(Aveline, 2006, p..231).

A qualitative study of experiences of feedback using the Session Rating Scale and the Outcome Rating Scale

The Family Unit, Buskerud Hospital in Norway, currently employs pencil-and paper versions of the Session Rating Scale (SRS) (Duncan et al., 2003) and the Outcome

Rating Scale (ORS) (Miller, Duncan, Brown, Sparks and Claud, 2003) to monitor practice[xii]. The unit has used SRS and ORS regularly since 2001. SRS and ORS are both one page measures consisting of four items each in the form of 10 centimeters visual analogue scales. SRS is formed from Bordin's (1979) concept of the therapeutic alliance and invites the service user to assess and give feedback about the session just finished. Item 1 invites evaluation of the emotional bond while item 2 and 3 concerns agreement on goal and methods. Item 4 invites the service users to score the overall experience of the session.

ORS invites the service user to score and give feedback on the current feelings of the service user concerning her or his well-being (item1), close relationships (item 2), work, school, friendships (item 3) and general sense of well-being (item 4). As in the computerized systems, this pencil-and-paper version on outcome informs clinicians on a session to session basis about the development of the therapeutic work. Scores are computed by simple applying a ruler, measuring each item marked from left to right with a maximum score of 10. Total score (well-being) is 40 and the continuous development of the outcome of therapy is expressed by physically drawing a trajectory on a supplementary sheet of paper. Scores below 25 is seen as the range where a need for therapy is indicated. Clinically significant change towards recovery is expressed by an increased score of more than 5 points; recovery is expressed by a movement from below to 25 to above 25. No development means scoring within a range of 5 points compared with the initial score and detrimental development is expressed by more than 5 points decrease.

Duncan et al. (2003) and Miller et al. (2003) investigated the feasibility, reliability, and validity of these tools. Their psychometric properties were found to support the conclusion that these tools yield measurements that fulfil the aims of supplying reliable and valid conclusions concerning the therapeutic alliance and the outcome of psychotherapy. As they are specifically designed as clinical tools, a reduction in their psychometric properties compared with the accepted research tools against which they are measured is viewed as a necessary trade-off.

The Family Unit is a small combined day-care and outpatient family unit in the Department of Child and Adolescent Mental Health in Norway. Common admission diagnoses are conduct disorder, ADHD, OCD and developmental or emotional problems. Many families have tried other treatment programs without success. Usually, there are multiple contextual issues related to the problems. The

concepts of multi-agency situation or complexity (Seikkula & Arnkil, 2006) describe the situation of these families. The work is eclectic but grounded in the collaborative language systems approach of Goolishian and Anderson (1987), the reflecting processes work of Andersen (1987), and the narrative practice of White (2007).

A qualitative study was instigated in 2003 to investigate the practice of the unit. Interviewing the four therapists and ten of their families, in total 30 persons, descriptions of the use of these measures (Sundet, 2009a) and the practices in which they were embedded (Sundet, 2009b) were developed. The study employed modifications of grounded theory (Glaser & Strauss, 1968) by Rennie, Phillips and Quartaro (1988) and Hill, Thompson and Williams (1997). The interviews were organized into texts composed of statements that constituted blocks of data (Hill et al., 1997) or meaning units (Rennie et al., 1988). The meaning units were organized into different domains from which core ideas (e.g. the "essence" of statements) were abstracted. These core ideas were compared within and across cases using constant comparison (Glaser & Strauss, 1968) to create categories.

Hill et al. (1997) advocate the use of teams to establish consensus of analysis while Rennie (1992) argues for the use of one researcher as a viable position and maintains that consensus is no guarantee of objectivity. In this study, the author considered the concerns of Rennie as legitimate and this position was taken. At the same time, the use of external judges was seen as an important way of securing different voices and the variety of perspectives in the material. Therefore a participant check (Elliott, Fischer, & Rennie 1999) was performed. The author presented the results to the therapists and two families familiar with their practice. Both groups accepted the findings as valid descriptions of their experience. In the following a brief summary will be given of the developed categories describing the use of SRS and ORS (Sundet, 2009a).

Both the families and their therapists emphasized SRS and ORS as tools for creating and shaping conversations (Sundet, 2009a). All the above mentioned aspects of the measures and theirs scores are in this study revealed as different openings for conversational types and processes by being opportunities for asking questions. All the participants identified questions at the centre of helpful therapeutic practice. Categories expressing six different types of conversations were identified in the therapist interviews: Conversations about feedback, progress and change; conversations that create routine and structure; conversations that expressed

experiences, meanings, and perspectives about the therapeutic work; conversations characterized by the not-knowing position; externalizing conversations and conversations that brought forth a product or result (Sundet, 2009b). The conclusions of the therapists were that the feasibility (Duncan et al., 2003) of these measures was tied to their function as tools that created and opened up possibilities for conversations. For instance in many of the families originally referred to work on interactions within the family, responses on both SRS and ORS revealed that changes outside the family connected to economy, employment, social and educational support in the school and broader network were often a main concern that had to be attended before working on internal interactions. The last type of conversation concerning products and results often revealed these situations.

The interviews with the families identified another perspective on these measures as tools. They did invite different conversational processes. First of all, they invited the family members to express anything that came to mind and more specifically about areas of acceptance and change; they initiated *processes of communicating*. In addition, many family members reported situations in which they had difficulties verbally formulating why they had scored as they did. The score became a visualization of nonverbal impressions and repeated questioning gave these verbal forms: *"I only had the feeling of being troubled at the school meeting when I did my scoring, and now I see that this had to do with never being listened to or taken into account"*. The movement from non-verbal impressions to the verbal could be seen as a *process of focusing* the therapeutic work. The different items on the SRS and ORS represented different directions in which to move the conversations and work (*"My relationship with my son's teachers"*). Having chosen a direction, the therapist might use questions to crystallize a theme to be investigated within this direction: *"How can I express myself in the school conference in order to be better listened to?"* This process established the agenda for the therapeutic work at any particular point in time. The therapeutic work was then built contingent upon the continuous conversations established through the accessed feedback on process and outcome. The treatment plan became an end result rather than a pre-planned package. This movement represented a *process of structuring* the therapeutic work.

The families used the word "thorough" to specify the process of asking questions (Sundet, 2008b). The scores on both the SRS and ORS provided opportunities for this process, and questioning often led to discovery of something not

previously thought of. When a discovery was made, knowledge about it could be deepened and transformed into new options for meaning and action: *"I discovered the importance of not escalating conflicts in school meetings by criticizing the teachers, and instead to only state my preferences*". This movement represented *a process of exploration.*

From both therapist and family perspectives, the use of these tools was helpful in establishing focused flexibility with opportunities for making changes in work approach in response to experience. Their use was also helpful in attaining and upholding structure according to decisions made by the participants. Therapy was not seen as a whimsical and haphazard event, but as an ordered process that followed decisions made by the participants with a flexibility that allowed changes according to their actual experience of the processes. Therapy thus became both contextual and ordered.

Family therapy, instrumentalism and the use of tools

One branch of family therapy has moved away from a technical and formalized method-oriented form of practice. Hoffman (1993) has documented this development and notes that central to it was the development of "…an overall framework for systemic change that is as much as possible non-hierarchical, non-instrumental, and non-pejorative" (p. 13).). The inspirational sources of the Family Unit (Andersen, 1987; Goolishian & Anderson, 1987; White, 2007) were central in this development. Tom Andersen , speaking from a position of scepticism with regard to the technical aspects of therapy, stated: "Therapy is not a technique. It is a way for the 'therapist' to engage in client relationships" (Andersen 1993, p. 305). His fear was that the use of techniques and tools could turn the therapeutic relationship into an instrumental one in which clients become objects of scrutiny and the objectification of persons and relationships is the result.

This position denotes not only a fear of destructive forms of therapy, but represents also a revolt against particular conceptualizations of science and research. The traditional view of the scientist as explicated by McNamee and Gergen (1992) depicts a person who observes accurately and systematically and who applies rigorous and rational procedures to evaluate and synthesize information. This is

> "….the scientist who builds in safeguards against emotions, values, and errant motives, and stands independent from the objects of observation

> lest his or her conclusions are contaminated. It is this image of the expert that therapeutic practitioners have largely adopted in the present century…Little confidence now remains in the optimistic program of scientifically grounded progress toward identifying 'problems' and providing 'cures'" (McNamee & Gergen, 1992, p.1-2).

The use of tools in the form of the SRS and ORS has become a central aspect of therapy in the Family Unit and could be understood as standing in opposition to its inspirational sources. A different understanding of the use of tools applying the ideas of Vygotsky and Bakhtin will be investigated and discussed in this paper. Here, tools are not regarded as techniques that objectify and estrange the participants of conversations, but rather as the means to enhance the dialogical and collaborative potential of their users. The aim is to investigate possible conceptualizations of the use of tools like the SRS and ORS by looking more closely at Vygotsky and Bakhtin in an effort to supplement the inspirational sources of therapeutic work in the Family Unit.

Mediation, dialogicality and voice

An expansion of the traditional linguistic focus of post-modern family therapies is inspired by Vygotsky and Bakhtin (Rober, 2005; Seikkula, 1993; Seltzer & Seltzer, 2004). In the following Wertsch' (1991, 2007) treatment of these authors will be central especially in connecting human mind and action. Further, dialogue and dialogicality and the use of tools are unified through the concept of mediation. Mediation is presented as reaching a goal through "… (indirect) methods." (Vygotsky, 1978, s.26). Wertsch (2007) introduces the concept of mediation in the following manner:

> "…a hallmark of human consciousness is that it is associated with the use of tools, especially 'psychological tools' or 'signs'. Instead of acting in a direct, unmediated way in the social and physical world, our contact with the world is indirect or mediated by sign. This means that understanding the emergence and the definition of higher mental processes must be grounded in the notion of mediation." (p. 178).

First of all, this notion of indirect action suggests that the tool or sign can be seen to replace something else. A concrete example is that the hammer replaces the hand for

driving the nail into the wood in a more effective manner than the hand alone. Wertsch continues:

> "….the inclusion of signs into human action does not simply lead to quantitative improvements in terms of speed or efficiency. Instead, the focus is on how the inclusion of tools and signs leads to qualitative transformation…" (p. 179).

One way of understanding this is that the act of replacement makes the tool or sign also stand for that which it replaces. In a sense the hammer can stand for the hand; it can symbolize the hand. By letting the hammer both replace and stand for the hand, the process of supplementation is present. The hammer and hand are both similar and different and this difference becomes a surplus. This surplus point to how the hammer also is an extension of the hand, and to how the difference between them points to a possible transformation of the hand. Through the hammer, the hand becomes something more than it originally was, and can create and produce something new through this surplus quality of the hammer.

A more abstract example is the metaphor of a family as a system. This image highlights particular similarities between systems and families such as the interrelationship between parts. At the same time, the concept of system with its specification of feedback processes (von Bertalanffy, 1968) introduced these as something new and different in the history of family therapy (Hoffman, 1981). This difference made it easier to talk about such processes in families and made it possible to at least enhance and perhaps also actually create such processes in families. This move connects to a second aspect of Vygotsky's work as identified by Wertsch. He writes:

> "Mediation also provides the foundation for another of Vygotsky's theoretical goals…building a link between social and historical processes, on the one hand, and individuals' mental processes, on the other. It is because humans internalize forms of mediation provided by particular cultural, historical, and institutional forces that their mental functioning (is) sociohistorically situated (p.178)".

The actual use of tools and signs in interaction with the social environment in a cultural and historical situation is internalized and becomes a mental phenomenon through this process of internalization. Mental phenomena are thus always connected to cultural and historical circumstances.

Referring to Habermas (1984), Wertsch (1991) points to the concept of teleological action where the actor "…brings about the occurrence of a desired state by choosing means that have the promise of being successful in the given situation and applying them in a suitable manner (p.9)." I will argue that this is a good description of the therapeutic agenda itself. The central agenda for therapists and family members is choosing appropriate courses of action which can lead to a desired or preferred state of affairs. Wertsch (1991) differs from Habermas in underlining that the main focus is not the solitary agent. For him and Vygotsky, higher mental phenomena derive from social life and interaction and as such the focus is moved away from the solitary agent and unto the social interplay and relationships between more than one agent or voice. This conceptualization can be deepened by Bakhtin's concepts of dialogue and dialogicality.

Dialogicality is connected to face-to-face vocalized communication between conversing participants. The basic principle is that when a person speaks an utterance, at least two voices are present simultaneously (Wertsch, 1991). There is the voice of the one speaking, and there is the voice of the one being addressed. This voice must be reckoned with or seen as part of what makes the spoken voice understandable. Understanding involves matching the speaker's words with counterwords (Wertsch, 1991). In this way the voice of the other is always implied in the original spoken voice: this is the basis of dialogicality. Sociologist Stein Bråthen (1988) has transported this principle into his understanding of mother-infant interplay, where dialogicality manifests itself as an inborn "virtual other" that exists as a virtual space waiting to be filled by an actual other. This places dialogicality at the centre of human development and functioning.

The Bakhtinian view on voices underlines the idea that there are multiple ways of representing reality (Wertsch, 1991). Dialogicality as the existence of two or more voices in face-to-face-dialogue points to an acceptance of heterogeneity in how reality can be described, and that privileging one voice over another is an act of power rather than merely the question of which representation of reality is correct. The concept of social languages (Wertsch, 1991) points to speakers as part of a group and exposed to particular constraints inherent in the social language of the group. In my work as a psychologist, voices are privileged in my social language that increase my ability to see families from the perspectives implied in these voices The same is

the situation for the family. They are part of a kinship network, a class and/ or neighbourhood that again connects to a social language with its particular voices.

The work of the Unit seen in light of mediation, dialogicality and voice

Central for the inspirational sources of the Family Unit is the asking of questions from a not-knowing position. Harlene Anderson writes:" As a therapist ….I am not a *'knower'.* I am always *striving to know"* (Anderson, 1990, p.197). This attitude opens up possibilities for family members to get to know something about themselves. Anderson connects her preference for this position to the acknowledgement of the diverse experiences of what we call reality. To ask questions from a not-knowing position, then, can be seen as a way to acknowledge and explore all the voices that exist concerning a problem without privileging any of these descriptions. The therapist collaborates within a field of tensions when all the different voices are acknowledged and explored. A central therapist metaphor describing important aspects of the Family Unit is "the lingering conversation and the big toolbox" (Sundet, 2009b). This mixed metaphor brings together the not-knowing position expressed as lingering and the use of tools, and the close braiding of these processes are upheld as central to the work of the unit.

In a conversation that *lingers* (Sundet, 2009a) one always asks one more question and keeps oneself in a position from which it is always possible to hear a new voice and experience another perspective. The not-knowing position and the lingering conversation establish an arena in which all the voices involved can be explored. In this process, the social languages of the family and therapists can become mixed; they are given the opportunity to interanimate (Wertsch 1991), and in this process, new voices and new perspectives can be created. Through this collaboration in a field of tension can develop.

The big tool box contains a diverse set of tools that stretches from measures like the SRS and ORS and specific therapy packages, to possibilities for enactments and role plays, games and other activities. Common is that these tools braid language and action together (Sundet, 2008b): the 'lingering conversation' and 'the big toolbox' braid talking with the application of different techniques and tools. For instance, through a lingering conversation, the need for training is pointed out: *"I need to train myself in how to say 'no' to my son."* This need for training may then be met by the therapist organizing a role-play on how to say no in different situations.

This role-play has a double agenda: to be a situation of actual training, and to become an opportunity for new conversations and dialogue. In this situation the role-play may be seen as a tool for collaboration and generating new actions.

Another example is drawing trajectories in connection with the scores on the ORS. After having measured and computed the total score, a trajectory is drawn. The score and the trajectory can then provide openings for questions: *"What do you think, seeing this?" "What does this tell you?"*; or the other way around: the therapist may say; *"seeing this curve makes me think……. What do you think about this?*" The family may have clear answers to these questions, but just as likely, the answering process can bring forth new thoughts and ideas for the user. A dialogical process is set up in which new ideas are constructed, nuances created and new knowledge generated which again can mediate new forms of action.

A very important point is that often the families do not have any clear vocabulary for their situation. Instead, there are impressions, a 'sense', hints, intuitions not yet put into words; this is a situation without clear voices - they are muffled, indistinct and in need of clarification. The following is a situation illustrating the complexity one may meet in working with this situation. The problem is one of how to stop the disruptive behaviour of a child. When driving, the father experiences the son creating a disturbance that puts his driving at risk. The father experiences anger and his behavioural responses become an extension of the problem. He has no vocabulary, no utterances that can mediate more appropriate action. The therapist suggests a role-play in which the therapist plays the son, the son plays the father and the father plays the therapist in an observing mode. The role-play becomes an intense event filled with both laughter and gravity. The therapist needs some instruction from the son in how he plans to play anger, and the son demonstrates the anger of the father in a very instructive manner. After the role-play the father becomes intensively involved in discussing his anger. He recalls being angry as a child and that this anger always ended in tears and feelings of shame. This led him towards renewed anger. The decisive experience was one of not being able to influence his surroundings. His lack of articulation in the situation with his son is identified as a direct repetition of these experiences.

The role-play, seen as an action-oriented event, is an event that mediates the possibility for dialogue about his reactions, and the dominant voice brings this out as repetition. The therapist notices some differences in the father's stories about his

childhood anger and his anger towards his son. The therapist hears the father report clear inner speech about trying to do the best in the situation, and think what to do differently. The father acknowledges that this is different from his childhood experiences, which were much more wordless. He now constantly works on how to change and tries out different actions, but sooner or later the anger takes over. This anger is full of contempt for his son and his behaviour. At this point, the father becomes very agitated and remembers how wounded he felt when he was exposed to similar contempt. He starts to wonder aloud how his son must feel meeting his contempt. He states that the problem is not the force of his anger or his direction of it towards his son; it is his contempt that contaminates the relationship and produces anger and contempt in his son and thus disruptive behaviour. The question becomes one of how to stop his son in a non-contemptible manner. New dialogues arise which mediate new forms of action and relationship between his son and himself.

Two themes are exemplified here. First, in situations where there is lack of vocabulary, action oriented events like role-play can mediate dialogue. This is *a process of focusing* and the movement from visualization of impressions towards distinct verbal expression (Sundet, 2008a). The story above describes a wordless action-oriented event in which the emotion of anger and kicking behaviour were played out. These actions became a starting point for conversation and dialogue. As such the action-oriented event mediated a linguistic event. Participants doing things together generated themes to talk about. Second, during the acting together and discussing, the linguistic part of the event was braided with the action oriented parts. The role play brought forth actions and utterances that mediated the possibility of seeing first the repetition of an original past event, and then the differences inherent in this repetition. The role play and the conversational situation afterwards became opportunities for participants to discover forgotten voices and to invent new ones. A new voice was heard from the father when he stated that the problem was not his anger in and of itself, but the contempt aspect of his anger. This helped him look into new ways of relating to his son which in turn gave the son opportunities for developing new actions toward his father. The difference in the repetition (Deleuze, 1994) became an opportunity for new meaning, mediating possibilities for new actions.

The zone of proximal development, scaffolding questions, and the use of feedback

Experiences of being stuck, of failure and not knowing what to do for both service users and their therapists are recurrent experiences in therapy (Sundet, 2004). In such situations both therapists and service users are in need of new options for learning, change and development. In the following a closer look at Vygotsky's conceptualization of development will be related to the use of feedback. Through this collaboration between the family and their therapist will be suggested as situations of mutual learning and development for all involved parties

For Vygotsky (1978) " …development is a complex dialectical process characterized by periodicity, unevenness in the development of different functions, metamorphosis or qualitative transformation of one form into another, intertwining of external and internal factors, and adaptive processes which overcome impediments that the child encounters…" (p.73). This description is a precursor for mental phenomena as emergent (Bunge, 1980). For Vygotsky an essential mechanism in such qualitative transformations or emergence of new mental phenomena "…is the creation and use of (…) artificial stimuli" (p.73). To study such processes, he developed "…*the functional method of double stimulation"* (p.74). This is a method where the child is presented with a situation that is beyond her or his capabilities and which cannot be solved by existing skills. Neutral stimuli is then presented in proximity to the child and Vygotsky reports that these stimuli are used by the child and "… (take) on the function of a sign" (p.74). In situations in which difficulties are experienced using one set of stimuli to solve a task, the child incorporates a second set of stimuli that takes the function of signs that can mediate new and possible solutions.

The use of the SRS and ORS as conversational tools that open up avenues for conversations that are hard to establish can be compared to this experimental situation. As stated above, it is sometimes difficult for service users to answer therapists' questions because they simply do not have words to describe their experience. The questions asked can be seen as a first set of stimuli and the scales as a second set that mediates or establishes opportunities to answer the questions by visual representation of that which is difficult to put into words. The SRS and ORS supply a surplus to the experience of the service users through their character as visual analogue scales. The surplus that the visualization represents becomes an opportunity

for asking questions that can bring forth new verbalizations and new meaning which again can become a source of new action.

The concepts of mediation, dialogicality and voice, and the method of double stimulation all point to and describe what happens in the moment. Vygotsky's concern is not only how change as qualitative transformation happens in the moment but how this is expressed as development over time. In the therapeutic context the same concern is important especially in the above situations of stuckness and experience of failure. The Family Unit and its inspirational sources attach central importance to collaboration as a leading aspect of therapeutic work. In both the family and therapist perspectives, production of conversations that create a therapy that fits and works for the family was a joint theme. Participants presented this from different angles with the same agenda: therapeutic collaboration as a central avenue to healing and problem solving (Saggese, 2005; Sundet 2009a, 2009b). As demonstrated above the use of questions is a central thread in this collaboration.

In narrative practice (White, 2007) and within cognitive therapy (James, Milne and Morse, 2008) the metaphor of scaffolding (Bruner, 1986; Wood, Bruner and Ross, 1976) has been adopted. This is an explication of Vygotsky's concept of the zone of proximal development, defined as "…the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers" (Vygotsky, 1978, p.86). James et al. (2008) write within the context of supervision, but their ideas are relevant for this study. They suggest two aspects of the scaffolding process: questions and platforms. Questions drive learning forward and platforms are seen as "…supportive information (summaries, reminders, or statements) used to set up a question…" (James et al, 2008, p.31). Platforms consolidate the knowledge or developmental level of the person and set the stage for questions that can advance learning. The difference between the actual developmental level and the level of potential development under adult guidance or in collaboration with more capable peers constitutes the zone of proximal development.

In patient-focused research, the following developments are defined: clinical significant change, full recovery, no-change and detrimental development; the last two constitute not-on-track cases (Lambert, 2007). In cases showing clinically significant change or full recovery, there is no reason to change therapeutic practice.

The situation is different with not-on-track cases. Here the methods introduced by the therapists are unhelpful, and alternative ways of working are needed. We can use the metaphor of the zone of proximal development to explicate the following: in on-track situations the manners of doing therapy ("the developmental level") is adequate for solving problems and relieving suffering. Not-on-track situations point to the necessity of a scaffolding strategy. For the family, change has to do with alleviating suffering and solving life problems. For therapists, change has to do with developing new and expanded manners of doing therapy. Both parties are in need of scaffolding towards new learning and development. An important part of the therapists' perspective was to privilege the service users' ideas and perspectives (Sundet, 2009b). The family was seen as "more capable peers" (Vygotsky. 1978, s.86). Through investigating feelings, impressions, signs, cues, ideas and perspectives of the family, the therapists could discover something that led to new manners of working. The situation could be described as follow: In not-on-track cases the family did know or have hunches about what would be helpful, but did not necessarily know how to transform these into effective help.. The therapists did not know what would be helpful (they had tried "everything"), but knew something about how to transform ideas into viable therapeutic practice. Their expertise was in organizing conversations and not deciding what to talk about (Anderson & Goolishian, 1988). For this purpose, feedback was decisive. Feedback meant cues, prompts and ideas about one's practice if it developed in the right direction. At the same time, every act of the therapists in this collaborative process functioned as an invitation for the family to expand their way of being together. Here we can talk about a joint scaffolding process involving two zones of proximal development. Lack of change within the service users' zone was fed back to the therapists. In not-on-track cases, feedback became the main driving force in a process characterized by intertwining two mutually influencing zones of proximal development. The identification of not-on-track cases emerged as an event of possible transformation and change. The use of formalized feedback was central and decisive for this process.

Michael White (2007) has created maps for the "scaffolding conversation" as a movement from the known and familiar to what is possible to know. Central in creating this movement is the formulation of questions that fit the family in ways that gradually distance the participants from the known towards what is possible to know. The processes described through the analysis of the experiences with the SRS and

ORS in this study are examples of such distancing processes. In *the process of communicating* one moves from expressing oneself in a more general manner to giving voice to the specifics of acceptance and change. In *the process of focusing*, one moves from impressions through the use of visualizations toward gradually giving these a verbally more distinct form. Through the establishing of distance towards one's impressions these are then related to in new ways mediated by the verbal forms they have acquired. In *the process of structuring* one moves from seeing many possible directions for the therapeutic work to choosing and investigating one. A sequence (James et al., 2008) setting a structure for the work is then established through which one acquires distance to the different possible directions that work can take. Lastly, *the process of exploration*, following the same format, leads to deeper knowledge in the sense of becoming more detailed and explicated about the discovered option, with the possibility of gaining new perspectives and possible choices. All these processes are joint scaffolding processes moving participants from the known towards the not-known and which depend upon feedback.

Concluding remarks

The work presented here concludes that any therapeutic practice, classically evidence based through clinical trials, or theoretically or personally argued as effective and helpful, most be continuously monitored in each single case, and the results of this must be fed back to the participants of that practice, especially the therapists. It is also concluded that such a use of standardized feedback can be implemented within a practice guided by post-modern, language oriented family therapies. Central to this implementation is taking a perspective on these standardized measures as tools for conversation. Vygotsky's perspective on tools as mediating action helps us see how standardized tools as conversational tools can expand options for conversation and action in therapeutic contexts. Bakhtin's concept of dialogicality helps us both to acknowledge the heterogeneity of the therapeutic reality and see that collaboration means to let all the voices be given ample time and space. This is the responsibility of the therapists and the evaluation of the continuous success of such therapeutic work can not be handed over to these therapists alone. This again necessitates the systematic use of formalized feedback. By doing this conversation and collaboration between families and their therapists becomes the backbone of therapy. The concept of collaboration explicated here brings mutuality to the centre stage of therapy. There

is a mutual dependency between families and their therapist in generating change and development. The concepts of the proximal zone of development and scaffolding are in this work embedded in such an understanding of mutuality. Both families and therapists are in not-on-track situations in need of scaffolding to new levels of development and it is suggested here that the participants can supply each other with the needed scaffolding. For the therapists then, it is the conclusion of this study that the mutual dependency involves something more than traditionally acknowledged by the therapeutic field. When stuck as a therapist, the impressions, ideas and theories of change (Duncan & Miller, 2000) of the family is the road to new possibilities for the therapists and when these are transformed into therapeutic tasks and options by the therapist, these can again be opportunities for development and change for the family. It is the responsibility of the therapists to have access to methods and techniques that can function as tools within the conversational and collaborative relationship between families and their therapists. As such evidence-based methods must be embedded in a practice-based evidence (Barkham and Mellor-Clark, 2003) generated within each session and the therapeutic course over time. For the Family Unit this is the meaning of tailoring treatment (Norcross, 2002).

Notes:

i. The ORS is based on the OQ 45 (Lambert, Lunnen, Umphress, Hansen and Burlingham, 1994). Several scales influence the structure and content of the SRS (Duncan *et al*., 2003).

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Notes:

[i] It is outside the scope of this dissertation to discuss the relationship between difference and similarity. See Deleuze (1994) for such a discussion and explication.
[ii] A clinical social worker, a clinical teacher and two clinical psychologists (one was the researcher), each with 20–30 years' experience as individual and family psychotherapists and a student therapist participated in the project.
[iii] The project was accepted by the (national) Social Science Data Service and by the Medical Ethics Committee.
[iv] Therapist X stopped working at the Family Unit before project start.
[v] T.A. T.B etc. is therapist A, B etc. F1, F2 etc. are family number 1, 2 etc.
[vi] The unit uses two measurements, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) (Miller, S. D. & Duncan, B. L., 2004) to monitor process and outcome.

[vii] Therapist X stopped working at the Family Unit before project start.
[viii] A falling curve expresses increasing outcome in systems using OQ45 while a rising curve expresses the same in the system using ORS.
[ix] F1, F2 etc. means family nr. 1, 2, etc.
[x] Both the ORS/CORS and the SRS/CSRS have a version for smaller children where they can point to a "smiley" or draw their own "smiley" as feedback.
[xi] Therapist X stopped working at the Family Unit before project start.