

THE MAP OF COMPETENCES IN SYSTEMIC THERAPY

**A qualitative study of the systemic competences in Norwegian child and adolescent mental health that target the associated abnormal psychosocial situations
in axis 5 (ICD-10)**

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“It is paradoxical that what treatment professionals want for the families is to be achieved through descriptions of how they’ve failed previously”

(“Einar”, a participant in this study)

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ABSTRACT

The overarching aim of this research project is to identify a comprehensive and detailed outline of the systemic therapist competences in the Norwegian child and adolescent mental health (BUP) that target the psychosocial difficulties that are categorized as associated abnormal psychosocial situations in the multiaxial classification of child and adolescent psychiatric disorders/axis 5 (ICD-10). The project is based on twelve qualitative in-depth interviews with six experienced systemic family therapists, fieldwork observations of the therapists (participants) in practice and an analysis of the Norwegian Directorate of Health's guidelines for child and adolescent mental health institutions. The specific research questions for this research project are:

1. In the context of child and adolescent mental health, what are the different competences in a systemic family therapy approach that address the associated abnormal psychosocial situations?
2. What are the legally binding requirements in the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?
3. How does systemic family therapy interconnect with the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?

Grounded theory (GT) was chosen as the main methodology for this study. During the analysis, the following six overarching categories were identified: (1): *legally binding requirements*; (2) *the importance of ethical and contextual awareness in systemic therapy*; (3) *the systemic therapist's stance*; (4) *therapeutic processes*; (5) *therapeutic practices*; and (6) *session-specific features*. Challenges, such as limiting the systemic approach to six overarching competences, are discussed alongside this study's strengths and limitations, and suggestions for future research are presented. The detailed outline of the systemic therapist competences and the legally binding requirements in the Norwegian Directorate of Health's guidelines was compiled into a "map of competences". The findings show that the legally binding requirements interconnect and overlap with the identified systemic competences, although their wording and their inclusion of diagnosis can challenge the systemic ideas of using a non-pathologizing language. The map of competences is intended to be applied as a tool for clinical supervision, clinical practice, education and training in family therapy. This research may also facilitate a "bridge-building process" between mental health and postmodern systemic ideas.

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1 INTRODUCTION

This research aims to identify a comprehensive and detailed outline of systemic therapist competences in child and adolescent mental health (BUP) in Norway. The identified competences are adapted to meet the legally binding requirements of the Norwegian Directorate of Health (2008) and to target the psychosocial difficulties that are categorized as associated abnormal psychosocial situations in the multiaxial classification of child and adolescent psychiatric disorders/axis 5 (ICD-10) (WHO, 1996). These competences will illuminate how experienced systemic therapists use systemic competences in the context of Norwegian child and adolescent mental health.

1.1 Background of research interests

When I was in the third year (of a four-year programme) of study for a master's in family therapy and systemic practice, I got interested in exploring the extent to which it was possible through research to identify a comprehensive and detailed outline of systemic therapists' competences that are adapted to meet the legally binding requirements of the Norwegian Directorate of Health's (2008) guidelines. The guidelines for child and adolescent mental health also demand specialized services, such as difficulty-specific approaches. I therefore intended the identified competences to target the psychosocial difficulties that are categorized as associated abnormal psychosocial situations in axis 5 (ICD-10) (WHO, 1996).

In recent years, I have largely supervised and taught systemic therapists. This practice has made me certain that the theme of my research represents an important and long-awaited project. Therefore, the results of this research are intended to be used as a tool for clinical supervision, clinical practice, education and training in systemic family therapy. My research also attempts to facilitate and "build bridges" between the diagnostic focus of mental health and postmodern systemic ideas.

1.2 Research purpose and aims

The overarching objective of this research is to identify a comprehensive and detailed outline of the systemic therapist competences in child and adolescent mental health that target the associated abnormal psychosocial situations (axis 5) in the multiaxial diagnostic system (WHO, 1996). This outline of systemic competences can contribute to how therapists in

mental health can use systemic therapy when working with the psychosocial situations of families. In addition, systemic competences can be a valuable contribution to clinical supervision and the training of systemic therapists in educational institutions. Systemic therapists in BUP must work within the organizational and political framework. Therefore, researching the legally binding requirements of BUP in relation to systemic therapy competences attempts to contribute to a greater inclusion of systemic ideas in the field of mental health.

In the initial phase of my research my aim was to develop a manual for systemic family therapy to target the psychosocial difficulties that is categorized as associated abnormal psychosocial situations in the multiaxial classification of child and adolescent psychiatric disorders/axis 5 (ICD-10) (WHO, 1996). However, during my data collection, I realized that this was too ambitious for my doctoral research project. Instead, I narrowed my research project to identify systemic family therapy competences, targeting axis 5 and adapted to meet the legally binding requirements in child and adolescent mental health. This will be a useful starting point for future research on developing a manual for systemic therapy.

1.3 Research questions

Based on the purpose and objectives of this study, I address the following research questions:

4. In the context of child and adolescent mental health, what are the different competences in a systemic family therapy approach that address the associated abnormal psychosocial situations?
5. What are the legally binding requirements in the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?
6. How does systemic family therapy interconnect with the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?

1.4 Some clarifications of terms

Here, I will present some clarifications of terms. *Competences* mean the documentation and description of the fundamental elements of systemic therapy (Northey, 2011) that are expected to be mastered by systemic therapists (Stratton et al., 2011). In the professional

literature, both the words *client* and *patient* are used. In my research project, I have chosen to use the term clients when I discuss the users of BUP because this choice accords with the words that are used by the participants in the interviews. An exception is made for text excerpts (for example, from the Norwegian Directorate of Health's guidelines, 2008), which refer to words such as *patient* or similar terms. I have used the term *he* as a gender-neutral pronoun throughout the entire thesis. The word *family* is often used in this thesis. However, the term *family* is meant to include the persons who are considered significant to the referred patient and his family.

1.5 Guide for the reader

This thesis is organized into 8 chapters. Chapter one (1) is the introduction, which describes the background of my interest, the objective of this research and the research questions. In chapter two (2), I critically review the relevant literature, such as the context of Norwegian child and adolescent mental health, the World Health Organization (WHO)'s multiaxial diagnostic system, and relevant systemic therapy theory. The chapter ends with a presentation of the relevant research literature. Chapter three (3) consists of methodological considerations that relate to this research, such as a detailed explication of the research methods that are used, recruitment of the participants, data collection, data analysis and possible limitations of the research. In chapter four (4), I present the findings from the thematic analysis of the Norwegian Directorate of Health's guidelines (2008), chapter five (5) present the findings from the grounded theory analysis of the qualitative interviews and fieldwork observations. Chapter six (6) consists of the map of identified systemic competences. Chapter 7 present the discussion, implications for practice, training and supervision, questions for future research and my personal learning from this research. Chapter 8 consists of the concluding remarks.

2 THEORETICAL FRAMEWORK

Introduction

In this chapter, I present the theoretical framework and relevant research literature concerning my research objective and research questions. The theory chapter is divided into three parts.

Part one (1) presents the context of Norwegian child and adolescent mental health that forms the basis of this research, the ICD-10 Multiaxial diagnostic system, specifically the axis 5 category that this research targets, and a short presentation of how systemic therapy aligns with the ideas from the diagnostic paradigm. Part two (2) presents a historical review of systemic therapy theory from its inception to contemporary postmodern descriptions. Part three (3) presents the relevant research literature in relation to my research objective and research questions.

2.1 Norwegian child and adolescent mental health

The Norwegian child and adolescent mental health service (BUP) is a specialist health service that is organized as an outpatient service (Norwegian Directorate of Health, 2008). The main responsibility of BUP is to help children aged 0-18 years and their families with diagnostic assessments, treatment and consultancy that are connected to psychiatric problems (op.cit).

BUP services are primarily aimed at the difficulties (e.g., specialized problems such as anxiety, depression) that the communal health services, such as the general practitioner, health visitor, pedagogical psychological services (PPT) or the child protection service, cannot be expected to resolve. BUP is cross-disciplinary in composition (typically a doctor, psychologist, psychiatrists, clinical social worker, family therapist, neuropsychologist and clinical pedagogues) and cooperates with primary care persons and primary services. For conditions that require specialist treatment, the patient is referred by the primary health service (e.g., doctor, child protection service, paediatric psychiatric service or authorized psychologist) (Norwegian Directorate of Health, 2008; The Norwegian Psychological Association, 2016). However, clients who already are enrolled at BUP can also be referred internally between the different BUP departments (e.g., family units, infant and toddler clinics etc.). Thus, all of the clients that I observed during my fieldwork observations were referred by some of the abovementioned primary health services.

2.1.1 The multiaxial diagnosis system

The focus on diagnosis has never been emphasized more, and it has become a central focus for therapeutic work in Norwegian child and adolescent mental health (Brinkmann & Petersen, 2015; The Norwegian Directorate of Health, 2008). Examination and diagnosis have traditionally been explained in terms of the individualization of problems, with little focus on context and other potentially contributing factors (Ekeland, 2014), and are thus in direct contrast to systemic therapy. Systemic therapy focuses on interpersonal connections and relationships rather than individual characteristics to address the differences in family members' perception of events and relationships (Tomm, 1988). Systemic therapy prioritizes understanding the context of peoples' experiences and behaviour (op.cit), and it emphasizes that what people observe around them can be understood in unique and different ways (Campbell, 1999). Therefore, the use of marginalized and thin descriptions, such as diagnoses, is controversial in the field of systemic therapy (Lorås, 2016b). However, all employees in Norwegian child and adolescent mental health are required to conduct diagnostic assessments that are based on the WHO's (1996) multiaxial system of classification where appropriate (Lorås, 2016b). Therefore, it is important that systemic therapists in Norwegian child and adolescent mental health know well the multiaxial system of classification.

In approximately 1970, during a WHO seminar, a multiaxial approach to the classification of child psychiatric disorders was advocated (Rutter, 1996). The multiaxial system began with three axes, namely, (1) clinical psychiatric syndromes, (2) levels of intellectual function and (3) associated or etiological factors (physical or environmental).

Over subsequent years, the multiaxial system of classification included a fourth axis when the third axis was divided into two separate axes. The fourth axis (4) was designated the *level of physical or environmental function*. In 1975, yet another axis for specific developmental disorders was included.

However, studies indicated that the reliability of the four axes was low. With the new edition of the ICD-10 that was expected in 1990, a working group was therefore established to redraft the psychosocial axis based on the much more detailed specification of the coding criteria, such as in the other axes in the ICD system (Rutter, 1996). In 1996, the ICD-10 multiaxial classification of child and adolescent psychiatric disorders was presented (WHO, 1996). The multiaxial system classification now consisted of the following six axes: (1) clinical psychiatric syndromes (i.e., mood [affective] disorders); (2) specific disorders of psychological development (i.e., specific developmental disorders of speech and language);

(3) intellectual level (i.e., mild mental retardation); (4) medical conditions that are often associated with mental and behavioural disorders; (5) associated abnormal psychosocial situations; and (6) the global assessment of psychosocial disability (i.e., moderate social functioning) (WHO, 1996). This research targets the difficulties that are categorized as associated abnormal psychosocial situations (axis 5) (WHO, 1996). Axis 5 is therefore the priority of the remainder of this presentation.

2.1.2 Axis 5 Associated abnormal psychosocial situations

Axis 5 is a tool for the coding of seriously abnormal aspects of a child's psychosocial situation regarding the child's developmental level, previous experiences and the relevant socio-cultural conditions (Norwegian Directorate of Health, 2008). The current category should be coded independently of whether the described psychosocial conditions are viewed as a direct cause of the psychiatric condition. This coding is because abnormal psychosocial conditions often comprise etiological factors that contribute to the disturbance but are insufficient to explain it by themselves (op.cit). Axis 5 is not intended to include all potential etiological factors. For example, axis 5 does not contain genetic factors, insofar as they are unconnected to one or more of the specified forms of abnormality in the psychosocial milieu. Similarly, axis 5 does not include any of the forms of strain that are connected to puberty or other physiological transitional periods (op.cit). Abnormal social conditions could have been influencing as early as infancy and could have caused a vulnerability that has been present long before the "outbreak" of the psychiatric condition. Similarly, the abnormal psychosocial conditions may have had the greatest importance in the months before the "outbreak" or may have been present during the lifetime of the child (WHO, 1996).

It is unavoidable that the 9 categories (with subcategories) that comprise the axis do not cover all of the different variations in the psychosocial conditions that can be relevant in each individual case (Norwegian Directorate of Health, 2008). Therefore, axis 5 is limited to covering the categories in which the available documentation indicates the direction of the potential cause of a significant psychiatric risk factor for a significant number of children. Several categories are likely to be relevant/overlap with one another in relation to the same situation in individual cases. For example, a psychologically ill parent can also be connected to disharmony in the family (op.cit).

2.1.3 Categories in axis 5

Axis 5 is divided into nine main categories with relevant subcategories. Most of the categories are developed so that they refer to a time period of six months. The time period was chosen because the quality of the abnormal conditions that have influenced the child can be judged for a sufficiently long period of time (WHO, 1996). The presentation of the categories is based on the WHO's (1996) multiaxial classification of child and adolescent psychiatric disorders. In the following presentation, I have used the same category numbering as in the original ICD-10 (op.cit). However, this numbering can be confusing because by the time the multiaxial classification was made, the convention was that the category that is designated "other" must always be given a designation of 8 (ex: 1.8 *Other*). The apparent "jump" from, e.g., category 1.4 *Sexual abuse (within the family)* to category 1.8 *Other* does not mean that the other categories (i.e., categories 1.5, 1.6, 1.7) are omitted; instead, the number 8 for "other" is merely the convention that was used at the time (personal correspondence with Sir Rutter by email 14.01.16 and 25.01.16).

1 Abnormal intrafamilial relationships

Category 1 concerns the negative forms of interactions and relationships in the family that are damaging to a child's social/emotional development. All relationships are concerned with two-way interactions that are influenced by the behaviour of all co-players. Therefore, abnormal relations in the family likely may have arisen because of the child's own actions, attitudes and reactions, and it is often difficult to judge the extent to which this has been the case. Regardless, the codes should be set exclusively on the basis of the abnormal aspects of the behaviour of other people, and the child's contribution should not be included (WHO, 1996, p. 226).

1.0 Lack of warmth in the parent-child relationship

This category concerns the child's parent's/parents' distinctive lack of expression of warmth toward the child in the home situation. Warmth is expected to be expressed in the manner in which the parent speaks to the child and in nonverbal behaviour such as affectionate touching or physical comforting. The frequency and context of the expression of warmth vary among cultures and also in relation to the gender of the parent. The degree of warmth should be assessed relative to the expected parental behaviour in the same culture. A lack of warmth must not be confused with the presence of critical or negative feelings, because "warm" parents can also be critical of their child's behaviour (WHO, 1996, p 226-228).

1.1 Intrafamilial disorder among adults

This category is concerned with disharmony between the parents or other adult members of the child's home (including the child's siblings if they are aged 16 years or older). The disharmony must be revealed, for example, in negative arguments or in a pervasive atmosphere of tension because of distinctly tense relationships. Typically, the disharmony is characterized by negative verbal exchanges between the parties, but swear words or physical abuse by one of the parties should also be included (WHO, 1996, p. 228-229).

1.2 Hostility toward or scapegoating of the child

This category concerns distinctive negative feelings that are directed toward the child by one or both parents (or possibly another care person). Aggression toward or scapegoating of the child is included, whereas general disharmony or negative feelings that do not generally impact family members are not included (WHO, 1996, p. 229-230).

1.3 Physical child abuse

This category includes all examples in which the child has been injured by an adult in the household to such an extent that the injury has had medical significance. Violence that is abnormal in the subculture is included (WHO, 1996, p. 230-231).

1.4 Sexual abuse (within the family)

Sexual abuse within the family is defined as incestuous relationships between members of the family who, according to the law, cannot marry one another. Non-incestuous relationships between the child and other adult members of the child's household are also included. Therefore, the abuse that is committed by the biological parents, adoptive parents, step-parents, older siblings, other relatives in the home, renters or friends of the family is included in this category (WHO, 1996, p. 231-232).

1.8 Other

This category concerns any and every abnormal relation within the family that satisfies the general criteria of form and degree of severity but cannot be coded under points 1.0 to 1.4 (WHO, 1996, p. 232).

2 Mental disorder, deviance or handicap in the child's primary support group

The conditions that are included in this category have a negative influence on the child to such an extent that a potential psychiatric risk factor is present (WHO, 1996, p. 232-233).

2.0 Parental mental disorder/deviance

Category 2 includes all forms of invalidating psychiatric conditions in a parent that are independent of whether the person concerned is receiving psychiatric treatment. It is not necessary for the child to have contact with the parent, and it is considered irrelevant if the parent is present in the child's household. However, the parent's condition must have influenced the child's life to a great extent. The definition of a parent in this category is any adult in the household who has a parental role relative to the child (independent of whether he/she is biologically related or is legally expected to take on the role of parent) (WHO, 1996, p. 233-234).

2.1 Parental handicap/disability

This category includes all the forms of functional disability in parents that are not included in 2.0. The condition must have such a character that it leads to poor functioning in one or more areas of the adult's social life. The condition must also have such a type that it most likely interferes with the child's life and is a possible psychiatric risk factor (WHO, 1996, p. 234-235).

2.2 Disability in siblings

Category 2.2 has the same criteria as 2.1 but concerns siblings, not a parent (WHO, 1996, p. 235-236).

2.8 Other

Any psychological disturbance, abnormality or functional disability in one of the members of the household apart from parents or siblings that satisfies the general criteria for the category (WHO, 1996, p. 236).

3 Inadequate or distorted interfamilial communication

It is a common perception that poor communication in the family forms a psychiatric risk factor. The most important types of disturbed communication in the family are confused or contradictory messages, small pointless arguments and the failure to use communication in the family to effectively manage family members, problems or conflicts. Keeping family secrets or hiding important information from a child who requires this knowledge is also included (WHO, 1996, p. 236-237).

4 Abnormal qualities of upbringing

This category involves certain forms of upbringing of such an abnormal quality that they likely form psychiatric risk factors for the child. The upbringing can be performed by the parents or other care persons in the household. There are great socio-cultural variations relative to how one raises children. Typically, a form of upbringing that is acceptable in the child's own subculture (or religious group) should not be viewed as abnormal despite differing from what is usual in the surrounding culture. Abnormality in a child's upbringing should also be assessed concerning what is reasonable regarding the child's developmental level, behaviour, physical condition and socio-cultural condition (WHO, 1996, p. 237-239).

4.0 Parental overprotection

Here, the term "overprotective parents" refers to a method of upbringing in which a parent (most often the mother) uses the relation and/or discipline such that it severely limits the child's opportunities to develop or maintain other contacts and/or to take on age-appropriate decisions/responsibilities. Parents in this category often make decisions on behalf of the child that the child can be expected to make for himself such that it leads to dependency, hinders the child in taking on age-appropriate responsibility and is limiting with regard to acquiring social experiences (WHO, 1996, p. 239-240).

4.1 Inadequate parental supervision/control

This category is concerned with a distinctive lack of effective control over or attention to the child's activities and is viewed in the context of the child's maturity and socio-cultural background. There are distinctive socio-cultural variations concerning the degree of desirable control. Inadequate parental regulation/control should only be coded when it is so serious that it is both socio-culturally abnormal and represents a probable psychological risk factor (WHO, 1996, p. 241-243).

4.2 Experiential privation

Children learn skills and establish social relationships through conversations, play and activities, both with parents and other family members (and persons outside the home). This category concerns the distinct lack of development-promoting interactions because of parental actions (limitations or prohibitions) or a lack of intervention (failure in relation to ensuring relevant opportunities) regarding linguistic, social, perceptual or motor activities. This category must be assessed considering the child's developmental level and the socio-cultural situation (WHO, 1996, p. 243-245).

4.3 Inappropriate parental pressures

This category concerns the pressure from parents that is discordant with the child's developmental and socio-culturally adequate needs and wishes. This category includes unreasonable pressure from the parents on the child to be different from who he/she is, for example, dressing a boy in girl's clothes (or the reverse), pressuring the child to appear younger/older than he/she actually is, or pressuring the child to obtain results that do not accord with his/her abilities or wishes. Pressure can be exerted by one or both parents, but to be coded, it must be perpetual or extensive such that it represents a considerable invasion in the child's life. Pressure that is based on an unusual behavioural pattern in the family that is viewed from a cultural perspective (such as in religious groups) should normally not be coded. However, this type of pressure can be included in cases where parental norms/customs are forced on the child despite his/her wishes to adapt to the dominant cultural norms of the greater society in which the family lives (WHO, 1996, p. 245-246).

4.8 Other

Other abnormal aspects of upbringing that do not satisfy the criteria for the situations that are described in 4.0 to 4.3 should only be included if they are sufficiently abnormal to pose a psychiatric risk to the child (WHO, 1996, p. 247).

5 Abnormal immediate environment

This category covers different aspects of the social or physical structures in the child's milieu that can create conditions for a negative psychosocial situation and thus form a potential psychiatric risk factor (WHO, 1996, p. 247).

5.0 Institutional upbringing

This category covers all conditions in which the child is under the care of a residential institution instead of a family. The implication is that the child is taken care of by many adults with shared regulatory responsibility (care personnel have fixed breaks in which others take over the regulation). Most forms of upbringing in institutions involve a form of shift service, which is abnormal relative to family care in which the child lives with one or several adults who give constant care without fixed free time. A lack of continual upbringing care from a relatively small number of adults to whom the child regularly has access is the most obvious difference between institutional and family care, and it is claimed to constitute the greatest psychiatric risk factor (WHO, 1996, p. 247-248).

5.1 Anomalous parenting situation

This category includes relationships that diverge from a traditional upbringing with two biological parents. For example, this category concerns the upbringing in single-parent families, by adoptive parents, by step-parents, by foster parents, when a child who is born out of wedlock is raised by people other than the biological parents and when a child lacks stable cohabitation relationships between the parents (WHO, 1996, p. 249-250).

5.2 Isolated family

The *isolated family* is characterized by the family as a unit that isolates itself from positive social contacts or that other people have isolated themselves from because of the family's behaviour. Whether the reason for isolation is negative interactions with, for example, neighbours, representatives of helping services or similar figures is less important. Coding requires that the social isolation also includes the children (with the exception of the child's social contacts at school). The isolation can have many causes. These causes include the following: parents who share the same paranoid perceptions; a closed family system that is characterized by rigid personal attitudes that are considered different from the dominant attitudes in the subculture; the family fears that a family secret will be discovered; a parent's abnormal personality; and neighbours' isolating themselves from the family because it has a behaviour that is experienced as offensive or somehow worthy of criticism (WHO, 1996, p. 250-251).

5.3 Living conditions that create a potentially hazardous psychosocial situation

This category has its basis in living conditions that cause a possible risky psychosocial situation that does not directly involve the degree of poverty or lack of facilities in the home. This category is limited to living conditions that lead to a psychosocial situation that is not covered by the other categories but that most likely is created by a possible psychiatric risk situation. This category can be summarized in the following two main categories:

- The conditions that contribute to unfortunate limitations on interactions in the family; and
- The conditions that are connected to unfortunate effects that relate to the environment.

The criteria include living conditions that are both atypical of the culture and have such a nature that they represent a psychiatric risk factor (WHO, 1996, p. 252-253).

5.8 Other

This category involves the living conditions that satisfy the general criteria for abnormal environments but do not satisfy the criteria for 5.0 to 5.3 (WHO, 1996, p. 254).

6 Acute life events

Acute life events in this category predispose a person to or promote psychiatric disturbances. Acute life events are closely associated with discomfort and either cause a long-term negative change in circumstances or lead to an individual's long-lasting reduced self-image. In addition, unusual, extremely frightening or humiliating experiences can have long-term consequences if the short-term psychological trauma is sufficiently serious. Therefore, the category of *acute life events* includes different subcategories that share the likelihood of causing significant psychiatric risks. The events that should be coded are individual events that are followed by a significant worsening in the child's life situation (WHO, 1996, p. 254-255).

6.0 Loss of a love relationship

For "loss" to be coded, it must concern a relationship with sufficient emotional closeness and involve the opportunity for trust and psychological support, which will typically apply to all parent-child relationships and important love relationships in youth. Loss can also apply to relationships with other adults if they are caregivers in or outside the family or if the child has

frequent or regular contact with them and they provide emotional security or support. The same definition can apply to siblings or special close friends if there are clear signs that they are a security or support or if the relationship involves reciprocal trust (WHO, 1996, p. 255).

6.1 Removals from the home that carry a significant contextual threat

Research findings suggest that the placement of children in residential institutions often encompasses experiences that involve significant psychosocial strain. The extent to which a placement will be experienced as a strain will vary concerning both the circumstances and the child's age. Younger children are most likely to experience their removal from the home as a significant trauma both because they are less able to maintain close emotional relationships with absence over time and because they are less able to understand what is occurring and its necessity. Placement in a foster home or children's home for any length of time is assessed as involving a significant strain because it can imply rejection. Individual admissions to the hospital can also lead to short-term disturbances, but only repeated admissions are assessed as being a risk factor (WHO, 1996, p. 257-258).

6.2 Negatively altered pattern of the family relationship

This category codes greater negative changes in the child's relationships in the family that are caused by a new person's entry into the family. To a certain extent, the new person can divert attention from the child or be experienced as an intruder relative to the close emotional relations that the child has (WHO, 1996, p. 258-259).

6.3 Events resulting in a loss of self-esteem

A loss of self-esteem represents a significant psychosocial stress factor. The central characteristic of the events that satisfy the criteria of this category is that the events create a change that causes the child to reassess him/herself in an extremely negative manner (WHO, 1996, p. 260-261).

6.4 Sexual abuse (extra familial)

Epidemiological data suggest that sexual episodes involving children are extremely common and that it is likely that most of the more minor episodes have little psychological importance. It can be assumed that the degree of psychiatric risk is influenced by the extent to which the episode directly involves the child or was focused on the child. This psychiatric risk is also

influenced by the extent and directness of the personal sexual invasion. Regardless, sexual episodes must be coded in the following cases where: the abuser is considerably older than the child; the episode arose because of the abuser's position/status (e.g., doctor, teacher); the child was unwilling; there was touching/attempts to touch one's own or the abuser's genitalia; there was exposure of genitalia with the intention to achieve touching/intimate contact; the abuser attempted to undress the child (get the child to undress) under inappropriate circumstances; and the abuser lured or attempted to lure the child into a car or to a place where the circumstances can be assessed as posing a psychological threat (WHO, 1996, p. 261-262).

6.5 Personal frightening experiences

Short frightening experiences can involve a considerable risk factor if the character of the event or the context in which it arises has such a type that the child's future wellbeing can be indirectly or directly threatened. To be coded, the experience must lie outside the framework of normally expected events and must involve a threat to the child's future, for example, uncertainty regarding the extent to which the child will survive without permanent damage, such as in earthquakes or volcanic eruptions (WHO, 1996, p. 262-263).

6.8 Other

This category covers all acute events that are not covered by categories 6.0 to 6.5 and that satisfy the general criteria for events that involve a considerable long-term threat (psychological or physical) (WHO, 1996, p. 264).

7 Societal stressors

This category covers the stress factors that reflect the conditions with origins in cultural elements in a greater society and that are not characteristics of the child's own environment or own experiences. To be included, the events must have a direct effect on the child and cause a considerable degree of long-term psychological or physical threat (WHO, 1996, p. 264).

7.0 Persecution or adverse discrimination

This category covers the events or experiences that have a direct effect on the child and that cause a long-term threat and involve persecution or negative discrimination based on the child's association with a greater ethnic, religious or other group. The group is defined by, e.g., skin colour, religion, or ethnic origin. The coding should be limited to cases in which the

events/experiences lead to physical damage, exclusion from important activities for the child or public stigmatization/humiliation that goes further than the expected stress factors in life (WHO, 1996, p. 264-265).

7.1 Migration or social transplantation

Moving is assessed in individual cases to be a considerable psychiatric risk factor when the move, for example, is provoked by humiliating circumstances (i.e., for refugees or in cases of deportation), leads to greater personal breaks/broken relationships, involves moving to a very different subculture, requires the child to learn a new language or results in a greater loss of social status (WHO, 1996, p. 265).

7.8 Other

This category covers all social stress factors that are not covered by categories 7.0 to 7.1 and that satisfy the general criteria for societal stress factors (WHO, 1996, p. 266).

8 Chronic interpersonal stress associated with school/work

This category involves abnormal relationships that the child experiences at school or work and that have such a type and degree of seriousness that they most likely pose a psychiatric risk factor for young people. Examples include rejection by peers, being made a scapegoat by teachers (or superiors at work), or a general disturbance and disharmony at school/work. The code should be exclusively assigned based on the abnormality in other people's behaviour, and the child's own contribution to the poor relationship should not be considered (WHO, 1996, p. 266).

8.0 Discordant relationships with peers

This category concerns disharmony between the child and his/her peers. For this factor to be coded, there must be serious, actively negative interactions. The relationship/s must be lasting and generally negative. Therefore, short, repeated episodes of arguing or a lack of positive relationships are insufficient. Disharmonic relationships should be coded although good relationships with other people can compensate (WHO, 1996, p. 266-267).

8.1 Scapegoating of child by teachers or work supervisors

This category concerns one or more teachers/supervisors with distinctly negative feelings that are focused on the child or personally directed at the child. The expressed negative feelings must be present over time to be coded (WHO, 1996, p. 267).

8.2 Unrest in the school/work situation

This category concerns a disharmony or disturbance in the school/work environment that to a discernible extent, has influenced the child but that primarily is characterized by disharmony among other people, not the child him/herself. To be coded, the situation must be abnormal in the socio-cultural context and must have involved the child to a significant extent. The situation must also be so comprehensive that it disturbs the child's engagement in work or disturbs the interpersonal relationships in the school/work situation (WHO, 1996, p. 268).

8.8 Other

This category involves any other chronic interpersonal stress that is connected to school/work and that satisfies the general criteria concerning the type and degree of seriousness in this category, but it cannot be coded under 8.0 to 8.2 (WHO, 1996, p. 268).

9 Stressful events/situations that result from the child's own disorder/disability

This category is strictly limited to the events/relationships that result from the child's own disturbance/functional disability (and that therefore cannot be coded in categories 1 to 8) but that pose a significant additional strain on the child (WHO, 1996, p. 268-269).

9.0 Institutional upbringing

Coding of this category should be made according to the guidelines of category 5.0 but with the additional requirement that this type of upbringing was primarily caused by the child's own disturbance/functional disability (WHO, 1996, p. 269).

9.1 Removal from home that carries a significant contextual threat

The criteria for coding this category are the same as for category 6.1 but with the additional requirement that the move occurred primarily as a consequence of the child's own disturbance/functional disability (WHO, 1996, p. 269).

9.2 Events that result in a loss of self-esteem

This category follows the guidelines of 6.3 but with the additional requirement that the event occurred primarily because of the child's own behaviour (WHO, 1996, p. 269).

9.8 Other

This category involves any other event/situation that involves a long-term threat and that satisfies the general criteria for category 9. This category should be applied if it is clear that the event/situation results from the child's own disturbance/functional disability and that this event/situation has caused the stress factor to be significantly greater for the child (WHO, 1996, p. 269-270)

2.2 Beyond power and control

The advancement of systemic therapy and the inclusion of second-order cybernetics are considered a revolt against the established “truths” that are represented by traditional psychotherapy (Hårtveit & Jensen, 2008). Questions have been posed regarding the values of traditional psychotherapy, such as conservative attitudes (currently often expressed through diagnoses) and the acceptance of the differences in standards of living, imperialism and oppression. Psychiatric and psychotherapeutic practices have become viewed as a concrete expression of such attitudes/power that pressure clients to adapt to an unhealthy and unjust social system (op.cit).

The theme of power has a central position in the history of systemic family therapy, and for years, it has represented an ambivalence to the role of the systemic therapist (Hertz, 2003). In this connection, Hoffman's 1985 article “Beyond Power and Control” is central. Hoffman (1985) claims that power was retained as a core concept of systemic therapy: *Thinking back, it seems clear that the cold-war years set a pattern that was informed by a fascination with control* (Hoffman, 1985). Thus, Hoffman argues for a new paradigm that is characterized by being collaborative rather than hierarchical and that enters into the process of a co-created therapy (Hoffman, 1985). Hoffman's article sparked a long-running debate (beginning in 1982) in the family therapy field, and it is considered one of the milestones of second-order cybernetics (Hertz, 2003). Therefore, systemic therapy strove instead to be co-creative, egalitarian, relational and contextually based with a clear focus on clients' resources (Schjødt & Egeland, 1993). Nevertheless, the positivistic tradition with an increased focus on diagnosis

has continued to grow stronger (Brinkmann, 2014). The number of diagnosed children and young people with a psychiatric condition has also risen drastically over the past 15 to 20 years (Thomsen, 2015). Diagnosis currently can be said to be a dominant culture in mental health in which so-called objective diagnostic examinations are viewed as representative of “the truth” (Hertz, 2003). The diagnosis culture’s most characteristic feature is that it gives a specific psychiatric view of human suffering and deviation from societal norms, which, if it cannot erase other modes of understanding (e.g., moral, religious, social, psychological), nevertheless contributes to overshadowing them (Brinkmann, 2014). Therefore, the culture of diagnosis is not to be viewed as “innocent”, despite its stated objective approach to truth (Hertz, 2003).

However, in therapeutic terms, a diagnosis can contribute to the removal of guilt and/or shame or have the aim of marking significant deviations from normally expected development (e.g., autism) (Rimehaug & Helmersberg, 1995). Given the organization of modern society, a specific diagnosis can even release the right to specific forms of treatment, medicines or aids (e.g., anti-psychosis medicine, audiobooks for school). Depriving a child or adolescent and his/her family the right to a diagnosis that can help them in understanding, reunification, mastery and potential helping aids or interventions can therefore also be understood as an expression of therapeutic authoritarianism and an abuse of power (op.cit). The problem with the dominant diagnostic culture is the idea that once you have made the diagnosis, you have identified the essence of the suffering and solved the problem (Lorås, 2016a; Rose, 2015). Instead, a more useful distinction was made by Bertrando (cited in Lorås, 2016a), inspired by Bateson, that once you have made a diagnosis, you have made a somewhat useful distinction if it gives meaning to the involved persons. Therefore, the problem is perhaps not the technological aspect (e.g., ICD-10) of “traditional” psychiatry but its values (op.cit). This can pose a dilemma for systemic therapists in how to navigate and mobilise a system that is dominated by diagnosis.

Nevertheless, systemic therapists have never theoretically been aligned with the ideas of linear causality and the field of mental health’s focus on diagnoses (Hertz, 2003). The systemic idea is considered a contribution to counterbalance the tendency toward a reliance on bio-psychiatry and pharmacology that is too easy (Bertrando, 2009). Thus, the systemic therapist’s wish to be “beyond power” has created a situation in which central areas in the field of mental health such as diagnosis and to some extent evidence-based research have

been left to other analysts (i.e., cognitive therapists) (Hertz, 2003). Therefore, systemic therapy appears to be marginalized in the field of mental health. I see many possible reasons for this. One reason seems to be a lack of precise specifications in the systemic therapeutic approach (Pote et al., 2003). Simultaneously, the demands that are made in the neoliberal discourse, the Norwegian Directorate of Health (2008) and the implementation of New Public Management (NPM) in health care services focus more on effectiveness and documentation than on the quality of the therapeutic work (Kirchhoff, 2010). Another reason for the marginalized position of systemic therapy in the field of mental health can also be viewed in connection with the inclusion of the social constructionist ideas of the 1980s (Lorås, 2016b) and Anderson's (1990) "not knowing position". I wonder whether systemic therapists' dichotomous operationalization of social constructionist ideas and the not-knowing position has led to an assumed fear of positioning oneself as a knowledge- and research-based systemic therapist in the field of mental health. I also consider the social constructionist approach to research as a marginalized position in the current positivistic evidence based research climate, with randomised control studies (RCTs) considered as the gold standard for research. Systemic therapists seem to have almost exclusively focused on their own practice and have neglected to consider the shifting nature of society with a steadily greater focus on research (Nielsen, 1999). In this context, it seems like systemic therapists have neglected to position themselves in influential positions within the mental health field and therefore have emphasized a focus on stories with a basis in resources and opportunities (Hertz, 2003).

However, even if social constructionism claims that one can never reach the proper reality, research is not considered inappropriate but a process of transformation for both the researcher and the research participant (Gergen, 2015; Lorås, 2016a). Thus, the very process of inquiry invites all involved persons to take a reflexive stance toward their own unspoken assumptions concerning (1) what is the "right" way to proceed, (2) what are the "right" questions to ask, (3) what is the "right" analysis to employ, and (4) what is the "right" conclusion to draw (McNamee, 2010). In this manner, social constructionism argues that there are plural descriptions and understandings of the world (Gergen, 2015). Anderson's (1990) "not knowing position" emphasizes that the role of a therapist is to be humble regarding her knowledge but that her practice consists of several specific techniques (e.g., inviting the client's curiosity and having inner conversations to respond in a matter that invites dialogue) (Anderson, 1995).

2.2.1 Systemic therapy theory

While family therapists acknowledge the need for clinical practice to be evidence-based, the difficulty is identifying any one methodology that does justice to the work.
(Larner, 2004, p. 20)

The statement above from Larner identifies the heart of the concerns that I want to address in this research project. A historical review of the literature shows many different descriptions of systemic therapy competences. Currently, several models coexist under the umbrella term “systemic family therapy” (Boston, 2000). However, some unifying features of systemic therapy can be found, such as the importance that is given to understanding psychological difficulties in the context of social relationships and culture and the significance of drawing distinctions and marking “difference” as an aspect to create change (op.cit). In this section, I present my re-discovering process from the original work and descriptions of systemic therapy interventions from the early development of family therapy to Milan-systemic family therapy and postmodern descriptions.

2.2.2 The development of the field of family therapy

The first foundation for a family perspective was established with the development of psychoanalysis and Freud’s work around 1890 (Schjødt & Egeland, 1993). Sigmund Freud claimed that psychiatric symptoms could be viewed as the expression of conflict between an individual, his surroundings and his family (Freud, 1958). Therefore, Freud’s contribution can be viewed as the first family dynamic perspective on psychiatric difficulties. Nevertheless, Freud concentrated his work on how the conflicts were grounded in the individual, and the interaction was viewed retroactively (op.cit). The generation that followed Freud, which included his own daughter Anna, took these family dynamic ideas further through child therapy in which attention was directed toward the actual family interaction (Hårtveit & Jensen, 2008). Therefore, the focus on relationships can be viewed as having been established, although the relational perspective was limited to the relationship between mother and child (op.cit). Thus, I present the origins of family therapy with a basis in the psychodynamic tradition. Even the later leading systemic psychotherapists such as Helm Stierlin, Don D. Jackson, Donald Block and Nathan Ackerman received their training in the 1930s and 1940s at psychodynamic-oriented clinics, such as the Chestnut Lodge in Maryland and the Menninger Clinic in Kansas.

Jackson (1957) was one of the first psychotherapists to describe therapeutic work with the entire family system and was the first to link the physiological concept of homeostasis to families. The concept of homeostasis was later very central to the development of the MRI model. In 1959, psychiatrist Don D. Jackson founded the Mental Research Institute (MRI) in Palo Alto, California (Dallos & Draper, 2010). The original group at MRI also developed the strategic tradition, which was later further developed and reorganized in an array of clinics in Europe, Australia and the USA (Hårtveit & Jensen, 2008). Inspired by Milton Erickson's problem-solving approach, Jackson and his co-workers also began a short-term therapy project. The participants in the project were Paul Watzlawick, Arthur Bodin and Richard Fish (Johnsen & Torsteinsson, 2012). The group's theoretical starting point was built on the "Pragmatics of Human Communication" of Watzlawick et al. (1967). The group developed a model that was later known as the MRI model (Watzlawick et al., 1974). The MRI model views the family as a homeostatic system in which "family rules" contribute to maintaining the status quo. The difficulties of the family were understood as arising when the homeostasis of the family was threatened. Therefore, the foundational principle of the model was that regardless of the reason for a problem, the interacting persons' (i.e., the family members') maintaining behaviour was the real reason for the problem. If the problem-maintaining behaviour were changed, then the problem would be changed or solved (Watzlawick et al., 1967). The Palo Alto group is currently considered to be the group that has had the most decisive influence and is presently represented by several streams and schools of thought that are often described as strategic or systemic therapy¹ (Hårtveit & Jensen, 2008).

In 1952, the anthropologist Gregory Bateson started a research group with communications researcher Jay Haley, Doctor William Fry, anthropologist John Weakland, and Doctor John Jackson (Dallos & Draper, 2010). The Bateson group had its office close to a psychiatric hospital, the Veterans' Administration Hospital in Menlo Park, California. The group studied psychiatric patients and their families. With a foundation in, among others, systemic theory, the Bateson group wrote an article in 1956 entitled "Towards a theory of schizophrenia". In this article, the subsequently famous double bind hypothesis was presented for the first time. The Bateson group claimed that the revolutionary concept that was introduced by the double bind hypothesis was that disturbed behaviour can be understood to result from unfortunate interpersonal communication (between two or more persons, often a mother and her child),

¹ The word *systemic* was not used in the 1950s, and the term *family systems therapy* was preferred (Bertrando & Toffanetti 2000).

not merely as an intra-psychological or medical problem (Schjødt & Egeland, 1993). Therefore, the focus was directed towards patterns of communication instead of behaviour and the individuals' abilities (Bateson et al., 1956). The authors claimed that repeated exposures to such situations could lead to schizophrenia. This article led to a paradigm shift in which the focus and understanding were changed from a linear cause-effect model to an understanding that is based on a circular frame (e.g., from individual to whole/system/family) (op.cit).

2.2.3 The development of (Milan) systemic therapy, strategic-systemic

The Milan systemic family therapy approach was first presented by a group of family therapists from Milan, Italy, which was led by Selvini Palazzoli et al., (1978). Late in the 1960s, the group comprised eight psychiatrists and psychoanalysts who practiced psychoanalytic family therapy. Subsequently, Selvini Palazzoli shifted to the MRI model, followed by three members of the group, namely, Luigi Boscolo, Gianfranco Cecchin and Giuliana Prata (Lorås, 2016a).

The Milan team used the cybernetic definition of a system, which is any unit that is structured by feedback (Guttman, 1991). On this basis, they viewed pathological behaviour to result from individuals' being isolated or vilified in their struggles to maintain particular family relationships. For example, a person's symptomatic behaviour was viewed as a reaction to this isolation or because of the person's attempt to "strike back" against hurtful family relationships (Campbell, 1999). Therefore, the main goal for the Milan systemic therapeutic approach was to offer family members insight into their struggle for control over their family relationships. Among the systemic techniques that they used to counter the family's resistance to change were systemic focus, positive connotation, final reframing, family rituals, homework, and paradoxical ("counter paradoxical") interventions (Campbell, 1999; Selvini Palazzoli et al., 1978).

The early work of the Milan team (Selvini Palazzoli et al., 1978) was later described as first-order cybernetics, which was characterized by dispassionate therapists who observed the family system from the outside. This therapeutic practice was characterized by a systematic search for differences in people's behaviour in relationships, how different family members perceived an event, and efforts to uncover the connections that link family members and keep the family in homeostatic balance (Goldenberg & Goldenberg, 2008; Jones, 1993).

From another perspective, this practice, which was influenced by the ideas of MRI (Watzlawick et al., 1967), Haley (1963) and Minuchin (1974), can be described as strategic-systemic (Boscolo & Bertrando, 1996). On the one hand, these therapists had a definite idea regarding where to lead their clients and what type of change to pursue. On the other hand, they were no longer concerned with symptoms or presenting problems; instead, they were interested in the entire systemic family configuration. One example is the positive connotation, a prescription to the family to maintain its overall family interaction rather than to maintain the individual's symptom, such as in the symptom prescription of Watzlawick et al. (1974).

Many of these early pioneers were psychiatrists and/or were working with disorder categories (i.e., schizophrenia). Although they were critical of psychiatric diagnosis, they still adopted an expert position and described the family in almost diagnostic terms based on an implicit model of healthy family functioning. It is worth mentioning, however, that some of the early family therapists were also diagnosing family patterns (Kaslow, 1996).

2.2.4 Systemic epistemology: Batesonian therapy

A momentous shift in the Milan team's theory and practice occurred when it first encountered Gregory Bateson's original theories. Until that time, the Milan team had merely second-hand knowledge of these theories. The readings of the newly published "Steps to an Ecology of Mind" (Bateson, 1972) paved the way for a new understanding of therapy and shifted the focus from the observation of interactive sequences and patterns to questioning the family's belief system (Goldenberg & Goldenberg, 2008). Prompted by Bateson, the group now conceived all of the therapist's knowledge as inherently provisional and always open to be questioned and revised. Consequently, the fitness of the therapist's hypothesis concerning the system should always be checked against the client's feedback, and the therapist's stance towards the client should always be tentative and uncertain. These "guidelines" were advanced in the team's final joint article as hypothesizing, circularity and neutrality (Selvini Palazzoli et al., 1980). At this point, the term "systemic family therapy" began to be used to distinguish the team's model from other models, such as strategic and structural family therapy (Schjødt & Egeland, 1993). Systemic family therapy was first proposed as a definition of the Milan approach by Lynn Hoffman (1981).

The original Milan group, however, separated in 1980 (Lorås, 2016a). Selvini Palazzoli and Prata continued their search for classification and predictable interventions in families with psychotic members, whereas Boscolo and Cecchin began organizing a comprehensive training for therapists that further elaborated their systemic ideas (Goldenberg & Goldenberg, 2008). Because Palazolli and Prata went in a very different therapeutic directions after the separation, I have chosen to follow Boscolo and Cecchin's route in the remainder of this discussion. Boscolo and Cecchin initially worked on developing the new features of their method (Boscolo et al., 1987). This development was centred on the therapeutic interviewing process itself, particularly the use of circular questioning (Jones, 1993). Circular questioning stems from Bateson's (1972) ideas regarding information as news of difference, and it focuses on interpersonal connections and relationships rather than individual characteristics to address the differences in the family members' perception of events and relationships (Tomm, 1988).

During a 1982 meeting in Calgary that was organized by Karl Tomm, Boscolo and Cecchin contacted Humberto Maturana, Heinz Von Foerster, Vernon Cronen and Barnett Pearce, who were among the most relevant representatives of constructivism (Bertrando & Tofanetti, 2000). In seeking to advance a new systemic epistemology, Boscolo and Cecchin found a consonance in these authors' work, which became central in advancing first constructivist, then social constructionist and narrative approaches to therapy (Goldenberg & Goldenberg, 2008). All of these orientations deny that any objective reality is knowable as such to therapists and hold instead that the therapist's own personal and theoretical biases should be included as part of the observation (Boston, 2000).

2.2.5 Self-reflexivity: the influence of constructivism

Boscolo and Cecchin's ideas concerning circular interviewing were adapted and further developed by Tomm (1987a, 1987b, 1988), who assumed a more definite constructivist position. Tomm (1987a) claimed that systemic therapists know that they do not know and therefore must continue asking questions to gain new information and new hypotheses for their interventions. Therefore, Tomm implied that questions are themselves therapeutic interventions. The main goal of circular interviewing is to provide a new basis of information in the family that enables possibilities for new understandings of members' interactions (Tomm, 1987a; 1987b). Thus, the dialogic process can be viewed as an intervention in itself (Tomm, 1988).

The Milan systemic approach arrived in Great Britain at the beginning of the 1980s. David Campbell first developed training in systemic therapy at the Tavistock Clinic in London and with his group, became one of the main proponents of the Milan approach in the UK (Burck et al., 2012; Campbell, 1999). Campbell described his approach to systemic therapy as comprising three different ways of understanding what we see and hear. (1) First, systemic therapy is based on an appreciation that what people observe around them can be understood in unique and different ways because any event can be viewed from different contexts that each provide different meanings to different people. (2) Systemic thinking also implies an appreciation that there is a meaningful connection between a person's beliefs and his/her behaviour. Finally, (3) systemic therapy views the observer as a part of the therapeutic system. What he observes is his own construction, and it is affected by the interaction between him as a therapist and the members of the observed system. This approach has been called second-order cybernetics (von Foerster, 1982).

Campbell (1999) claimed that the systemic family therapists of the new millennium should pay allegiance to the core concepts of context, difference, feedback, patterns of interactions and meaning in language and change but should also incorporate a broader range of techniques and settings. In the following, I will consider systemic therapy according to a postmodern and social constructionist approach. Because the systemic approach in the mid 80's (and until today) has moved away from many of the original Milan systemic therapy characteristics (i.e. first order cybernetics, the use of thoroughly formulated hypotheses and paradoxical interventions) (Selvini Palazzoli et al., 1978). However, as they still use the systemic metaphor, have chosen not to use the phrase "post Milan." Instead I have named it "post systemic" (Lorås, Bertrando & Ness, in press) to describe its further developments.

Therefore, at the end of the 1990s, the divide between systemic therapy and other family therapy approaches (such as structural and strategic therapy) appeared to be growing. This background shows that systemic therapy in its constructivist period moved away from the implicit behaviourism of first-order cybernetics toward a more cognitive stance. Increasingly, information became the basic therapeutic means, and changing clients' premises – the unconscious cognitive foundations of our way of seeing the world, according to Bateson (1936) – became the main goal.

2.2.6 "Post-systemic": postmodern and social constructionist therapies

The inclusion of constructivist ideas introduced systemic therapy to second-order cybernetics in the mid-1980s (Hoffman, 1990, 2002). The implication was that therapists were asked to include their own personal and theoretical biases as part of the observational system (Boston, 2000), and they started to hypothesize about their clients as clients who are being observed by a therapist (Campbell, 1999). This shift led systemic therapists to be increasingly interested in understanding how the therapist (and the clients themselves) can shape their beliefs. A possible answer was found in social constructionist theory (Gergen, 1994; MacCormack & Tomm, 1998; McNamee & Gergen, 1992; Strong et al., 2008). Social constructionism focuses on people's use of language and meaning making in relationships and cultures (Gergen, 2009, 2015; Lock & Strong, 2010). Reality is not the product of an isolated observer; instead, it is a creation of the "linguistic dances" that we all dance together (Hoffman, 1992; Tomm et al., 2014). This shift is a radical change not only from the position that external reality is "knowable" but also from the idea that each observer constructs her own reality; instead, this approach focuses on how humans collectively interpret and construct their own way of understanding reality (Gergen, 2009, 2015).

The alternative view that is offered by social constructionists led systemic therapy to consider the social world to result from our interactions, with interpreted knowledge being socially constructed in a shared language (Anderson & Goolishian, 1988; Gergen, 1982). Social constructionism encouraged "post-systemic" (or "post-Milan") therapists to view clinical realities such as psychiatric diagnosis and family roles as a result of social interactions across many different levels, such as cultural, societal, familial and individual levels (Campbell, 1999). The family is no longer viewed as the most relevant human system, which also opened the way to the possibility of individual systemic therapy (Boscolo & Bertrando, 1996). Overall, most normative therapeutic theories were abandoned or placed in the background (Bertrando & Toffanetti, 2000). Overall, most so-called normative therapeutic theories were abandoned or placed in the background (Bertrando & Toffanetti, 2000). In this context, normative knowledge refers to statements and/or beliefs, which builds on assumptions and predefined descriptions (i.e. acceptable and expected behaviours), and involves an assessment about what "others" should or are expected to do (Meyer, 2007).

The inclusion of social constructionism, and the idea of reality as created through language in an ongoing and relational process, introduced systemic therapy to postmodernism (Boston, 2000). The postmodern turn also allowed the inclusion of narrative and solution-focused ideas (op.cit). The influence of narrative ideas on systemic practice is clearly observable in two books, "The Times of Time" (Boscolo & Bertrando, 1993) and "Systemic Therapy with Individuals" (Boscolo & Bertrando, 1996). At this time, Michael White was just becoming famous, but he had already influenced systemic therapy (Lorås, 2016a; White & Epston, 1990). The idea was that instead of considering a system in the present, we consider its development in time, and then we obtain a story. When we consider time, we think in narrative terms. Therefore, I argue that it is impossible to understand systemic therapy without considering narratives (Lorås, 2016a).

Solution-focused therapy became one of the most important developments of systemic therapy (actually, it was mostly a postmodern derivation of strategic-systemic therapy; deShazer, 1985) by granting an elegant approach that was centred on solutions outside the boundaries of problem solving. Although it is connected to strategic therapies, solution-focused therapy has evolved to be more collaborative and oriented around facilitating the family's own suggestions for solutions and meaning making (Dallos & Draper, 2010). However, solution-focused therapy did not have much influence on the therapists who were developing Milan-style models: the idea of finding simple solutions to intractable problems did not appeal to the Milan group or to its followers (op.cit). Rather than "chasing" solutions, the Milan group generated hypotheses (Selvini et al., 1980). However, the postmodern turn, with the inclusion of social constructionist ideas, generated a shift in the therapeutic approach that was formerly known as Milan systemic, and most of the paradoxical interventions were banned. Although Boscolo and Cecchin still performed some paradoxical interventions, their focus was on creating meaningful conversations (Lorås, 2016a). Therefore, in the following section, I abandon the term Milan systemic therapy and use the phrase "post-systemic therapy" to describe its further developments.

2.2.7 Meta-dialogues: the influence of reflecting team processes

The Norwegian psychiatrist Andersen (1992) originally aligned with the ideas of the Milan team but eventually rejected them, and he objected to their view of the therapist as an expert. Instead, in 1985, he introduced his own "reflecting team". In this practice, both the active therapist and the members of the therapeutic team share all of their observations with the

client, which avoids any secrecy. The idea that led to the development of the reflecting team was the desire to shift professional language towards everyday language, in addition to the idea of sharing the professional's knowledge directly with clients (Andersen, 1992). Andersen (1992) described this movement as a shift from an "either- or" to a "both- and" stance. This shift allowed family members to choose which of the team's reflections (if any) they wanted to explore in depth in the continuing conversation. Although Andersen never (to my knowledge) characterized his theoretical orientation in one specific method or epistemology, his authorship shows close ties to collaborative therapy and social constructionist theory and practice. Whatever his therapeutic orientation, Tom Anderson's reflective team had a significant influence on systemic therapy (Campbell et al., 1991).

2.2.8 Opening the dialogue: the influence of dialogical therapy

The Finnish therapist Jaakko Seikkula was initially influenced by Milan systemic therapy and later established his own "open dialogue approach" (Seikkula, 2002; Seikkula & Olson, 2003). In the "open dialogue approach", Batesonian references are replaced by Bakhtin's (1935) dialogical ideas. In open dialogue, all members of the relevant system around a problem have their own say regarding both the presenting issue and the therapeutic process, without necessarily searching for final agreement. Despite its apparent anarchy, this method has shown extremely promising results (Seikkula & Olson, 2003). A similar dialogical emphasis, although it is centred on the therapist's inner conversation, appears in the work of Rober (2005).

Pure dialogical approaches seem to have severed all of their connections with the systemic model, whereas dialogical systemic therapy, as proposed by Bertrando (2007), presents a new theoretical framework. This framework is based on Bertrando's (2007) original work in the Milan model to bridge the gap between a systemic and dialogical understanding. As a dialogical therapist, Bertrando (2007) claims that to entertain a relationship with the client on equal terms, therapists do not need to renounce their expertise/wisdom but "know not to know" about their clients' lives. Therapists maintain their opinions in the same manner as other involved persons in the dialogue but do not renounce their ideas and feelings. Therefore, Bertrando (2009) encourages an attitude of constant questioning and an ability to face dilemmas and doubts, without entertaining too many certainties. Bertrando (2007) describes the "new" dialogical therapy as being guided by the use of systemic hypotheses in a collaborative frame. Thus, hypotheses are reintroduced in the therapeutic process and are

considered the product of a joint creative effort by both the therapist and the clients (op.cit). From this perspective, therapy is moving towards a more specialized focus in relation to the use of systemic therapeutic competences, as shown in the Leeds manual for systemic family therapy (Pote et al., 2000).

2.2.9 The Leeds manual: the quest for consistency

Throughout most of its history, systemic therapy has involved many facets without attempting to identify a unifying description. However, the need for a unifying description became especially apparent when attempting to create manuals to use systemic therapy in specific situations, such as research (e.g., Asen & Jones, 2000; Trowell, 2007) and training (Pote et al., 2000). This research project identifies systemic competences. Although there are some clear similarities between competences and manuals, the differences are significant. Manuals tend to be written for use by trained therapists (or in training) and often omit some basic skills based on the assumption that they are knowledge that therapists should already have.

Competences, on the other hand, mean the documentation and description of the fundamental elements of systemic therapy (Northey, 2011) that are expected to be mastered by systemic therapists (Stratton et al., 2011). Therefore, I have included only the identified competences in the Leeds manual and have not presented the items that are specific to manuals (e.g., checklists).

The most important systemic manual is most likely the Leeds manual (Pote et al. (2000) that was created at the Leeds Family Therapy Research Centre (LFTRC). The research process that led to the manual was multifaceted and recursive and included several stages of data collection and analysis, followed by consultations with several participating therapists and other family therapists in the UK (Pote et al., 2003). To enhance clinical sensitivity and participant validation of the analysis, an iterative design was chosen (Elliott et al., 1999; Pote et al., 2003). Being primarily qualitative, the research was designed to be consistent with the social constructionist epistemology. When they were considered informative, quantitative techniques, such as ranking and scaling, were included. The key stages in the research process were as follows (Pote et al., 2003):

- Semi-structured interviews with five expert systemic family therapists that used both quantitative and qualitative analysis;
- Observational ratings of fifteen videotapes of expert family therapists;
- Development of a draft manual; and

- Trial of the manual in practice, which was validated through practice by three experiences with systemic family therapists.

The manual contains a synthesis of techniques from the Milan, narrative and solution-focused schools (Allison et al., 2002). The Leeds Family Therapy Research Team (LFTRC) identified 11 specific competences and epistemological positions that were central to systemic family therapy (Pote et al., 2000): (1) systems focus, (2) circularity, (3) social constructionism, (4) narratives and languages, (5) co-constructed therapy, (6) power, (7) self-reflexivity, (8) constructivism, (9) cultural context, (10) strengths and solutions and (11) connections and patterns. The 11 competences are presented in the following sections:

1 Systems focus

The phrase system theory was first used by the biologist von Bertalanffy (1950). At the beginning of his career (in the 1920s), von Bertalanffy was engaged in a "battle" between the mechanists and the vitalists (Ølgaard, 2004). The mechanists were interested in analysing living organisms, and organisms were understood as an aggregate of cells. The cell was viewed as a collection of molecules, and its behaviour was considered a result of the "total" or reflexes (op.cit). However, the vitalists argued that this view could not work without some form of life force. von Bertalanffy and colleagues took a position that they called organic and claimed that organisms should be considered an organized whole. On this basis, von Bertalanffy developed what he called general systems theory (op.cit). Currently, system theory is a collective term that involves very different theories, such as general system theory, control theory, information theory, cybernetics and game theory (Schjødt & Egeland, 1993). Based on the many different system theories, many different definitions of the phrase *system* (op.cit) exist. However, I chose to use Bateson's (1972) definition of a system as any unit that is structured by feedback. Therefore, a system is more than a collection of individuals and should be considered an organized unity whose parts function in a manner that transcends their separate characteristics (Minuchin et al., 2007).

On this basis, the central focus should be on the system rather than on the individual (Pote et al., 2000). A consistent view is that difficulties do not arise in individuals but in the relationships, interactions and language that develop between individuals (op.cit). Therefore, pathological behaviour is understood to result from the individual being isolated or vilified in his/her struggles to maintain particular family relationships (Selvini Palazzoli et al., 1978). For

example, a person's symptomatic behaviour is viewed as a reaction to this isolation or because of the person's attempt to "strike back" against the hurtful family relationship (Campbell, 1999).

2 Circularity

In 1972, the biologist and anthropologist Gregory Bateson introduced circular epistemology as an alternative understanding of human systems. Circularity emphasizes that an event must be viewed in the context of other events that simultaneously occur, interlock and mutually reinforce (Schjødt & Egeland, 1993). In a linear, progressive chain of causality, it is considered meaningful to describe the beginning and end of a "chain" (Watzlawick et al., 1967). In a circular view, problems are not caused by past situations but instead by on going, interactive, mutually influencing family processes (Bateson, 1972). Circular questioning stems from Bateson's ideas and focuses on family connections and relationships rather than on an individual's symptoms to address the differences in the different family members' perception of events and relationships (Goldenberg & Goldenberg, 2008; Tomm, 1988). The early work of Boscolo and Cecchins on the circular interviewing technique was adapted and further developed by Tomm (1987a, 1987b, 1988).

3 Social constructionism

A social constructionist argues that an exact replication of what is "out there" does not exist; instead, representations are variably mediated according to socially or communally shared meanings through language (Ness, 2011). Social constructionists emphasize that people's beliefs concerning the world and what constitutes reality are social constructions. Therefore, a common understanding of reality is developed through an interactive process of negotiation through language (op.cit).

Social constructionists take a critical stance towards taken-for-granted ways of understanding (Anderson & Gehart, 2007) and established truths, and they are concerned with the power and authority with which these truths accord. The universal and taken-for-granted truths that people acquire are not inevitable, fixed or stable. A basic idea of social constructionism is to rethink everything that one has learned regarding the world and oneself (Gergen, 2015). Everything that is considered real is viewed as socially constructed and is not real before people have agreed to regard it as real (op.cit). Truth is considered in terms of communal and relational constructions that change with the social context (Anderson & Gehart, 2007). Social

constructionists consider that people always speak from a cultural position when they define what reality is (Gergen, 2015). A social constructionist claims that there are no objectively defined problems "out there". Instead, how we construct "the good life" and what prevents us from achieving it become defined as problems. Therefore, any definition of reality or problems is always context- and person-dependent (op.cit).

Communication and meaning making are recognized as relational processes in which information is socially constructed (Cecchin, 1992). Therefore, a central tenet of social constructionism is that meanings and understandings of the world are achieved through coordination among and between persons (Gergen, 1994). Gergen (2009) asserts that people coordinate meaning and action through language, and the "coordinating" process is performed through negotiations, agreements and comparisons of views. Gergen (op.cit) further argues that the focus on language as essential to the meaning-making process represents a major shift in how language use can be understood.

4 Narratives and language

Inspired by Bateson (1972) and a systemic approach, in the early 1980s, White and Epston (1990) developed narrative therapy. White and Epston (op.cit) used narrative as a metaphor that indicates that we humans feel and experience our lives through the stories that we tell about ourselves and the stories that others tell about us. A central idea in narrative therapy is that people's lives and experiences are "richer and fuller" than the stories told/that are told about people, their actions and their identity (White, 2007). Meanwhile, in a psychiatric context, stories about people and their problems are typically formulated as pathological aspects of the person or as a psychiatric diagnosis (op.cit). This formulation is often a dominant narrative of man, which excludes the aspects of life that cannot be set in the diagnostic system (op.cit). In connection with systemic therapy, the idea is that if you take the idea of a system and you place your system in time, then you obtain a story. To consider time, you have to regard narratives. Thus, omitting narratives from systemic therapy is impossible (Lorås, 2016a).

The roots of the collaborative approach date back to the MRI and were developed by Anderson and Goolishian (1988). An underlying rationale contends that meaning is created and experienced in dialogue with other people and oneself (Anderson, 1997). Therefore, the human system is considered as language- and meaning-generating systems (op.cit). The

therapists who practice from a collaborative approach perspective strive to “open and make their invisible thoughts visible” (Cheon & Murphy, 2007).

The essence of a collaborative “therapy session” is the dialogical element and the engagement of the therapist and the clients in a shared inquiry, which are unique to each relationship and each conversation (Anderson, 1997). Therefore, the therapist collaborates with family members in having emphatic conversations to generate new meanings, new outlooks and to resolve problems (Anderson, 1995). Thus, the therapist is considered a conversational partner who emphasizes that problems are linguistically constructed in the here and now (op.cit). Therefore, Anderson (1995) claims that there is no such thing as one problem; instead, there are different descriptions and explanations of the problem. “Problems” are not considered solved but dissolved (op.cit).

5 Co-constructed therapy

The inclusion of social constructionism and second-order cybernetics led systemic therapy to acknowledge therapy as a co-constructed process (Boston, 2000). In addition to integrating the family’s ideas, wishes and goals of therapy, the therapist should simultaneously be conscious that members’ statements and expressions are affected by the therapist’s presence (Pote et al., 2000). Therefore, the therapist must hypothesize concerning the family as a family who is being observed by a family therapist (Campbell, 1999). Because of the equal impact of the therapist, the therapeutic team and the clients, they are all considered part of the same system (Pote et al., 2000). Therefore, the therapeutic process is considered to be co-constructed, with a shared responsibility for change (Pote et al., 2000; Stratton et al., 2009). Thus, particular attention should be paid to the contributions that all members of the therapeutic system make in the process of change (Pote et al., 2000).

6 Power

Power and control have been central to the family therapy literature and theory since the period of first-order cybernetics from 1950 to the mid-1980s (Hoffman, 1990, 2002). The early work on developing family therapy models that came out of Palo Alto used a powerful vocabulary based on war and adversarial metaphors (Hoffman, 1985). Jay Haley (1963, 1967) was central in this period and viewed the existence of a clear hierarchy, where the father had the most power, the mother the second most power and the children the least power, as an essential prerequisite for a family’s functioning. Therefore, Haley claimed that problems arose

when conflicts between parents threatened the family's hierarchy and when children obtained great autonomy (op.cit). This period is called first-order cybernetics.

Power was kept as a central core until family therapy moved toward second-order cybernetics at the beginning of the 1980s (Hoffman, 1985). This shift was a radical change. Systemic therapy moved away from a strategized use of power and control and the assumption that an external "force" (the therapist) is necessary to change the families' homeostasis (Schjødt & Egeland, 1993). The postmodern influence led systemic therapy to integrate the ideas of collaboration and a reflective stance in relation to the power differentials (Hoffman, 1990, 2002; Pote et al., 2000).

Regarding power, the French philosopher Michel Foucault and the work of Michael White have been central. Foucault (1973) emphasized that no power or knowledge can be total: *power is everywhere: not because it embraces everything, but because it comes from everywhere* (p. 93). Nevertheless, power relations in mental health care are an omnipresent and integrated part of all relations. Therefore, regarding how power influences one's relationships, the focus of systemic therapy is on therapist sensitivity. According to Foucault, a therapeutic goal is to not disclose "appropriate standards" or use applause in therapeutic reflections because applause from a power perspective is based on normalizing judgments (White, 2007). White (2007) claims that judging something another has done great, stunning, or amazing from a "one up" position implies the message *I can judge what is good in what you do and thus also what is good for you*. Therefore, a "post-" systemic family therapist is alert to his/her power as a therapist and/or as a representative of a power institution and avoids normalizing judgments and the use of applause. The therapist is reflexive regarding the power differentials in families and collaborates with families in finding new solutions to intractable difficulties.

7 Self-reflexivity

A self-reflexive systemic therapist attempts to be reflexive of his/her own participation in the process of inquiry. This intention helps the therapist to understand the influence of the dominant discourses and his/her choices to relate to them. The idea of self- reflexivity also signals that knowledge does not necessarily exist as an independent form that is separate from our own experience of who we are (Fook & Gardner, 2007). Therefore, the "therapy

delivered” is affected by our interpreting, punctuation, prioritizing and the dominant discourses.

Self-reflexivity is a prerequisite for providing systemic therapy, as proposed by the Leeds Family Therapy Research Team. Pote et al. (2000) claim that the therapist should attempt to apply systemic thinking to him/herself about the system (e.g., family members) and reject any other thinking that does not apply to a systemic epistemology. This statement can be considered a linear way of thinking. However, the aim of Pote et al.’s (2000) statement is that systemic epistemology should be the foundation of the delivered therapeutic approach, which should validate and safeguard the inclusion of a circular and multiple understanding of the system. The implication is that the therapist cannot turn his/her systemic thinking on and off when he/she enters the therapy room. Additionally, the team behind the screen cannot automatically change from negative talk about the family (or the therapist) to being constructively systemic. Therefore, to use systemic therapy as described by the LFTRC team, it is necessary for the therapist to be alert to his/her own constructions, functioning and prejudices so that his/herself can be used effectively with the family and simultaneously be aligned with systemic ideas.

8 Constructivism

In family therapy, the term constructivism is commonly associated with the Chilean biologist Humberto Maturana and is rooted in the biology of cognition and neurobiology (Maturana, 1978; Watzlawick, 1984). Maturana (1978) emphasizes that each person’s perceptions are filtered through our individual nervous system, which emphasizes the active role that each individual has in constructing reality, through his/her unique frame of reference (op.cit). Therefore, constructivists claim that our perception (regarding actually knowing “what is out there”) is limited because each individual brings different assumptions to the same situation. Thus, the construction of reality results from our own mental and symbolic processes and meaning making (op.cit). In social interactions, people’s understanding is constrained and affected by their own meaning system (Pote et al., 2000). The implication is that people cannot make assumptions regarding how meaning will be attributed to other people. Thus, there is only the possibility of disturbing other people’s meanings systems (op.cit).

In the literature, the concepts of constructivism and social constructionism are used interchangeably (Dallos & Draper, 2010; Gergen, 1997). I understand this conflation to be

built on dichotomies. In this dichotomy, the constructivist focus on biological processes has been marginalized, and its focus on language and discourse has been emphasized; thus, the constructivist distinctiveness has been marginalized. Nevertheless, in its manual (Pote et al., 2000), the LFTRC team emphasizes the differences. Although there are clear similarities, the constructivist tends to focus on individual experiences and believes that the problem is in the eye of the beholder (Goldenberg & Goldenberg, 2008). Therefore, a constructivist therapist may attempt to help the family change how the “identified” member perceives the problem. Although the LFTRC’s manual prioritizes a systemic epistemology, there is no implication that other epistemologies (such as constructivism) cannot be useful at certain points in therapy. This idea is described in the paragraph on self-reflexivity and in the Adherence Protocol as a proscribed practice (Stratton et al., 2009, p. 44).

9 Cultural context

The concept of context is fundamental in systemic family therapy (Pote et al., 2000). Bateson (1972) introduced the concept of context to expand our understanding and emphasize that context is our mental or psychological frame of understanding. People never understand anything in an isolated manner and will attempt to create meaning from what they see and experience. Therefore, we automatically select a frame from within to understand and create meaning (op.cit).

Context can function as a meta-communication because analogue communication often defines it (Jensen, 1994). Bateson (1972) considered every meta-communicative message to be a psychological frame. Based on context, every “frame” or its prerequisites convey how communication will be understood (op.cit). The concept of context offers an alternative view on how a message or a type of behaviour can be understood in this frame. Therefore, systemic family therapists should consider the importance of context relative to the cultural meanings and narratives in which people live their lives (Pote et al., 2000). Issues of race, culture, gender, disability and class should be included. It is crucial to be aware that despite having similar cultural backgrounds, context can communicate different meanings to different participants (Bateson, 1979). The relations among the abovementioned narratives, context, therapeutic relationships (including the therapeutic team) and families should be an important consideration throughout the entire therapy process (Pote et al., 2000).

10 Strengths and solutions

The family system in focus for therapy should be considered to possess a wealth of strengths and solutions (Pote et al., 2000), which can be considered to be the opposite of the diagnostic paradigm and its frequently individualistic and pathologizing descriptions of clients. Instead, the systemic therapist takes a non-pathologizing, positive view of the family system and the difficulties with which they struggle (op.cit). The positive view is safeguarded through the systemic epistemology (described in the paragraph on self-reflexivity) and positive connotations. A positive connotation reframes the “original” meaning and approves all of the behaviour of the "identified patient" that is traditionally regarded as pathological, such as supportive formulations that pertain to the family system (Selvini Palazzoli et al., 1974). Using a positive connotation, we implicitly assert that we are family "allies" (op.cit).

In the process of change, the family itself is considered to be in the best position to generate suitable solutions (op.cit). Therapists can facilitate this process by attending to the strengths and the solutions in the stories that the family system brings to therapy (Pote et al., 2000, p. 11). Therefore, a central idea is that people's lives and experiences are "richer and fuller" than the stories that are told about people, their actions and their identities (White, 2007). Through the identification of family strengths and previous solutions to intractable difficulties, the possibility of re-authoring the family narratives occurs. This re-authoring provides not only the family members a foundation for new initiatives to tackle the problems and dilemmas in their lives but also an alternative and preferred story of people's lives (White & Epston, 1990). Therefore, the objective of the therapeutic process is (to an extent) to rearrange already learned skills or help the client to rediscover his/her own resources.

11 Connections and patterns

In systemic family therapy, it is crucial to understand the relations and intractable difficulties in systems (Pote et al., 2000). Therefore, the connections among circular patterns of behaviour and the connections between beliefs and behaviour are some of the main focuses of the systemic therapist. Tomm et al. (2014) claim that problematic patterns of interaction in the family system actively produce individual pathology, which may be considered a chronic illness in the future. Therefore, Tomm et al. (2014) have developed an overall framework to work on patterns, which is known as “the HIP and PIP approach”. HIP is an abbreviation for “Healing Interpersonal Pattern”, and it consists of the patterns that are considered to have positive effects on the involved person. The HIP is also enacted in the interpersonal space

between the involved persons and is considered to have a potentially positive effect on both parties (op.cit: 7). PIP means “Pathologizing Interpersonal Pattern”. PIPs consist of the identified patterns that invite or increase negativity, pain and/or suffering in one or more members of the systems who interact or that result in significant stress in the relationship (op.cit).

Tomm et al. (2014, p. 7) claim that by interrupting these patterns early, it is possible to prevent or ameliorate subsequent entrapment in individual pathology. Therefore, a therapeutic goal is to enable family members to consider the connections between the patterns and develop new perceptions or actions, which can help them to resolve or make their difficulties manageable (function improvement) (Pote et al., 2000). In the Leeds manual, function improvement is described as change (op.cit). When change occurs, therapists are responsible for emphasizing it to the family to encourage the process of further change and to punctuate the lived stories that made the changes possible (DeJong & Berg, 2002; Pote et al., 2000).

2.2.10 Summary of the historical development

The systemic approach has been developed considerably throughout the years and incorporates elements from first- and second-order cybernetics, structural, strategic, narrative and solution-focused therapy, constructivism, social constructionism, and postmodernism, among others (Carr, 2012). Overall, postmodern therapies seem to shift the focus of therapy from the realm of concepts, cognition and epistemology and move it closer to experience. The lived experience of clients, in narratives and dialogues, seems to be the main target of the therapeutic interventions, which reintroduces into therapy the relevance of not only clients' perspectives and beliefs but also their bodies, sensibilities, and feelings (Bertrando & Arcelloni, 2014). Contemporary postmodern systemic therapy can therefore be described as having undergone a paradigm shift, and it moved away from strategizing and diagnosing. Instead, postmodern systemic therapy emphasizes collaboration, context, co-creating, strengths, solutions and relationships and positive connotations rather than hierarchical, individualistic and pathologizing descriptions of clients (Hertz, 2003; Hoffman, 1985). Thus, systemic family therapy challenges the medical, diagnostic and structured model of contemporary mental health (Hertz, 2003).

In the field of psychotherapy, there is a growing need to explicitly document the specific interventions for the therapeutic approach, both to validate the training of therapists and to

review the effectiveness of the delivered intervention (Cottrell & Boston, 2002). The Leeds Family Therapy Research Centre's manual for systemic therapy (Pote et al., 2000) offers precise descriptions of systemic therapy and provides (to some extent) the flexibility to include different epistemological positions (i.e., medical/diagnostic models) at certain points in therapy, if it is asked for by the family. The Leeds manual also includes and emphasizes the necessity for the therapist to include his/her own judgments.

However, even if the systemic therapy literature is considerable, I will claim that there is lack of focus on the context the therapy is being offered (i.e., mental health institutions, family counseling services etc.). I consider this as a paradox, because the notion of context is one of systemic therapy's main ingredients (Bateson, 1972). By not emphasizing the cultural, organizational and legal context the systemic therapy is being offered, places systemic therapy theory in danger of being irrelevant for the field of mental health. Bertrando (2007:19) reflected upon this: "*any theory that cannot be immediately present in practice, may be a cultural enrichment for the therapist, but is not relevant for actually doing therapy.*" However, the changes in legally binding requirements and evidence base shifts in organisations are relatively recent. It is therefore important to acknowledge and address this changing context. The abovementioned theories and models arose out of their context, and we are now in a different context, which poses different challenges. Thus, the Leeds manual (2000) can be seen as a contribution to help adapt systemic therapy to the need and demands of the wider context from powerful institutions, such as the Norwegian Directorate of Health and its like. Systemic therapy literature do not seem to adapt to the fact that some of mental health's clients ask for diagnostic assessments and the fact that diagnostic assessments can also have the paradoxical effect of removing shame and guilt (i.e., in the case of mental retardation etc.) (Rimehaug & Helmersberg, 1995). Following the systemic idea of a multiverse of possible understandings, not even diagnostic assessments should be considered as inappropriate, if it's carried out in a systemic manner (i.e., by using diagnostic tools as "guides" rather than as instructive manuals and by including the family's "significant others" as part of the empirical material) (Lorås, 2016b). I therefore consider parts of the systemic therapy literature as theoretically emphasizing diversity and different ways of understanding, but in practice being quite polarized and quite slow to respond to ideas, such as diagnosis, that do not immediately "fit" within the social constructionist and systemic paradigm.

2.3 Presentation of the relevant research literature

Part three (3) presents the research literature that concerns my research objective and research questions. The Leeds manual (Pote et al., 2000) that was presented in part two should also be examined with part three (presentation of the relevant research literature) because I consider the Leeds manual to be a theoretical framework that is based in research.

In this section, I present the research that relates to the research's purpose, objective and questions. However, much of the research that has been conducted to identify competences has focused solely on "family-based treatments", which rely more on psychodynamic or cognitive behavioural concepts than on the theoretical orientation that is based in "systemic therapy" (i.e., Diamond & Siqueland, 2001; Figley & Nelson, 1989; Lebow & Gurman, 1995; Scheib & Wirsching, 2004; Sydow et al., 2007). Therefore, the abovementioned presentation of competences is excluded in this section. I have also chosen to exclude Gehart's (2010) book, "Mastering Competences in Family Therapy". This is because the author presents theoretical approaches as more general theory, not as a presentation of systemic competences, as described by Northey (2011), on which my research is based. In addition, Gerhart's presentation of therapeutic competences (part 1 in the book) is also based on several therapeutic approaches. These approaches are not grounded in theoretical and practical descriptions of systemic therapy. Instead, Gerhart has included elements from psychoeducation and cognitive and behavioural therapy, among other sources. To delineate the presentation, I have also excluded Sperry (2010) and Nelson et al.'s (2007) general descriptions of generic competences in the wider field of psychotherapy.

Furthermore, in this section, I present the competences and occupational standards (CORE competences) for systemic family and couples therapy (Stratton et al., 2011). The work on the CORE competences of Stratton et al. (2011) was based on many manuals, including Asen and Jones' (2000) manual for depression. Therefore, the depression manual is not presented in this chapter. I also present Tomm and Wright's (1979) descriptions of therapeutic skills.

2.3.1 Competences and occupational standards for systemic family therapy and couples therapy

From 2007 to 2010, the Department of Health in the UK initiated a research project concerning the development of systemic family therapy competences (Stratton et al., 2011). The goal of this research project was to delineate professional standards of systemic therapy and to specify the expected levels of competence. In addition to the work on identifying the

systemic competences, an attempt was initiated by the Skills for Health² organization to specify a set of occupational standards for cognitive behavioural therapy (CBT), psychoanalytic therapy and psychodynamic therapy (op.cit). The movement towards developing systemic competences arose partly from the need to validate family therapy training in the USA and to establish systemic therapy as equivalent to other therapies in the field of mental health (op.cit).

Therapeutic competences were identified from treatment manuals that have shown their efficacy in randomized controlled trials (RCTs) through thematic analysis. An expert group then considered the identified competences through a sequence of meetings and e-mail correspondence. Peter Stratton chaired the expert group. The criteria for the expert group were clinicians who had been involved in outcomes research, in developing treatments and writing manuals and in developing and delivering supervision and training (op.cit).

The identified competences were thereafter categorized into five domains, which must be brought together to effectively conduct systemic therapy. The five domains are as follows:

- (1) generic competences: used in all psychological therapies;
- (2) basic competences for systemic therapies: techniques that are employed by most (not all) forms of systemic therapies;
- (3) specific systemic competencies: techniques that are employed by most (not all) forms of systemic therapies;
- (4) problem-specific systemic competences: adaptations of systemic interventions to discrete evidence-based approaches; and
- (5) meta-competences: generic and systemic overarching, higher-order competences that practitioners must use to implement systemic therapies (op.cit:130).

The first domain (1) consists of the competences that were considered necessary in all four forms of psychotherapy (CBT, psychoanalytic therapy, psychodynamic therapy and systemic therapy). The second domain (2) presents three basic areas of knowledge, namely, knowledge of systemic principles, knowledge of systemic theories of psychological problems, resilience

² The Skills for Health organization is licensed by the Secretary of State for Education and Skills to profile the UK's National Health Service (NHS) psychological therapy workforce (Stratton et al. 2011).

and change and knowledge of systemic approaches that promote change. Therefore, the second domain is the domain that represents the basic propositions of systemic work that must be indicated and mastered and that differentiate systemic therapy from other approaches. The third domain (3) describes the following seven strategies and interventions that a systemic therapist is expected to master (Stratton et al., 2011, p.131):

- Systemic hypothesizing, which is the ability to develop and continually revise hypotheses and use them to promote understanding, curiosity and the development of new perspectives;
- Circular interviewing to explore the range of possible views and as an agent of change that specifically targets change (such as externalizing, reframing, role playing, sculpting and helping to develop new narratives);
- The exploration and encouragement of using strengths and positive experiences;
- The ability to map systems, genograms, role play and sculpt to create new perspectives, understandings and choices;
- The use of enactment to facilitate new forms of behaviour together;
- Specific problem-solving techniques, such as the collaborative planning of approaches and goals; and
- The ability to work in a team, both in reflecting teams and the wider team of professionals, and the ability to convey a rationale for this way of working to clients.

The fourth domain (4) reflects a selected range of elements and pathways that are necessary to address specific interventions for conduct disorders in children and adolescents, such as anorexia, and for depression in systemic couple's therapy. The final domain (5) indicates the ability to attend to the demands of each individual client by having many interpersonal skills such as being reflexive, which is guided by a high-level understanding of both therapy in general (the generic meta-competences) and specific systemic meta-competences (op.cit: 131). The generic meta-competences reflect the therapist's ability to implement an intervention flexibly and responsively. A specific systemic competence involves applying high levels of understanding and practice to therapy that are consistent with systemic philosophy and shows the therapist's sophisticated ability to use specific techniques (Stratton et al., 2011).

2.3.2 Family therapist skills: the work of Karl Tomm and Lorraine Wright

In the 1979 paper, “Training in Family Therapy: Perceptual, Conceptual and Executive Skills”, Karl Tomm and Lorraine Wright presented their work on identifying a detailed outline of systemic family therapist skills. Their objectives were to build a helpful collection of systemic skills for clinicians and trainees. The term “skill” refers to the four identified basic skills, which are further differentiated into general therapeutic competences.

A description of the four competences follows: (1) *Engagement* refers to the process of establishing and maintaining a meaningful relationship between the therapist and the client/family. (2) *Problem identification* is an on-going process and includes both the clarification of the presenting problem and the process of identifying other problems in the family and possible connections among them. (3) *Change facilitation* is considered the core of the therapeutic process and includes interventions that attempt to alter the interpersonal patterns of interaction and individual family members’ behaviour, thinking, experience and efforts to replace problematic patterns with adaptive patterns. (4) *Termination* is the process of ending therapy in a manner that encourages the client/family to maintain the constructive changes and increases the client/family’s ability to solve future problems. Although these skills are listed in a somewhat logical sequence, considerable flexibility must be envisioned.

The four competences also consist of more specific microscopic skills (Tomm & Wright, 1979).

1. Engagement

- developing a rationale for the family therapy approach
- establishing a positive relationship
- conveying professional competence
- maintaining the therapist-family alliance

2. Problem identification

- elucidating the presenting problem
- centring on the immediate process
- identifying and exploring interpersonal problems
- clarifying individual problems
- integrating the assessment

3. Change facilitation

- breaking maladaptive interaction patterns
- clarifying problematic consequences
- altering affective blocks
- initiating cognitive restructuring
- implementing new adaptive patterns
- mobilizing external resources as required

4. Termination

- assessing the family's initiative to terminate
- initiating termination when indicated
- concluding the treatment constructively

Each microscopic skill, in turn, includes perceptual/conceptual skills (such as understanding the basic axioms of systems theory) and executive skills. Perceptual skills involve what is occurring in the therapist's mind, which forms the basis for his actions (executive skills).

Each executive skill consists of two components: the therapist's affective response and overt intervention. The therapist's affective response involves the therapist's ability to use his own emotional reactions constructively in the therapy process (such as giving recognition and status to all family members through some direct interaction with each one). For the complete lists of perceptual and executive skills, see the article by Tomm and Wright (1979).

2.3.3 Summary of the research presentation

Stratton et al. (2011) present an impressive and multifaceted work on identifying systemic competences. Their findings are categorized into five domains: (1) generic competences, (2) basic competences, (3) specific systemic competences, (4) problem-specific systemic competences and (5) meta-competences. The identified competences specify the expected levels of competence of systemic family therapists to validate systemic family therapy training and to establish systemic therapy as equivalent to other therapies in the field of mental health. Although the CORE competences can be considered to be a more comprehensive and more "up to date" description of systemic therapy, I consider the Leeds competences to be more descriptive and therefore more relevant to clinical practice and training. Nevertheless, the CORE competences seems to be more "in line" with the demand

for mental health to be problem-specific and evidence-based, which could be considered as a contrast to the Leeds manual (Pote et al., 2000). However, the CORE competences still offer a valuable contribution to understanding the diversity and multiple perspectives that systemic therapists should possess. I therefore consider that both the CORE competences and the Leeds manual can inform each other. The CORE competences are more related to RCT studies, and the Leeds manual is more descriptive and theoretical. By drawing on both, they will contribute and be in line with the Norwegian Directorate of Health's expectations on relying on outcome and efficiency and on detailed descriptions so that the competences can be used in practice and when training systemic therapists.

Tomm and Wright (1979) present a comprehensive and detailed outline of beginning, intermediate and advanced levels of systemic family therapist competences and skills. The four overarching competences, i.e., (1) engagement, (2) problem identification, (3) change facilitation and (4) termination, with the accompanying microscopic skills, offer a detailed "map" of systemic competences to clinicians and trainees. I consider Karl Tomm and Lorraine Wright's work on skills to be a somewhat postmodern work although it was written in the late 1970s. This is considered to be the first-order cybernetic era, without the inclusion of social constructionist ideas. Therefore, Tomm and Wright's facilitation of the process of exploring interpersonal problems should be viewed as a social constructionist approach that is helped by the use of circular interviewing. However, in their article, Tomm and Wright mainly focus on the problematic patterns that are maintained in families by family members. Tomm later (i.e., 1987a, 1987b, 1988) emphasized that even the therapist "must examine his or her way of identifying family patterns, and be self-reflexive in regard to how his/her punctuation affects his/her behaviour and patterns of interaction with the family members" (Tomm, 1998). Despite "lacking" some second-order cybernetic considerations, I consider the ideas of Tomm and Wright (1979) to be not "expired" or "out of date" but instead a valuable contribution to giving precise descriptions of systemic competences.

3 METHODOLOGY

In this chapter, I describe and discuss the present study's methodology. The chapter is divided into nine parts. In part one (1), I present the overarching research objectives and research questions. Part two (2) offers a rationale for this research, philosophical stance and descriptions of the chosen methods and the qualitative research tradition on which I have relied. Part three (3) addresses the design of the study. Part four (4) presents the process of data analysis. Parts five (5) and six (6) evaluate this research's quality, which are based on the quality guidelines from Elliott, Fischer and Rennie (1999). Part seven (7) presents issues regarding reflexivity. As a reflexive tool, I have used Finlay's (2012) "five lenses for the reflexive interviewer". In part eight (8), ethical issues regarding anonymity are discussed. Part nine (9) presents the possible limitations of my study.

3.1 Introduction

The reasons for doing research are often to decide how to intervene in a particular situation to improve conditions of some kind. (Clarke, 2005, p. 302)

This quote summarizes the overarching purposes of my research project: to help and support systemic therapists in child and adolescent mental health (BUP), to offer a more unified version of systemic therapy and to meet the legally binding requirements of the Norwegian Directorate of Health (2008). This research especially targets the psychosocial difficulties that are categorized as associated abnormal psychosocial situations in the multiaxial classification of child and adolescent psychiatric disorders/axis 5 (ICD-10) (WHO, 1996).

3.1.1 Research aims

The overarching aim of this research is to identify a comprehensive and detailed outline of the systemic therapist competences in child and adolescent mental health that target the associated abnormal psychosocial situations (axis 5) in the multiaxial diagnostic system (WHO, 1996). This project is based on twelve qualitative in-depth interviews with six experienced systemic family therapists, the fieldwork observations of the therapists (participants) in practice, and the Norwegian Directorate of Health's (2008) guidelines. Thus, the identified detailed outline of systemic therapist competences intends to be applied as a tool for clinical supervision, clinical practice, education and training in family therapy.

3.1.2 Research questions

Based on the purpose and aims of the study, the research questions are the following.

1. In the context of child and adolescent mental health, what are the different competences in a systemic family therapy approach that address the associated abnormal psychosocial situations?
2. What are the legally binding requirements in the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?
3. How does systemic family therapy interconnect with the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?

In this thesis, I have used research question nr 1 to serve as the starting point for the GT analysis of the twelve in depth interviews and the fieldwork observation notes. Then I used, research question nr 2 as the basis of the thematic analysis of the Norwegian Directorate of Health's guidelines for child and adolescent mental health (2008). The findings presented in chapter 4 *Findings from the thematic analysis of the Norwegian Directorate of Health's guidelines* and chapter 5 *Findings from the GT analysis of the qualitative interviews and fieldwork observations* served as the basis for the discussion of research question nr 3.

3.2 Philosophical stance

The philosophical stance of this research is multifaceted and complex, and it includes different epistemological positions and two qualitative methods. In the following section, I present the rationale for the research aim, the description of the chosen methods and the ontological and epistemological stance.

3.2.1 Ontological and epistemological stance

This research identifies a comprehensive and detailed outline of the systemic therapist competences. The phrase "identify competences" indirectly implies that there is a "correct way" to practice systemic family therapy. However, this research does not claim to represent a "blueprint" for how systemic therapy should be performed. Instead, to be clinically relevant, I attempt to offer a fair representation of systemic competences in the context of Norwegian child and adolescent mental health.

Researchers' philosophical stances have substantial significance because of their different ways of approaching and making sense of data (McNamee, 2010). Thus, it is necessary to provide detailed descriptions of the ontological and epistemological stance of this project. Ontology is the study of being and existence, and it attempts to discover fundamental categories of what exists and what is there to know in the world "out there" (Burr, 2003; Harper & Thompson, 2012). Epistemology concerns the theory of knowledge and provides an answer to the question "How and what can we know?" (Willig, 2008). Therefore, epistemology involves considering the nature of knowledge itself and the validity and reliability of claims to knowledge development (op.cit). Although ontology and epistemology are described differently in the literature, Bateson (1972) claims that epistemology should not be separated from ontology. Therefore, in the philosophical stance of this research project, I use the term epistemology to cover both how we know (epistemology) and what there is to know (ontology). In compiling the complexity of therapy into a detailed outline of systemic therapist competences, there is always some danger of becoming reductionist. Because human systems are complex, I consider it reductionist to merely rely on only one epistemological position. Therefore, I position my research in the postmodern paradigm (Gergen, 2015). The inclusion of multiple epistemological assumptions also facilitates the inclusion of different perspectives of knowledge and knowledge production.

The epistemological stance of this research project is complex and multifaceted and based in *social constructionism* (Gergen, 2015), *critical realism* (Pocock, 2013) and *circular* (Batesonian) epistemology (Bateson, 1972). Thus, to some extent, this research is based on the assumption that there is no such thing as an exact replication of what is "out there"; instead, representations are variably mediated according to socially or communally shared meanings through language (Ness, 2011). These ideas can clearly be traced to social constructionist theory (op.cit). Social constructionism is a "broad church" with many positions on the relation between construction and reality; therefore, there is always a risk of misrepresenting the nuances (Pocock, 2013). Pocock (2013) further divides social constructionism into two different positions, namely, *strong* and *moderate* social constructionism. Pocock (2013) defines strong social constructionists as the scholars (including Gergen, 1998, 2009) who claim that constructions should be understood as "ontologically mute" and that the world outside our ideas cannot be considered or discussed independently of our constructions of it. However, Bhaskar (1979) argues that the idea of being "ontologically mute" is a "linguistic" fallacy and claims that social constructionism

fails to recognize that there is more to reality than its expression in language. Following Bhaskar (1979) and Pocock (2013), the objective of this research is in direct contrast to what Gergen (2005) claims from a strong social constructionist paradigm:

To label human problems as ‘mental illness’ can not only have injurious consequences for the suffering, but for the culture as a whole. It is not only that such constructions are groundless, but they are specious parallels to our understanding of biological illness. (p. 137)

A critical realist position (Andersen, 2007) is relevant as an epistemological perspective regarding how one relates to behaviour that "falls" outside acceptable social norms, for example, part of the diagnosis criteria in axis 5 (WHO, 1996). Critical realism can be defined in a post-positivist domain and assumes that reality exists regardless of people's knowledge of it (Pocock, 2013). Critical realism supports the understanding of multiple interacting causal tendencies, from genetics to discourse, which provides a new platform for eclecticism and integration and a renewed but cautious relation with science (op.cit). I argue that critical realism is a combination of the individual (genetic) perspective from constructivism (Maturana & Varela, 1987, p.88), the focus on discourse from post-structuralism (Butler, 1990, 1993) and the focus on meaning making through language from social constructionism (Gergen, 2015). These perspectives are combined in the same epistemological assumption (Houston, 2001; Pocock, 2013).

Although I think that we should not attribute any “models” to Bateson’s (1972) ideas, he introduced circular epistemology as an alternative understanding of human systems. Circularity emphasizes that an event must be viewed in the context of other events that simultaneously occur, interlock and mutually reinforce (Schjødt & Egeland, 1993). This research project recognizes the mutual influence between the therapist-client and the researcher through the inclusion of moderate social constructionist and Batesonian ideas, the importance of context (i.e., the mental health institutions where therapy is offered) and the simultaneous seeking of repeating patterns in therapeutic practice and the clients’ behaviour. My research project is clearly inspired by Bateson's (1972) ideas of cybernetics, patterns and schizogenesis (a term that describes the progressive differentiation among social groups or individuals). Therefore, the epistemological stance of this research project is complex and multifaceted, and I describe it as inspired by moderate social constructionism, critical realism and Batesonian circular epistemology.

3.3 Research design

I now present the design of my study. First, I explain the qualitative methodology, which is based on Grounded Theory. Then, I present the sampling procedures, which are followed by a presentation of the sampling process flowchart. I also describe the research context in which the interviews and fieldwork observations were conducted. Furthermore, a description of the recruitment strategies and a brief overview of the participants are presented. The data collection method of this research is also described. Part 3 concludes with a description of the process of data recording and transcription.

3.3.1 Grounded Theory – the chosen qualitative research methodology

Based on the aim of this research, the epistemological stance and research questions, a qualitative research project is the most useful methodology to achieve my research aims and to answer my research questions. Qualitative research seeks to study people in their own contexts and natural settings (Willig, 2013). Qualitative research, which is situated in a social constructionist paradigm, claims that social reality can be researched but not without considering that reality is subjective, multiple and construed by the participants with a cultural sensitivity (Burck, 2005). Because I am not claiming to offer a “blueprint” of how systemic therapy should be conducted, this research should be considered the results of a co-constructed process among me as the researcher, my participants and the data material. Qualitative research corresponds well with the objectives of this research by eliciting in-depth descriptions from experienced therapists through qualitative interviews and fieldwork observations.

I used Grounded Theory (GT) as the overarching methodology for this study. Similar to my research project, the overall goal of GT is to produce an inductively driven theory that is grounded in data and linked to the relevant literature, which illuminates an under-researched domain (Wren, 2000, p. 96). The lack of a theory that integrates the legally binding requirements of the Norwegian Directorate of Health’s (2008) guidelines with a detailed outline of systemic therapist competences makes GT seem suitable for this research project.

GT was initially developed and elaborated by Glaser and Strauss (1967) as an empirical approach to study social life through qualitative research and analysis. After their initial collaboration, Glaser and Strauss diverged in distinct directions (Morse, 2007) on how to conduct GT. Glaser (1992) adopted more positivistic beliefs concerning his version of GT and

focused on theoretical coding, whereas Strauss, with Corbin (1990), focused on an interpretative approach that used selective coding (Heath & Cowley, 2004). Charmaz (2006, 2014), a student of Strauss, further developed GT in a constructivist direction. Unlike “traditional” GT in which theory emerges from the data without considering the researcher, constructivist grounded theory acknowledges the interpreting process of the researcher and views the interpreting process as co-constructed (Charmaz, 2006).

Charmaz (2006) divides Grounded Theory into the two main schools of Objective Grounded Theory and Constructivist Grounded Theory. I use Charmaz' (2006, 2014) version of Constructivist Grounded Theory. Constructivist grounded theorists prioritize the phenomenon of study and view both data and analysis as created from shared experiences and the relations between the participants and other sources of data (Charmaz, 2006). GT is a method of designing studies and a form of data analysis (Charmaz, 2014) that gives the researcher the opportunity to gather a greater amount of varied data and to analyse them by using different methods before combining the results for a larger and final grounded theory analysis. The consequence of this perspective is that any analysis is contextually situated in time, place, culture and situation (op.cit). Therefore, meaning should be considered the result of a co-construction process among diverse dynamic interactions (e.g., the researcher, the participants and the “reality”) (Charmaz, 2006).

Because my research is directed towards an under-researched domain, I chose GT as the main framework for the analysis and for the purpose of theory construction (Charmaz, 2014; Wren, 2000). Nevertheless, this study consists of multiple qualitative sources such as in-depth interviews, fieldwork observations and a thematic analysis of the Norwegian Directorate of Health's (2008) guidelines. In addition, I used my fieldwork observations to gain a broader understanding of the participants' therapeutic practice to develop an interview guide for the follow-up interviews. The fieldwork notes were also included in the grounded theory analysis process.

3.3.2 Sampling

Theoretical sampling in GT involves collecting additional data considering the categories that have emerged from the earlier stages of data analysis (Willig, 2013). Charmaz (2014) describes sampling procedures as “going back and forth” from emerging tentative categories and collecting new data to elaborate and refine the categories in the emerging theory. Ideally,

a GT sampling process should include extending the analyses of each interview before the second interview is conducted. Geographical distances and the participants' busy schedules made this expansion challenging. Therefore, the need to modify the GT sampling procedures became evident. Thus, the fact that GT involves flexible guidelines rather than rigid prescriptions was significant to this research project (Charmaz, 2014). Therefore, most interviews had to be planned at an early stage, and I had to conduct most of them over the course of three weeks. This time constraint shows that it was not possible to implement extended analyses of each interview before the follow-up interviews were conducted. Therefore, to safeguard the pivotal moments of sampling, I performed an alternative version of GT's sampling procedures. After the first interview was conducted, I listened and re-listened to the audiotape. I then developed new questions concerning the themes that I wanted to further explore in the second interview. I also noted tentative hypotheses regarding the participant's practice, which I would look for during the fieldwork observation. The fieldwork observations were conducted shortly after the initial interview. Based on the questions that were developed in the audiotape listening and re-listening process and the reading and re-reading of the fieldwork notes, new questions were developed and the follow-up interviews with the same participant were held shortly after the fieldwork observation. Ten of the interviews were conducted in this way during three weeks in December 2014. The last two interviews were conducted over six weeks from November to December 2014. The entire sampling process and data analysis is detailed in the "research flowchart" below and in appendix 10, 11 and 12.

3.3.3 Sampling process flowchart

The process of data collection and analysis was as follows.

- Recruitment of participants
- Development of a semi-structured interview template
- Completion of the first interview
- Listening and re-listening to the audiotape, developing new questions for the follow-up interview and noting tentative hypotheses that I wanted to further explore in my fieldwork observation
- Fieldwork study of the first participant's practice

- Development of the follow-up interview based on the listening and re-listening process and the fieldwork observation
- Conducting the follow-up interview with the first participant (i.e., during fieldwork observations with Roar, I experienced a lack of structure in the therapy, which I asked about in depth in the follow-up interview)
- Development of a semi-structured interview template for the first interview with the second participant, where some of the questions from the interview with the first participant were included and some were developed based on interesting topics from the meeting with participant no.1 that I wanted to further explore

The data collection and analysis for the first interview with participant no. 2 was as follows.

- Listening and re-listening to the audiotape, developing new questions for the follow-up interview and noting tentative hypotheses that I wanted to further explore in my fieldwork observation
- Fieldwork observations of the second participant's practice
- Development of the follow-up interview based on the listening and re-listening process and the fieldwork observation
- Conducting the follow-up interview with the second participant

The same procedure was conducted with all six participants. Thereafter, the process consisted of the following.

- Transcribing
- Sending the transcripts to the participants for their opportunity to comment
- Initial coding of all 12 interviews and the fieldwork notes
- Focused coding of all 12 interviews and the fieldwork notes
- Memo writing
- Constant comparison
- Categorizing

3.3.4 Research context

My participants worked in three different institutions in the field of child and adolescent mental health in Norway. Eleven of the interviews and all of the fieldwork observations were conducted at their respective workplaces, which were dispersed from northern to southern Norway. The last interview was conducted through Skype®. All institutions were obligated to work under the Norwegian Directorate of Health's guidelines and, among other services, had their own family units (where my participants worked).

3.3.5 Recruitment of the participants

In GT, the researcher actively and strategically seeks participants who can reveal something concerning the object of interest (Charmaz, 2006). The respondents were chosen to obtain a strategic and heterogeneous range, which is a characteristic of qualitative studies (Thagaard, 1998). A strategic range means that the participants are chosen based on the characteristics or qualifications that are strategic relative to the research questions and the study's theoretical perspectives (op.cit). Morse (2007) describes an excellent participant for GT as someone who has been involved with and observed the area in question and who can be described as an expert in the object that is under study. The participants were recruited through recommendations by my research supervisors and by searching for systemic therapists who have made important contributions to the research topic.

I based my inclusion criteria on Rønnestad and Orlinsky's (2006) criteria for experienced therapists. They argue that experienced therapists have more than 15 years of clinical experience. Based on Rønnestad and Orlinsky's (2006) criteria, all of my participants have more than 15 years of clinical experience, either as systemic therapists or as therapists in mental health, if not both. Although gender is not the subject of this research, I ensured that both men and women were represented.

In the process of informed consent, all participants were informed at different stages regarding their participation. An invitation letter that described the purpose and objectives of the study was sent to the participants after a verbal introduction (phone call) from me (Appendix 1). The participants also received an information letter and consent form for the child and adolescent and their parents that were attending therapy, describing my presence as an observer of the participating therapists practice (Appendix 2,3 & 4) in addition to copies of the ethical approvals for the doctoral project (Appendices 5 & 6).

All families who were participating in the therapeutic process (which I was observing) were given an informed consent form, and they signed a declaration of consent (Appendix 2,3 & 4). All of the families were recruited by my participants and were informed about the project at an early stage. The families also received a verbal description of the goals and focus of the project before I conducted the fieldwork observations. The main difficulties of all of the recruited families were considered to be associated psychological situations that were categorized in axis 5. However, several of the referred clients (and their families) whom my participants were treating were also rated on other axes, such as anxiety and depression. This research does not initially address sensitive information because the focus is on therapist competences rather than patient information. Therefore, no identifying information regarding the families and their members is included.

Important considerations at the start of this project were how the research process would affect the participants' identities and interests (Denscombe, 2002). Therefore, a careful process of ethical considerations was necessary. All participants in this research largely belong to the same network because they were chosen through strategic criteria and the Norwegian family therapy community is somewhat small. Thus, whether this small community also enables my participants to be identified or the participants can identify one another are relevant questions. However, all private and other identification information regarding the participants was omitted from the research.

3.3.6 Details of the participants

A total of six experienced systemic therapists participated in my study. Their professional backgrounds were four psychologists, one social worker and one professional with an education as a health care worker. All of the participants had considerable additional education and training in systemic family therapy. There were four men and two women. At the time of the interviews, all of the participants worked in the Norwegian child and adolescent mental health system (BUP). However, two of the participants also worked as educators in family therapy and mental health. The participants worked in three geographically different BUP institutions. Because the family therapy environment in Norway is small, I have chosen not to share more detailed information regarding the participants for purposes of anonymity. To ensure their confidentiality, I have used pseudonyms in the presentation of the findings. The ages of the participants ranged between 50 and 65 years.

1. *Martin*, psychologist; 29 years of experience in mental health care; 28 years of experience as a systemic family therapist.
2. *Nora*, social worker; 25 years of experience in mental health care; 9 years of experience as a systemic family therapist.
3. *Tuva*, psychologist; 30 years of experience in mental health care; 11 years of experience as a systemic family therapist.
4. *Stein*, health worker; 24 years of experience in mental health care; 10 years of experience as a systemic family therapist.
5. *Einar*, psychologist; 27 years of experience in mental health care; 17 years of experience as a systemic family therapist.
6. *Roar*, psychologist; 30 years of experience in mental health care; 35 years of experience as a systemic family therapist.

3.3.7 Data collection through semi-structured interviews

One method of collecting the data in this study was through semi-structured interviews (Kvale & Brinkmann, 2015) with the six systemic family therapists. Semi-structured interviews are neither an open conversation nor a closed questionnaire-based conversation. They are conducted according to an interview guide that revolves around specific topics and that may include suggestions for questions (Kvale & Brinkmann, 2015). To guide the interviews, I developed an initial semi-structured interview guide. The interview questions (Appendix 7) were based on my own experience as a systemic therapist in child and adolescent mental health (at this time). The interview questions were co-constructed with my supervisors, the Norwegian Directorate of Health's (2008) guidelines for therapeutic approaches and the descriptions of the associated abnormal psychosocial situations/axis 5 (WHO, 1996). This interview guide was further changed according to GT sampling procedures. Therefore, the follow-up interview was based on the interesting data from the first interview and the fieldwork observations that I wanted to explore.

For me, relating to an interview template, although semi-structured, was a significant challenge. For years, I have worked as a systemic therapist with few (if any) pre-planned questions. In the interview situation, it felt somewhat strange to me to refer to an interview guide that was used as a template and to repeatedly need to look down at it instead of at the client, while simultaneously not following the participant's own language and interest. However, this strangeness changed for me during the research process as I gained more

experience in interviewing. Therefore, in the later interviews, I experienced a greater degree of flexibility in following the conversation and the topic with which the informant was concerned, without diminishing the goal of the interview.

3.3.8 Fieldwork

As part of the GT sampling process, I included fieldwork observations. Fieldwork observations can provide a fuller and more nuanced picture of clinical practice than the interview alone, and they can be an important starting point for a possible follow-up interview with the therapist (Timmermans & Tavory, 2007). Therefore, I began by conducting an initial interview with my participants, which was followed by fieldwork observations of their practice. The fieldwork notes (see Appendix 8 for an example) were taken during the observations of six to eight hours of clinical practice with each of the participant therapists. All fieldwork observations were conducted in what the participant therapists described as the “middle phase” in the therapeutic process. This means that all clients were well known for the participants while I was doing my fieldwork observations. The main focus of my observations was to obtain “in-depth descriptions” of the systemic family therapists’ competences that were used in practice.

During my fieldwork observations, I obtained a broader understanding of the participants’ theoretical approach that targeted the associated abnormal psychosocial situations. However, the participants’ practices were also likely influenced by context and local traditions and simultaneously subject to strict regulatory requirements (Madden, 2010). The influence of the context and legal requirements is significant in this research. The fieldwork observations made me interested in investigating the theoretical choices that were made and the areas (such as the use of applause and praising) that I wanted to further explore. Therefore, the fieldwork observations informed the development of the interview guide for the follow-up interviews.

3.3.9 Data recording and transcription

All 12 interviews were recorded by using a Sony digital recorder. A paid research assistant transcribed all interviews. All identifying information was “left out” of the transcripts. The transcripts were then analysed by using a Constructivist Grounded Theory approach (Charmaz, 2006, 2014).

3.4 Data analysis

To make sense of the raw data material and to follow the GT methodology, I used constructivist GT analysis on the interview transcriptions and fieldwork observation notes (Charmaz, 2014). Shortly after implementation, the analysis began with repeatedly listening to the audio-recorded interview and reading and re-reading the fieldwork notes. The identification of missing links or thin descriptions that needed further research formed the basis of the follow-up interviews. When all of the interviews were transcribed and the fieldwork observations were conducted, the key techniques of GT were adhered to (op.cit). These techniques include initial coding, focused coding, categorizing, constant comparative analysis and memo writing, and are discussed in more detail below.

3.4.1 Initial coding

In Constructivist Grounded Theory, Charmaz (2006, 2014) describes two stages of coding, namely, initial coding and focused coding. Coding is described as the pivotal link between collecting data and the development of an emergent theory. Coding involves categorizing segments of data and labelling them with a short name that summarizes and accounts for each piece. Codes should closely represent the data and shape an analytic frame to build the analysis (op.cit).

During the initial coding, I closely studied fragments of data, words, lines, segments and incidents for their analytic import, and I named each word, line or segment of data (Charmaz, 2014). In the initial coding phase, one of the goals is to remain open to all possible theoretical directions that are indicated by the reading and re-reading of the data (Charmaz, 2006). I sought to conduct a thorough line-by-line coding of the data, but because part of the material consists of information that was difficult to code, some parts of the data were coded in segments. The codes utilized the participant's own words and were kept short and entirely grounded in the data. Examples of initial codes are illustrated in Appendix 9.

3.4.2 Focused coding

Focused coding is the second major phase of the coding (Charmaz, 2006). Focused codes advance the theoretical direction of the work and concentrate on the initial codes that make the most analytic sense to categorize (Charmaz, 2014). These codes give more analytic reach and are more directive and conceptual. During the focused coding, I discovered that the initial line-by-line coding strengthened the quality of the focused codes. The initial codes that "by themselves" gave little or no meaning helped to illuminate connections, and by merging some

of the initial codes, they formed good and complete focused codes, some of which later served as subordinate categories. I gave all the focused codes numbers in the transcribed texts so that they could be easily found in the following process of analysis (see Appendix 9).

3.4.3 Thematic analysis of the Norwegian Directorate of Health's guidelines for child and adolescent mental health

In the system of Norwegian child and adolescent mental health, it is important for practitioners to know and understand the legally binding requirements that contextualize their work. Because one purpose of my research is to develop a comprehensive and detailed outline of systemic therapist competences in Norwegian child and adolescent mental health, I found it necessary to include in my analysis the legally binding requirements that are presented in the Norwegian Directorate of Health's (2008) guidelines. Before I included the guidelines in my GT analysis, I conducted a thematic analysis of them. The findings from the thematic analysis were later included in the GT analysis. The research question that guided the thematic analysis of the guidelines was: *What are the legally binding requirements in the Norwegian Directorate of Health's guidelines for child and adolescent mental health?*

The research question requests a specific textual identification. Therefore, line-by-line coding, such as in GT, is unnecessary. Thus, I used Thematic Analysis (TA). TA is a method to identify and analyse patterns (themes) in data (Braun & Clarke, 2006; Clarke & Braun, 2013). TA is described as a tool (not as a specific method) for use across different methods, often regarding GT. Therefore, TA was considered to be well suited as a basis for later integration into a GT analysis. Braun and Clarke (2006) and Clarke and Braun (2013) describe the following six different phases of TA:

1. Familiarization with the data by immersing oneself and becoming intimately familiar with the data, reading and re-reading and noting any initial analytic observation
2. Coding by generating pithy labels for important features of the data regarding the research question that guides the analysis
3. Searching for themes, collating codes into themes and gathering all relevant data for each theme
4. Reviewing the themes and checking that the themes work relative to both the code extracts and the full data set
5. Defining and naming themes and refining the specifics of each theme
6. Producing a scholarly report on the analysis

Although a full TA is conducted by these six phases, I used only the first two steps because I included the findings from the TA as focused codes in the overarching process of GT analysis. I now describe how I performed the first two steps of TA. First, the guidelines were read repeatedly to familiarize myself with the text, and initial ideas and emerging themes were noted consecutively. A total of 22 citations were identified in which the legally binding word *shall* was used, and pithy labels were given to the important features of the data concerning the research question that guides the analysis. In this context, *shall* means that the description is a legally binding requirement that must be followed by therapists (Norwegian Directorate of Health, 2008). Then, the 22 chosen citations were included in the GT analysis as focused codes and were part of the data that formed the basis of the later constant comparative analysis and categorizing.

3.4.4 Constant comparative analysis

Constant comparison methods are used to establish analytic distinctions and to make comparisons at each level of the analytic work (Glaser & Strauss, 1967). These methods describe an iterative process of creating further sub-categories by comparing data to find similarities and differences (Willig, 2008). For example, the interview statements were compared with the notes from the fieldwork observations, and the early and later interviews with the same individual(s) were compared (Charmaz, 2014). In this research project, the comparison between the interview statements and fieldwork observation notes was important because it showed the difference between the verbal descriptions of practice during the interviews and what I observed during my fieldwork observations. These differences are presented in part 4.5, *A descriptive account of the fieldwork observations*.

The constant comparative process was the stage at which I included the 22 citations (where the legally binding word *shall* was used) that were identified from the TA of the Norwegian Directorate of Health's (2008) guidelines. I also included some of the recommendations that were not legally binding because the text was so instructive (e.g., must do, are required to do) that it was unclear whether they were recommendations. Through the constant comparative analysis, I discovered that the TA findings needed to be an overarching category that was named legally binding requirements. The analysis of the 22 citations ended with the following main topics: (1) collaboration and user involvement; (2) diagnostic assessment when

appropriate; and (3) requirements of quality and competence in child and adolescent mental health.

3.4.5 Categorizing

The next step in my GT analysis was to identify categories. That is, through studying the data, comparing them, and writing memos, I defined the ideas that best interpreted the data as tentative analytic categories (Charmaz, 2006). Thoughts concerning tentative categories emerged as I conducted the interviews and were noted for the later building of categories. Focused codes were then grouped together based on their frequency and significance regarding the research questions. The categories are illustrated in chapter 6, *Map of competences*. Subsequently, the identified text was compressed, interpreted, labelled and categorized into themes and condensed into a coherent text, and it was merged with the "early" themes from the first reading (for example, ethical and cultural awareness).

3.4.6 Memo writing

Memo writing is described as the pivotal intermediate step between data collection and writing drafts of the paper, and it represents the framework for the developing concepts and categories (Charmaz, 2014; Jensen, 2008). Memo writing is a written record of theory development, from data collection to analysis, and it presents an opportunity to analyse ideas in creative ways. Memo writing includes presenting tentative categories, labelling and developing the relation between codes and categories (Willig, 2013). In my memos, I provided reflections regarding the research process itself as well as findings, diagrams, and flowcharts. I wrote memos throughout the process, and the memos were also used to explicate and fill out categories (Charmaz, 2014). I used a research diary to write my memos. An example of one memo is as follows:

The main therapist competences seem to be the use of metaphors, externalizing through language, system focus, positive connotation, focus on intentions/values, and the social constructionist stance to ensure that the language makes sense for your family. However, there is apparently little attention to denoting emotional expression.
(My memo, 11.12.15)

3.4.7 Saturation

Willig (2013) claims that ideally, the process of data collection in GT continues until theoretical saturation has been achieved. Data collection ceases when the properties of one's theoretical categories are saturated (Charmaz, 2014). Based on my study's epistemological

perspective, saturation is difficult (if not impossible) to reach. An understanding of meaning as co-constructed means that any statement or observation is provisional and relies on the reciprocal influence between the researcher and the participants. Therefore, the saturation of data in qualitative research functions more as a goal than a reality (Willig, 2013). However, based on my interpretation and the process of coding, saturation occurred to an extent during the interviews because most of the identified therapeutic elements were discussed by all of the participants. All employees in Norwegian child and adolescent mental health are subjected to the legally bindings requirements of the Norwegian Directorate of Health (2008). However, if I had chosen other participants or extended the range of participants, other elements and descriptions of systemic practice could have been revealed and described.

3.5 Quality of the research

There is agreement that the evaluation of qualitative research is necessary (Corbin & Strauss, 2008). However, there is a lack of consensus concerning what the criteria evaluation should consist of (op.cit). Elliott et al. (1999) propose useful guidelines to improve qualitative research. The guidelines are explicit but not rigid, and they seem to be a good method of evaluating qualitative research that is based on qualitative premises. Therefore, I have chosen to use the “checklist” by Elliott et al. (1999) to evaluate this qualitative research project. The “checklist” have two parts. Part one consists of seven elements that are shared by both qualitative and quantitative research. These elements are (1) an explicit scientific context and purpose, (2) appropriate methods, (3) respect for participants, (4) a specification of methods, (5) appropriate discussion, (6) clarity of presentation and (7) contribution to knowledge.

Part two consists of seven elements that are especially pertinent to qualitative research. These elements are (1) owning one’s perspective, (2) situating the sample, (3) grounding in examples, (4) providing credibility checks, (5) coherence, (6) accomplishing general compared with specific research tasks and (7) resonating with readers.

3.5.1 Guidelines for improving qualitative research. Explicit scientific context and purpose.

The first criteria concern clarifying the theory and relevant research on which this research is based. In this research project, the research goal, research questions and relevant theory and research have been presented. The presentation of theory starts with a historical review of systemic therapy theory, from the original work to postmodern descriptions. In the theory presentation, the Leeds manual is given considerable space (Pote et al., 2000). The LFTRC's manual was developed through a multifaceted and recursive process with several stages of data collection and analysis (Pote et al., 2003). This group's research was designed to be consistent with a social constructionist orientation.

The close relation to the theory of the LFTRC manual may be a limitation in my research project, because the theoretical descriptions of systemic therapy are normally presented as an epistemological stance. However, the LFTRC team provides more explicit descriptions of systemic therapy through the Leeds manual (Pote et al., 2000). In addition, a historical review of the literature shows that many different descriptions exist, and several different models are described under the umbrella term of systemic family therapy (Boston, 2000). Therefore, I have chosen to include the LFTRC's manual in this research project to refine and concretize systemic therapy.

The research presentation presents the relevant research concerning the research aim and the two research questions. However, much research has been conducted in regard to identifying the competences in the field of family therapy (e.g., Figley & Nelson, 1989; Gehart, 2010). Nevertheless, most of the earlier research focused solely on “family-based treatments” rather than on the theoretical orientation that is based in “systemic therapy” (such as in my research). I have not included research that has broad and abstract definitions of systemic therapy. One example is the research reviews of Carr (i.e., 2014a, 2014b, 2016), who includes multisystemic therapy (MST) and mindfulness in his descriptions.

3.5.2 Appropriate methods

This project emerged from my work as a systemic therapist in the field of Norwegian child and adolescent mental health. Although knowledge regarding child and adolescent families, relationships and networks is described as essential in the Norwegian Directorate of Health's (2008) guidelines, I found it challenging to work as a systemic family therapist in BUP. The

decisions makers, such as the Norwegian Directorate of Health or the chief psychiatrist, seemed to prioritize therapeutic approaches that were clearer and more specifically defined, such as cognitive therapy and eye movement desensitization and reprocessing (EMDR). For me, this situation was a paradox: health authorities emphasized the importance of knowledge concerning family relationships and relational work, whereas systemic practitioners found their therapeutic approach and frame of understanding marginalized. Accordingly, I wanted to explore whether possible reasons for systemic therapy's lack of influence in child and adolescent mental health can be considered to be caused by the irreconcilable differences between the systemic theoretical approach and the legally binding requirements in the Norwegian Directorate of Health's (2008) guidelines.

Therefore, one research question concerned identifying the legally binding requirements in the Norwegian Directorate of Health's guidelines (op.cit) and developing a comprehensive and detailed outline of systemic therapist competences in child and adolescent mental health. This outline is adapted to meet the demands of Norwegian child and adolescent mental health that target the associated abnormal psychosocial situations. Based on the purpose and objectives of this study, the research questions are the following:

1. In the context of child and adolescent mental health, what are the different competences in a systemic family therapy approach that address the associated abnormal psychosocial situations?
2. What are the legally binding requirements in the Norwegian Directorate of Health's guidelines for child and adolescent mental health?
3. How does systemic family therapy interconnect with the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?

Therefore, similar to Constructivist Grounded Theory, the goal of this research is to produce an inductively driven theory that is grounded in data for this under-researched domain (Wren, 2000). This research project is based on qualitative interviews and fieldwork observations of experienced systemic family therapist practice. Constructivist Grounded Theory consists of guidelines for theory construction that are grounded in qualitative data (Charmaz, 2014). Constructivist Grounded Theory considers the process of the researcher's construction of the research and the structural and situational encroachments on it (op.cit). Constructivist Grounded Theory coincides well with this research project's epistemological stance. The

flexibility of GT also gives the researcher the opportunity to gather and analyse a significant amount of varied data by using different types of methods before a final GT analysis (op.cit). Therefore, this research project's inclusion of fieldwork observations and thematic analysis supports the choice of Constructivist Grounded Theory.

3.5.3 Respect for participants

It is crucial for an ethical and good research project that respect is shown to the participants. Earlier in this chapter, I demonstrated transparency in all stages of the research process, and I ensured that all participants were fully informed of the research project and their opportunity to withdraw at any time. All participants were given the opportunity to question the project prior to its commencement, either with me and/or my research supervisors (by e-mail or phone). However, none of the participants took this opportunity. All parts of the research have followed the ethical procedures of the Norwegian Committee of Ethics (REK) (Appendix 5) and the ethics committee at East London University (Appendix 6).

3.5.4 Specification of methods

In the specification of methods, it is important to be transparent in every aspect of the research, such as the research design, data collection and analysis (Thagaard, 1998). Transparency is fulfilled through detailed descriptions of all methods and methodological customizations, such as the Constructionist Grounded Theory and thematic analysis that were explained above.

3.5.5 Appropriate discussion

An appropriate discussion presents the research data and the understanding that is derived from them, which are discussed concerning their contribution to theory, content, method and/or practical domains. The discussion is presented in tentative and provisional terms, and limitations are acknowledged. The discussion of the findings and implications for practice, training and supervision, questions for future research and my personal learning are given in chapter 7.

3.5.6 Clarity of presentation

Clarity in the presentation of the data has been a main goal throughout the entire process. Therefore, all material has repeatedly been subject to the scrutiny of my supervisor and has

been modified and continuously improved. All written material was finally copy-edited by a professional.

3.5.7 Contribution to knowledge

Charmaz (2014) claims that there are three different aspects that make a research project an “original contribution to knowledge”, namely, (1) an analysis of a new area, (2) an original treatise in an established or fading area, or (3) an extension of current ideas. The analysis in this research project is in a “somehow” new arena because it develops a comprehensive and detailed outline of systemic therapist competences in Norwegian child and adolescent mental health. This research contributes to a well-established professional paradigm (systemic practice) but is inspired by the LFTRC’s manual (Pote et al., 2000) and its descriptions of systemic family therapy. Therefore, this research is partly an extension of the ideas of Pote et al. (2000). However, this research also provides new knowledge in regard to connecting systemic ideas to the disorders that are categorized as associated abnormal psychosocial situations/axis 5 in the ICD-10 multiaxial classification system (WHO, 1996) and the legally binding requirements of the Norwegian Directorate of Health (2008).

3.6 Elements that are especially pertinent to qualitative research

In this part I will present seven elements that are especially pertinent to qualitative research.

3.6.1 Owning one’s perspective

Owning one’s perspective concerns the researcher’s theoretical orientation and personal expectations, both the expectations that are known in advance and those that arise during the research. This research project’s epistemological position has been made transparent in part 3.2.1, *Ontological and epistemological stance*. As the researcher of this study, I position myself as 36 years of age, heterosexual, white, middle class, and Norwegian. I am in the final year of the Doctoral Programme in Systemic Psychotherapy at East London University in conjunction with the Tavistock Clinic. My professional history began with the completion of a bachelor’s degree in social work at Finnmark University College in 2004 and was followed by Diakonhjemmet University College’s four-year master’s programme in family therapy and systemic practice from 2008 to 2012 and a two-year education in cognitive therapy (2010–2012). I worked as a systemic family therapist in BUP from 2010 to the fall of 2014. Starting in 2014, I worked in Oslo in a 30% part-time position as an assistant professor at VID

Specialized University's master's programme in family therapy and systemic practice. Since the beginning of 2016, I have worked as a full-time assistant professor in Bergen at the University College's institute for social work and social educators. As a clinician, I am inspired by postmodern ideas such as moderate social constructionism, critical realism, circular (Batesonian) epistemology and "post-"systemic family therapy. Therefore, my practice is somewhat multifaceted and complex. Based on my practice and interests, I attempt to facilitate and "build bridges" between mental health's diagnostic focus and postmodern systemic ideas.

3.6.2 Situating the sample

Situating the sample concerns providing descriptive information regarding the research participants to explain possible personal and contextual factors (Elliot et al., 1999, p. 221). The research participants and relevant circumstances are presented in detail in part 3.3.5, *Recruitment of the participants*, and part 3.3.6, *Details of the participants*.

3.6.3 Grounding in examples

Elliott et al. (1999) encourage the researcher to provide examples of the data to illustrate analytic procedures. An example of the initial and focused coding process is presented in Appendix 9. Throughout the presentation of findings (chapter 5), examples from the data material are used to exemplify and specify the categories.

3.6.4 Providing credibility checks

To achieve credibility, I discussed the entire process of analysis with my supervisors. All participants were also given the opportunity to comment on the transcribed interviews. The categories were "checked" with what I call the "Tavi-group" (a group of fellow students and teachers at the Tavistock Clinic) after an oral presentation during the spring of 2015. In early 2016, all participants were also given the opportunity (by e-mail) to comment on the emerging map of findings (in the continuum named *map of competences*) (Figure 1, chapter 6). Four of the six participants sent me their comments. One of the comments addressed whether "following the family's wishes" was described in the map of findings. This is clearly described in categories 4.2.1, *collaboration and user involvement*, 5.2.3, *collaboration with the family and private network*, and 5.6.1, *tailored therapy*. Three of the participants also commented on category 5.4.1, *child-centred family therapy*, and wondered whether different creative "techniques" to facilitate child-centred conversations were included and described.

However, several creative “techniques” (such as the use of “post-it” notes and future dreaming) that were identified through the data analysis are described in category 5.4.1, *creativity*.

3.6.5 Coherence

Coherence concerns presenting data in a manner that simultaneously achieves coherence and integration and preserves nuances (Elliott et al., 1999, p. 223). To achieve coherence, the material is presented as six main competences and several skills and micro skills. This presentation represents a comprehensive and detailed outline of the systemic therapist competences in Norwegian child and adolescent mental health that target the associated abnormal psychosocial situations (axis 5) in the multiaxial diagnostic system (WHO, 1996). The identified detailed outline of systemic therapist competences is meant to be applied as a tool for clinical supervision, clinical practice, education and training in family therapy.

3.6.6 Accomplishing general compared with specific research tasks

The participant therapists seemed to be sceptical of universal theories because they may be reductionist. Despite the stated scepticism, there was congruence among the participants' practice, attitudes, descriptions of phases in the therapy process and significant therapeutic competences (for example, the focus on strengths and solutions). Therefore, this research seems to be transferable to other family therapy units in Norwegian child and adolescent mental health, with necessary contextual adaptions. The inclusion of the legally binding requirements of the Norwegian Directorate of Health (2008) suggests that the “map of competences” is irrelevant beyond Norway. Nevertheless, the legally binding requirements mostly concern well-known themes, such as diagnostic assessments, power and collaboration (Lorås, 2016b). Therefore, I consider the map of competences to be relevant for the other European countries as well. However, it may still be questioned whether the families who received therapy (when I conducted my fieldwork) can be understood as "typical" representatives of families with difficulties that can be categorized as associated abnormal psychosocial situations. However, the multiaxial diagnosis system (WHO, 1996) (or any system of psychiatric categorizing) cannot encompass the total diversity of individuals and families' complex lives and challenges. Therefore, despite the multiaxial diagnosis system/axis 5, human systems in general can hardly be categorized as homogeneous.

3.6.7 Resonating with readers

To resonate with readers, Elliott et al. (1999) suggest that the material should be presented so that readers and reviewers determine that it has contributed to a clarified or expanded appreciation and understanding of the subject matter. Therefore, my two research supervisors read draft versions of each stage of this project. In addition, the “Tavi-group” gave its feedback on emerging categories. Finally, all written material was professionally proofread.

3.7 Reflexivity

Reflexivity is considered an important part of qualitative research (Charmaz, 2006; Finlay, 2002a). Finlay (2002a, 2002b, 2003) defines reflexivity as “a thoughtful and critical self-awareness of personal and relational dynamics in the research and how that affects the research” (p. 318). Mason (1996) explains that reflexive research requires researchers to take “stock of their actions and role in the research process” (p. 6) and subjects them to the same critical reviews as the rest of the data. Therefore, the reflexive researcher has a critical lens on the research process, context and outcome and simultaneously interrogates the construction of knowledge (Finlay, 2012). As a reflexive tool for self-reflexivity in this study, I used Linda Finlay’s (2012) “five lenses for the reflexive interviewer” throughout the entire research process. These five lenses are (1) strategic reflexivity, (2) contextual-discursive reflexivity, (3) embodied reflexivity, (4) relational reflexivity and (5) ethical reflexivity. These lenses are presented in the following.

3.7.1 Strategic reflexivity

Strategic reflexivity involves methodological self-consciousness. In Constructivist Grounded Theory, strategic reflexivity is used to demonstrate transparency throughout the research process to safeguard its trustworthiness (Charmaz, 2014). Therefore, my two research supervisors were widely used (in the initial part) to assure the quality of the research questions and my planned approach, such as the development of the semi-structured interview template, the development of the information and consent forms and my presence as an observer (fieldwork observations). At the later stages, the supervisors were used as discussion partners to examine the influence of my epistemological position in the coding/interpretation of the data.

The experienced systemic therapists were recruited through recommendations by my research supervisors and through their scholarly contributions to the research topic.

3.7.2 Contextual-discursive reflexivity

Contextual-discursive reflexivity considers the social context and the world of shared meanings concerning both the proximal research situation and the broader structural domain (Finlay, 2012). As a “tool” for analysing verbal reports and fieldwork observations, GT will always be subjective to a certain extent. All research is somewhat connected to or part of the research (Davies, 1998). Therefore, the stories that are heard and the researcher’s observations of practice are (to some extent) artefacts of the researcher’s presence and influence. Thus, the researcher’s interpretation of verbal reports and fieldwork notes can be somewhat different from the stories that are being told and the practices that are being performed (Finlay, 2012).

The field of family therapy in Norway is small and transparent. I have been in the family therapy field since 2008, first as student, then as a family therapist in child and adolescent mental health and currently as an assistant professor. Accordingly, I knew some of the participants briefly before this project. Thus, my background and competence are part of my observations and interpretations and may affect my participants. For example, the information sheets (Appendices 2, 3 & 4) explain that the focus is on therapist competences rather than on patient information. Therefore, this focus may have made the participants more aware of using their systemic competences (such as focusing on strengths and solutions) than they would have been otherwise. The participants are most likely also familiar with my great interest and substantial training in systemic therapy, which also could have exerted an influence. Therefore, I consider it probable that my presence may have influenced how the participants expressed/wanted to express themselves because they were aware of me implicitly considering their competences. I became aware of the potential influence of my presence when I occasionally observed (during fieldwork observations) that the therapists’ practice did not always match their abstract theoretical descriptions from the initial interview. In these situations, I turned my reflections and hypotheses into new questions that were further explored during the follow-up interviews.

Being a reflexive researcher, I needed to be aware of my interpretations during the process. In this study, the contextual-discursive elements were considered because I developed the interview guide for the follow-up interviews after listening and re-listening to the audiotaped interviews and after reading and re-reading my fieldwork observation notes. In this way, the follow-up interviews were used to further explore my reflections and thoughts with the participants.

3.7.3 Embodied reflexivity

Embodied reflexivity concerns the “language of the body” (Finlay, 2012). With this term, Finlay claims that the researcher should focus on the potentially significant implicit meaning that arises from the participant’s words in a “more than verbal” manner (op.cit, p. 322). As researchers, we can sense our body’s responses to our participants during the interviews and the observations. Therefore, I found it necessary to reflect with one of my research supervisors after some of the initial interviews because I noticed my embodied responses in these situations. I exemplify these conditions with two short extracts from my memos:

It seems obvious that I struggle with the shift from being a therapist to being an interviewer. It feels difficult to relate to a semi-structured template, probably because I’m trained as a systemic therapist with the focus on following the clients’ themes and language.

I experienced the therapeutic conversation that I observed as very unstructured and different from what the therapist described in the interview. I also noticed that I become very influenced by all the noise and became restless. (Memos, 27.11.14)

My bodily responses made me want to intervene (under certain circumstances) to get the therapeutic conversation “back on track”. However, the clients did not seem restless and stressed by what I perceived to be a lack of structure in the session. Nevertheless, I was still curious why the therapist(s) did not take more explicit control during the session. I asked about this point, for example, in interview number two with Einar, and his response was: *The structure of the therapeutic session is not important if it is not what they came here for* (E2, 128-142).

Because of the message to myself through the “language of my body”, my research supervisor recommended that I be more open to “what happens” in the conversation rather than strictly follow the interview guide. Burck (2005), who claims that the qualitative researcher has moved away from a format in which questions must be asked in a particular order, also supports this recommendation. The result was that the next interviews gave me more meaningful conversations and knowledge that strengthened the data material.

3.7.4 Relational reflexivity

The dynamics between the researcher and the participant are the domain of relational reflexivity (Finlay, 2012). A relational reflexive researcher recognizes that there is a dynamic between the researcher and the participant and that “reality” is co-constructed (op.cit). When the process of observation was initiated, I briefly introduced myself and the aim of this

research to the clients of the therapist who was going to be observed. All of the clients who participated received a written description of this project at an earlier stage (approximately one month before my presence). The opportunity to withdraw their consent for their participation was also described. As an observer, I was placed in a chair approximately two meters from the conversational area. I could see all of the clients and the therapist at all times, and simultaneously, they could see me. Although objectivity is not a goal in qualitative research (Willig, 2008), I asked all of the therapists (in the follow-up interviews) how my presence seemed to influence the therapeutic process with the clients. All of the therapists argued that my presence did not seem to have had any visible effects. As Stein said:

You have a very friendly, pleasant appearance. I think that made both the clients and the therapists relaxed. The families have been somewhat prepared, but it felt very real. You neutralized yourself very well. So, it was not anything like a laboratory experiment. (Interview no 2, line 1565-1580)

Thus, before the first fieldwork observation began, two of the participants commented that they felt slightly nervous because of my presence. Although all of the participants in the follow-up interview were positive regarding my attendance, it is reasonable to think that it may have affected their therapeutic expression, especially in the initial part of the conversations. Nevertheless, I did not observe any changed behaviour during my fieldwork observations.

3.7.5 Ethical reflexivity

Ethical reflexivity concerns safeguarding and considers the ethical challenges in the research project (Finlay, 2012). My collaboration with the participants involved not only interviews and observations but also an extended e-mail dialogue over several months. My participants (the experienced therapists) were responsible for the recruitment of the families who would be present during my observation. Therefore, the e-mails were necessary to ensure that my participants gave their approval on the information sheet and consent declaration, which they needed to present to the families. During this process, it became necessary to make several changes to the letters. The feedback was explicit regarding what some of the participants described as stigmatizing and normalizing wording in the information sheet for children who were aged 12 to 16 years. In the information sheet, the associated abnormal psychosocial situations were translated as “families who fight a lot” (to adapt the language to the children’s age). This translation, and more, was thus amended in collaboration with my participants.

3.8 Ethical issues and anonymity

Because this study was conducted in Norway, appropriate approvals were obtained for the study from the regional committee for ethics in medical research (REK; Appendix 5) and the ethics committee at East London University (Appendix 6). The audiotapes have been stored and locked in a safe at my home, according to the approval from the REK. The transcripts have been stored on my computer, which is protected by a personal password. All material is anonymized, and the e-mails have been erased.

All of the participants and clients who participated in the therapeutic conversations were given written information, including explanations of the process and purposes of the research, the limits of confidentiality and the opportunity to withdraw from the research at any time. All participants have signed a written informed consent form (Appendix 1,2,3 & 4) and have given me permission to use the transcripts of the interviews and the fieldwork observation notes as data material for this research project. This permission also includes all family members (over 16 years of age) who were present during my observations of therapeutic practice.

All participating therapists were offered the opportunity to comment on the transcript and were given the right to veto its use. The transcripts were sent to them by e-mail, and all participants confirmed that they were received. Nevertheless, none of the participants availed themselves of this opportunity.

My research does not initially address sensitive information because the focus is on therapist competences rather than on patient information. Nevertheless, thorough consideration must be given to how the research process will affect the people involved. Because of the public nature of systemic therapy, I believe that the therapists were able to make an informed judgment concerning the risks that they exposed themselves to by participating in this research.

3.9 Possible limitations of the research

The goal of this research was to identify a comprehensive and detailed outline of the systemic therapy competences in Norwegian child and adolescent mental health that target the associated abnormal psychosocial situations (axis 5) in the multiaxial diagnostic system (WHO, 1996). The use of the phrase “identify competences” indirectly implies that there is a

“correct way” to practice systemic family therapy. Nevertheless, as a relational reflexive researcher, I recognize that the identified systemic therapy competences occur because of a dynamic process among me as a researcher, the participant, the clients, and the text (Finlay, 2012). Therefore, the competences (findings) are somewhat subjective and cannot be expected to satisfy everyone, including this research’s participants. However, I consider that it is possible to obtain a certain agreement on the identified competences to account for a transparent, fair and reproducible research process (Daniels & Sabin, 2002). For purposes of transparency, the participants were also given the opportunity to comment on the emerging “map of competences”.

Another potential limitation of the use of the map of competences is that the identified competences are bound to target the associated abnormal psychosocial situations (axis 5) (WHO, 1996). Therefore, all of the recruited participants were informed that all of the clients/families who participated in the therapeutic conversations that I observed should mainly have difficulties that either were or could be categorized as axis 5. This standardization was also an informed and constant underlying backdrop for all of the conducted interviews. Nevertheless, human systems are multifaceted and complex. Therefore, the human systems (i.e., families) who were observed during my fieldwork observations can hardly be categorized as a homogeneous group, although they fulfilled the criteria of multiaxial diagnosis system/axis 5. Several of the clients also had additional diagnoses, such as anxiety and depression, and it is difficult to conclude which diagnosis (if any) was dominant. Thus, it may still be questioned whether the families who received therapy (when I conducted my observations) can be understood to be "typical" representatives of families with difficulties that can be categorized as associated abnormal psychosocial situations. Accordingly, it can be questioned whether the identified systemic therapy competences tend to favour the associated abnormal psychosocial situations instead of child and adolescent difficulties in general.

The inclusion of an unbound competence group that consists of experienced systemic therapists could have strengthened the compilation of this research’s findings into systemic competences. However, my analysis has been subject to the scrutiny of my supervisors and the “Tavi-group”. The participants have also been given the opportunity to comment on both the interview transcription and the emerging “map of competences”. This was to enhance my reflexivity in relation to both the research process and data analysis.

The fieldwork observations were limited to six to eight hours of clinical practice with each of the six participant therapists. If the hours of fieldwork observations were extended and/or were conducted to include observations before the first interview, then the data material could have been even more comprehensive and a thicker descriptive account considering the aim of this research. Although I conducted 12 interviews with six experienced systemic therapists, this research is based on the practice of a relatively small number of practitioners. By extending the number of participants and their different child and adolescent mental health contexts, this could have nuanced my analysis and maybe given me more variations in my data material. However, I consider that the idea of saturation in qualitative research functions more as a goal than a reality. The social constructionist idea of meaning as co-constructed also means that knowledge should be considered provisional and to rely on the reciprocal influence between the researcher and the participants (Willig, 2013). Nevertheless, saturation somewhat applied during the interviews because most of the identified therapeutic competences were discussed by all of the participants.

4 FINDINGS FROM THE THEMATIC ANALYSIS OF THE NORWEGIAN DIRECTORATE OF HEALTH'S GUIDELINES

In this chapter, I present the findings that were identified through the process of thematic analysis of the Norwegian Directorate of Health's guidelines (2008) for child and adolescent mental health. The research question, which was the starting point for the thematic analysis, was: *What are the legally binding requirements in the Norwegian Directorate of Health's guidelines for child and adolescent mental health?* Through the thematic analysis of the Norwegian Directorate of Health's (2008) guidelines, the overarching theme *legally binding requirements for child and adolescent mental health* were identified.

4.1 Some clarifications to guide the reader

In the professional literature, both the words “client” and “patient” are used. I primarily use the word “client” because it accords with the words that are used by my participants in the interviews. An exception is made for the text excerpts (for example, from the Norwegian Directorate of Health's (2008) guidelines) that refer to the word “patient” or similar terms. Because these excerpts are direct quotes, I used the original wording. Regarding the use of the excerpts from the interviews, the grammar and sentence structure have been somewhat altered in some cases to make the text more readable but without altering the meaning of the content.

4.2 Legally binding requirements for child and adolescent mental health

Here, I present the overarching theme, the legally binding requirements for child and adolescent mental health that are presented in the guidelines. The legally binding requirements are presented as “shall” in the guide: *When shall appears in the guide, this means that something is the law or rule-bound or so clearly professionally established that it will seldom be responsible not to do as recommended* (Norwegian Directorate of Health, 2008, p. 7). The general recommendations of the guide (in which “shall” does not appear) are not legally binding. However, the general recommendations should appear in the user's journal if he or she does not follow them (op.cit). Therefore, the guide is a clearly directional document regarding the practice of the therapeutic methods that are employed in child and adolescent mental health (BUP). Three legally binding themes that were emphasized in the analysis were (1) collaboration and user involvement, (2) diagnostic assessment when

appropriate, and (3) requirements of quality and competence in child and adolescent mental health. These themes are now presented.

4.2.1 Collaboration and user involvement

Collaboration and user involvement were identified as a central theme in the guide and are described as necessary to offer predictable and holistic services. The therapists' collaboration with the service user is also described as central regarding the quality control of therapeutic work. Therefore, the users own experience of the treatment is given considerable consideration in the guide and can be illustrated in the following two quotations.

The treatment professional should actively inquire about and gather points of view and information and suggestions for improvement from children, youth and families concerning the services they receive. Quality of the services is also a question of experienced quality and treatment. Professionals in outpatient clinics must recognize service users' rights to define quality, goals and results on their own behalf. (p. 14)

Users have the right to influence services at the systemic and individual levels. Service users of services directed towards children and youth are defined as children, youth and their parents. (p. 13)

Therefore, the therapist's dialogue with and recognition of the user's knowledge about him/herself is explicitly expressed as the basis for understanding the individual and his/her life challenges and difficulties.

Dialogue with and acknowledgement of the patient's ability to understand and interpret him or herself shall provide the basis for a shared understanding that can contribute to solutions to the patient's difficulties. A reflective practice applies different models of understanding and approaches in the attempt to contribute to solutions to the patient's difficulties. (p. 29)

Although the users' and/or their parents' attempts to change are acknowledged by professionals in their collaboration with them, there is a duty to report to Child Protection Services the situations where children are at risk.

Public authorities shall, by their own initiative and without hindrance of confidentiality restrictions, provide information to the Communal Child Protection Services when there is reason to believe that a child is being abused at home or that there are present other forms of serious neglect, jf 4-10, 4-11 and 4-12. Or when a child has shown lasting serious behavioural difficulties, jf §4-24. (p. 17)

The guide indicates that the referred patient has a legal right to be involved throughout the entire therapeutic process, and simultaneously, the services are restricted to conducting

systematic surveys of patient satisfaction. *Users' experiences and satisfaction should be surveyed regularly and the information used as a basis for improvement of the service* (p. 71).

The guide also states that users have the legally binding right to be included in the decision-making concerning the process of ending therapy.

Discussion of the endings of treatment shall always occur in consultation with the patient and the family. (...) Change and satisfaction should be the focus. The patient, parents and professionals should contribute to the evaluation process of the treatment. (p. 34)

The guide has legally binding requirements that state that therapists in BUP shall collaborate at the system level: *Service providers shall collaborate with user organizations on the system level* (p. 12). By collaborating with user organizations, the goal is for user experiences and knowledge to be part of the knowledge base for the entire service. The therapists in the specialist health service shall also collaborate with the municipality health service, which involves outpatient clinics that contribute to their primary preventative work.

The specialist health service law §6-3 states that health personnel employed in the specialist health service shall give the municipality health service advice, supervision and information about health-related conditions necessary for the municipality health service to be able to perform its tasks in accordance with applicable laws and regulations. (p. 41)

Children and adolescents are clients who find themselves in a particularly vulnerable position, because they are dependent on their environments, primarily their parents. Therefore, the collaborative relationships with parents and guardians are viewed as a means to secure the inclusion of children and their experiences of being heard, which is described in the guide.

Children and adolescents' right to user involvement requires that the outpatient clinic in collaboration with parents ensure that children and youth can be included and participate on their own terms. When children and adolescents are invited to participate and be involved, it is central that they find that their experiences are taken seriously and that they have real influence. (p. 15-16)

Children and their parents have the right to real influence in treatment, and the Patients' Rights Law (Lovdata, 2016) also states that they have the right to be heard regarding which treatment is offered to them. This right is stated in the guide (Norwegian Directorate of Health, 2008).

It can also be the case that those who seek help do not desire the recommended treatment or that the treatment professional/outpatient clinic does not have the necessary expertise required for the treatment approach. If the outpatient clinic lacks

the necessary expertise, it should be acquired or the patient should be referred to an appropriate service. (p. 34)

Collaboration and user involvement are continually repeated and emphasized topics in the guide. However, few of the recommendations concerning user involvement are legally binding requirements according to the wording in the text. Nevertheless, the wording in several of the recommendations is so instructive (e.g., shall, need to, demands) that it remains unclear to what extent they are intended to be legally binding.

4.2.2 Diagnostic assessment when appropriate

Diagnostic assessments are the topic that is most often presented as legally binding in the guide (14 times). Therefore, diagnostic assessments are a clear focus of the therapeutic work in BUP.

All patients who receive help in outpatient clinics shall where appropriate be investigated for current problems, symptom development, functional level, care situation, educational situation, risk factors, resources and patient/parents' wishes and expectations. (p. 28)

The justification for diagnosis (if diagnostic assessment is deemed appropriate) is the desire for a systematic assessment of symptoms and functions (Norwegian Directorate of Health, 2008). Therefore, there are requirements for documentation: *Diagnostic assessments are to be documented in the patient journal*³ (p. 32) or: *The journal shall document what has occurred in the consultation and the guidelines for further work* (p. 36). Another example is the following. *Explicit and well-grounded assessments and summaries are to be written down. The journal shall be written in such a way that it can be read by the patient and the family* (p. 36).

According to the guide, all psychiatric diagnostic conditions (for example, anxiety and depression) shall also be coded (diagnosed) independently of their duration. *Temporary or tentative diagnoses considered in the investigation phase shall only be documented in the running journal* (p. 37). Further, the guide states that

Every condition that has been managed or taken into consideration in treatment shall be coded even though it is present for only a short time. The coding is only completed at the conclusion of the series of treatment. (p. 38)

³ A patient journal is a compilation of recorded and documented information concerning a patient in connection with health care (<https://lovdata.no/dokument/SF/forskrift/2000-12-21-1385>).

At the conclusion of an investigative period and eventual completed diagnosis, the diagnosis and/or diagnoses are not necessarily final or “set in stone”; instead, they can be reassessed or changed. *Coding shall be changed or supplemented during the treatment phase if new information provides a basis for this* (p. 37). The main focus of diagnostic assessment is quality that is assured through the explicit requirements of mental health employees’ expertise.

Relevant assessment competence includes the application of general and specific assessment methods. The competence plans of the clinic should include sketches of assessment methods and tools that all co-workers shall master as well as specific assessment expertise that is covered by the different professional groups. (p. 56)

Furthermore, the treatment of infants and toddlers shall be conducted through the parents.

Outpatient clinics shall have specific diagnostic assessment and treatment expertise in relation to infants and toddlers. In work with infants and toddlers, much of the treatment must be conducted through the parents. (p. 44)

The guide also places legally binding conditions to ensure that therapists shall survey the client’s difficulties “broadly” by stating that: *The diagnostic assessment in connection with the assessment shall be a summary of the patient’s condition and life situation, both problems and resources* (p. 31). Therefore, to ensure a validated assessment of psychosocial conditions, the WHO’s (1996) multiaxial classification system shall be used: *In the process of coding (diagnosing), the multiaxial classification of child and adolescent psychiatric disorders shall be used, and all six axes shall be coded* (Norwegian Directorate of Health, 2008 p. 38). Axis 1 concerns psychiatric symptoms; axis 2 is based on specific developmental disorders. Axis 3 defines psychological developmental disability, and axis 4 concerns somatic conditions. Axis 5 is a tool for coding the associated abnormal psychosocial situations; axis 6 is a global assessment of the child/adolescent’s functional level at the time of referral and at the point of the treatment’s conclusion (CGAS).

The guide’s legal requirements regarding diagnostic assessment are thoroughly described with clear requirements of the clients’ involvement and a survey of the contextual and family conditions. In the cases where it is necessary to conduct a multiaxial diagnostic assessment, the assessments should be conducted in collaboration with the client and/or the parents and form the basis of further treatment.

Following investigation and diagnosis, there shall be developed a treatment plan with the patient and/or the parents. This plan shall be concrete and time-limited and be used actively when planning the conclusion and evaluation of the treatment. (p. 32)

The findings of the legally binding requirements show that diagnostic assessments should be considered when appropriate and in collaboration with the families.

4.2.3 Requirements of quality and competence in child and adolescent mental health

A final main theme that is identified in the analysis of the guide (Norwegian Directorate of Health, 2008) is the requirements of quality and competence in child and adolescent mental health. The quality of the services at outpatient clinics is decisive to ensure that children and adolescents receive satisfactory service. Therefore, several legally binding requirements and recommendations are given in the guide to identify the quality and competence that each professional is expected to have. Additional general requirements and recommendations for outpatient clinics are also provided:

The professional areas to be covered as part of the clinic's competence areas are diagnostic assessment, treatment, user involvement, evaluation, collaboration supervision/consultation and research. Competence is defined in this context as the knowledge, skills and attitudes that are relevant and necessary in the work of investigation and treatment, in the internal collaboration in the outpatient clinic and in collaboration with other services. (p. 55)

The collaboration in a BUP outpatient clinic is described as contributing to ensure an “interdisciplinary” approach to treatment:

Interdisciplinary cooperation in the clinic is a form of collaboration that shall ensure good use of different specific competences/expertise (profession-based, method-based and personal). This contributes to quality assurance of the services when all co-workers have a certain “interdisciplinary knowledge” in the sense that they have knowledge of the other professions' core areas and that each co-worker is acquainted with his or her colleagues' expertise. (p. 57)

The guide (Norwegian Directorate of Health, 2008) also describes the methods and tools that professionals shall master and that shall be included in the competence plans of the clinic.

The clinic's competence plans should sketch the methods of investigation and tools that all co-workers shall master, as well as specific investigatory expertise that must be maintained by the different professional groups. (p. 56)

The guide (Norwegian Directorate of Health, 2008) repeatedly indicates that services shall be professionally responsible. *The health services shall at all times practice in a professionally responsible manner and in accordance with good professional practice* (p. 6). The term “professionally responsible” is still not defined in the guide. However, the guide describes what characterizes good quality of treatment:

Health services of good quality are characterized by being effective, safe and secure, coordinated, accessible and fairly distributed, and that users are involved and resources are used in a good way. (p. 61)

The point of departure for good treatment is a thorough understanding of the patient's situation in terms of problem areas and accessible resources. The investigation must cover significant psychological, medical, pedagogical and psychosocial conditions, as well as daily rhythm, nutritional habits, and physical activity, and result in a concrete description of the difficulties that one can assume are barriers to the child/youth and the family in their everyday functioning. (p. 56)

The guide further explicitly describes the elements that treatment professionals should possess if they have adequate treatment competences. *Treatment competence includes parental supervision, family, group, environmental and individual therapeutic approaches and medicinal treatment* (p. 56). Furthermore,

All co-workers in psychiatric health care for children and youth must have fundamental knowledge about normal development and abnormal development, as well as psychological disturbances in children and youth that are connected to a bio-psychosocial understanding. Further, all must have the necessary competence in investigation and treatment within their specific professional area as well as in interdisciplinary and interdepartmental cooperative work. (p. 56)

Through the guide's descriptions of the importance of a holistic and psychosocial understanding of difficulties, a selection of relevant approaches is specified. *In order to ensure holistic help for children/adolescents and parents, the family and network-based approaches must be a part of the basic competence of the clinic* (p. 56). Furthermore,

The professional's relational competence is fundamental along with the skills connected to motivational work and the mobilizing of resources in and around the patient. Relational competence is developed and maintained through reflection over practice experiences, feedback from users and supervision. (p. 56)

Therefore, there are requirements of many modes of understanding on mental health disorders (such as the requirement of being able to survey all 6 axes), and this breadth is difficult to

achieve without interdisciplinary work and/or the help of several treatment professionals who work together:

Referred children and patients have the right to be met by personnel with the competence to assess and employ treatment in relation to a broad spectrum of conditions and factors that can affect child and youth development and psychological health. (p. 55)

It can be good prioritization with regard to competence that several treatment professionals cooperate on the same case. In complicated cases, the treatment professionals can take on different positions in the work, for example, active/directing and listening/reflexive positions. This can provide opportunities for different perspectives and reduce the likelihood of important information being overlooked. (p. 58)

The requirements of quality and competence in child and adolescent mental health are thorough and cover diagnostic assessments, treatment, user involvement, evaluations, cooperation, supervision/consultation and research. Therefore, interdisciplinary cooperation is both necessary and a good way to secure the rights of clients and guardians through the legally binding conditions of the guide.

4.3 Summary

In this chapter I have described the findings from the thematic analysis of the legally binding requirements in the Norwegian Directorate of Health's (2008) guidelines. During the analysis the overarching theme (1) *legally binding requirements* was identified. This theme consists of all the legally binding requirements in Norwegian child and adolescent mental health that must be considered by all systemic therapists unless there is a weighty professional reason not consider it.

5 FINDINGS FROM THE GT ANALYSIS OF THE QUALITATIVE INTERVIEWS AND FIELDWORK OBSERVATIONS

In this chapter, I present the findings that were identified thorough a GT analysis of the interviews and fieldwork notes. GT was chosen to analyse both the interviews and fieldwork notes. The research question, which was the starting point for the GT analysis, was: *In the context of child and adolescent mental health, what are the different competences in a systemic family therapy approach that address the associated abnormal psychosocial situations?* Relevant excerpts from the interviews (“in vivo” codes) are also presented continuously in the text. Nevertheless, the grammar and sentence structure are somewhat altered to make the text more readable but without altering the meaning of the content.

The fieldwork notes were originally meant to serve the GT sampling process to develop the second interview with each participant. Nevertheless, I included the fieldwork notes as a part of the material for analysis because the fieldwork notes occasionally challenged the participants’ descriptions in the interviews. Therefore, a few field notes are included in the presentation of the findings as “in vivo” codes.

5.1 Some clarifications to guide the reader

The word “family” is often used in this thesis. However, the term “family” is meant to include persons who are considered significant to the referred patient and his family. All “in-vivo” codes have been anonymized, and the line placement from which the quotations are gathered is continuously cited. For example, a reference to M1, 123-129 indicates that the quotation is collected from interview no. 1 with Martin and that the quotation is from lines 123 to 129.

In this presentation are the identified overarching categories are named competences. The subcategories are named skills and the “sub-sub“ categories are named micro-skills. The term “skills” and micro-skills refers to the overarching competences operationalized into detailed and practice oriented descriptions.

5.2 The importance of ethical and contextual awareness in systemic therapy

The first competences that emerged from the qualitative interviews with the participants was the importance of “ethical and contextual awareness” in systemic therapy. The competence

“ethical and contextual awareness” is based on the participants’ continual considerations of the ethical aspects of therapy, in addition to the different contextual understandings. The overarching competence “ethical and contextual awareness” is divided into three skills namely, (1) ethical considerations, (2) contextual considerations and clarifications, and (3) collaboration.

5.2.1 Ethical considerations

Ethical awareness was characterized by the participants as continual considerations of their role as both a therapist and a “social controller”. The therapist should be considered the family’s ally in its struggles; however, the therapist is legally bound by the Norwegian Directorate of Health’s (2008) demands to notify Child Protection Services when required. Therefore, the role as a systemic therapist in BUP consists of a constant consideration of whether the therapy may be contraindicated or if the need for urgent (and perhaps normative) interventions is covered. Contraindication concerns considering any factors that weigh against an intervention or treatment (amv.legehandboka.no). The participants also emphasized an ethical understanding of the clients’ behaviour as always being guided by good intentions. Although the clients’ verbal responses and actions can seem inconvenient, they were considered an unfortunate result of basic good intentions. The category of “ethical considerations” is divided into four micro-skills: (1) the assessment of contraindication, (2) therapist/social controller, (3) power relations and (4) normative judgments.

The assessment of contraindication

All of the participants in the research project emphasized that it was important to continuously assess whether the offered therapy was contraindicated concerning the child’s best welfare. One example is if the therapeutic treatment from BUP causes the other relevant collaboration partners, such as the child welfare department, to not make the necessary initiatives regarding the fundamental care of the child (if they think that the fundamental care is safeguarded by BUP interventions).

Although systemic family therapy was not assessed as contraindicated regarding mental conditions or diagnosis, all of the participants ensured that the child’s need for fundamental care was safeguarded, both before and during the therapy process. Tuva and Nora explain that:

Family therapy is not contraindicated in some of the cases, but we “find ourselves wondering” sometimes if negligence is of such a type that other interventions are needed before therapeutic treatment like, for example, taking care of the fundamental care needs in the child. (T1, 958-973)

It is contraindicated to work family therapy in those cases in which therapeutic treatment cannot be expected to have a quick enough effect in relation to a child living in an unacceptable care situation and such. (N1, 1061-1065)

The participants agree that there are no mental health conditions that make therapeutic work impossible. Nevertheless, therapeutic work can be considered contraindicated. Although there are no mental health conditions that make therapy impossible, some individual behavioural patterns can make treatment difficult. According to Martin,

I don't really like diagnoses of personality disorder but agree that some people have a way of relating to themselves and others that is extremely dysfunctional and that just makes things worse. Some people manage, to a very limited extent, to take the other's perspective, and then it's difficult to pose circular questions. Others can't read analogue communication, for example. Everything from context to bodily attitude to tone of voice. (M1, 1515-1545)

Therefore, family therapy was assessed as being contraindicated by the participants if the therapeutic process could delay necessary decisions concerning children who were living in unacceptable care situations. Thus, the participants expressed a concern if a family's participation in treatment could be considered from the outside (for example, by Child Protection Services) as evidence that the child's basic needs were being taken care of, despite the unsatisfying care situation.

Being both a therapist and a social controller

As emphasized by the participants, systemic therapists should be regarded as the family's “ally” in its fight against its problem(s). However, simultaneously, the therapist is an employee in BUP, with accompanying responsibilities as a “social controller”. Being a social controller means that the systemic therapist must ensure that the basic needs of children and adolescents are safeguarded and taken care of. Therefore, an employee in BUP has the duty to report (hereafter, called social controller) to the police, social services, and/or Child Protection Services if illegal events (i.e., abuse and/or maltreatment) have occurred or if the child's care situation is not considered satisfying. As Martin said,

When I become seriously worried about the situation of the family, I make it clear to the family that I'm leaving the domain as therapist and changing to social controller

because if I'm unclear, the family won't know who they are dealing with. (M1, 1462-1490)

A systemic therapist is required at all times to accommodate these different positions. Therefore, the participants were concerned that the families were informed about their positions and responsibilities as early as possible in the course of therapy. According to Martin,

It is important to inform about the role as therapist and social controller early because otherwise the chances are great that they believe that I have discovered something that means that I'm only just now informing them about my two domains. (M2, 122-128)

The participants described that it is important to be transparent at all times in the therapeutic process. For example, parents are invited to comment on potential reports to Child Protection Services before they are sent. If the parents disagree with anything that is described in the report, then the participants indicated that this disagreement is an opening for this information to be added to the report. Therefore, the therapeutic alliance is not necessarily damaged, and one can work systemically with the family after the child's care situation is secured.

Power relations

All participants describe that power and power relations are evident in all therapeutic work. Thus, therapists need a reflexive response to the power relations that unfold in therapy. Accordingly, the therapists were concerned with organizing meetings with clients so that these meetings provided an experience to increase the authority in clients' own lives. Although the therapists occasionally "managed" things (for example, getting a silent child to talk), this management did not indicate anything negative about the parents. Instead, this management demonstrated the therapist's position of power, competence and role. Therefore, the participants said that an important goal is to negotiate equality and space in the therapeutic relationship. As expressed by Roar,

I try to make relationships with my clients that are both egalitarian and asymmetrical. By egalitarian, I mean that there is a power differential between me and them as clients. However, in the conversation, I try to make sure that all the voices have the same amount of space. (R1, 1725-1737)

The participants also said that the voice of the therapist often weighs far more than the voices of the parents, even in cases where they are saying the same thing. As expressed by Roar,

I use my specialist role with all the weight it involves when I am bringing the parents/family's message to the cooperation partners, when I know that in a communication situation, I weigh heavily. (R2, 792-808)

The participants emphasize their role as a “specialist” when they are collaborating with other services (e.g., school, Child Protection Services). For example, in the search for change and solutions, therapists can use their professional authority as the clients’ “ally” and advocate for them in the collaboration so that the clients’ goals, solutions and wishes are expressed and assessed in these other services.

Normative judgments

In the Systemic Family Therapy Adherence Protocol (Stratton et al., 2009), normative judgments are described as a proscribed practice. In response to this description, the participants seem to agree but have some concerns. Several of the participants describe that the influence of developmental psychology makes normative assessments acceptable to a certain extent. Therefore, developmental psychology’s descriptions of, for example, the child’s expected development, must be a part of systemic therapists’ basic knowledge. As Nora and Tuva explained,

I am inspired by developmental psychology with regard to normative functions in children. I also think that one must be normative if one has thoughts about parental behaviour/functioning that is harmful for the child's development. (N1, 377-385)

Developmental psychology makes it so that we have with us some thoughts about what is good for a three-year-old, for example, and what one can expect with regard to the mentalization of the child. (T1, 895-906)

The participants described that it is necessary to be normative at times when the therapist’s most important task is to meet the child’s own perspective. For example, the therapist can defuse the potentially harmful statements (i.e., “It’s obvious that it’s my son who is to blame for our difficulties”) of parents or other family members in a mild, normative manner. The participants indicated that this neutralization can be accomplished by emphasizing what can be understood as normal development, and the therapist can provide examples from his/her own life. The participants describe this process as part of a systemic therapist’s practice to investigate with the parents what they consider to be normal behaviour or expressions of something else. Tuva said,

Often, we sit and assess with the parents to what extent the child's behaviour is an expression of normal teenage rebellion or something else. That is to say, we do many sorting work with the parents. (T1, 816-831)

The participants emphasized that in working with the problems that relate to axis 5, they must tolerate arguing in the therapy room. Although arguments are experienced as unfortunate and potentially challenging, they also provide the opportunity to obtain a “taste” of the everyday life of the family. As Stein explained,

I have to tolerate some painful comments with the whole family present as well, when I anyway only have a little “peephole” into the child’s daily life and what he encounters every day. If you are too quick to disarm or normalize, you can miss valuable information about the family’s everyday communication/behavioural patterns. What we see as the family’s interaction and communication through our “peephole” is probably a mild version of what is really happening anyway. (S1, 1042-1092)

The participants described that if parents demand, for example, psychoeducation, then they can “take a step back” and let it be a small part of the treatment. However, systemic therapists do not initiate psychoeducation. The participants also expressed scepticism whether psychoeducative interventions protect the client’s interests when his/her difficulties have changed to a more “general” level. As Roar said, *When the therapist uses psychoeducation as a method, the client often loses interest because then you’re not talking about them anymore but on a more general level (R1, 796-803).*

Nevertheless, my observation during the fieldwork was that some psychoeducative elements were used to a greater extent than the statements in the interviews implied. For example, on some occasions, the therapists began to lecture the client concerning their diagnosis.

Psychoeducative elements were also used when there were signs of “chaos” or a lack of direction/focus in therapy. I interpreted the use of psychoeducative interventions as a strategic move to regain control over the therapy process through the manifestation of the therapist as an expert. I also think that the use of psychoeducative interventions indicates that the participants may utilize some normative ideas.

5.2.2 Contextual considerations and clarification

The participants expressed that contextual awareness is crucial in systemic therapy. The therapists emphasized that to generate good solutions in families, they must consider the clients’ own contexts (such as home or school). All participants highlighted a focus on the

surrounding and contextual factors and an understanding that there are significant differences between the therapy room and the family's everyday life. As described by Einar, *When people live chaotic lives, one must take a step back and look beyond the individual level because the one concerned is so affected by the events surrounding them* (E1, 750-759). Therefore, the participants were concerned with creating solutions that were transferable to families' "everyday life". As expressed by Roar, *My suggestions must be in accordance with how the difficulties develop in "real" life and must therefore be context-relevant* (R1, 1059-1069). The therapy should involve participant observation and participation in the contexts in which the difficulties are experienced. In this way, the participants emphasized that therapists will have experience-based knowledge concerning the phenomenon. In particular, the participants described this knowledge as being necessary in cases in which there is reason to suppose that the surrounding expectations of the child are unrealistic. For example, if the contextual surroundings of the family impede the child's ability to invite friends home. Mental health institutions and the family's everyday life are two different contexts. Accordingly, the participants emphasized that systemic therapy's focus on family conversations is beneficial in making contextual assessments:

Our therapeutic setting gives us the opportunity to be with the family members over a longer period of time. This gives us a good opportunity to see and experience different situations with them and provides many "openings" for asking them about how they are doing in concrete situations. (E1, 1078-1091)

The participants' focus on context allows the understanding that the family's difficulties can be "at the mercy" of the chaos in which they live and that even a small change of context can change the difficulties and ensure that their difficulties are viewed in a new way. Thus, contextual assessments provide opportunities for preferred and positive understandings of people's actions and potential for change. As Einar said,

If I see something in one of the parents that gets me to thinking that this is completely crazy, I'm committed to first being certain that this wasn't a reasonable reaction to the situation. The understanding is often changed by one asking how the conflict has influenced you and "getting hold of" to what extent the person concerned experienced that the person they appear to be in conflict with represents who I really am or another person. (E1, 1035.1054)

Additionally, the participants argued that although systemic family therapy prioritizes the family's contextual descriptions of their difficulties, the Norwegian child and adolescent mental health services also have a significant focus on diagnoses and medical thinking.

Although no demands are made for the production of reports with subsequent diagnosing, demands are made so that every individual case assessment is person-centred and appropriate for each family. Although the relational work of systemic therapy should be prioritized, there is always an individually referred (and thus also identified) patient in child and adolescent mental health. As described by Tuva,

As a family therapist in child and adolescent mental health, I must take account of diagnoses and reports. I must therefore accept some contextual factors that are part of our treatment system. I'm therefore not free to choose. (T1, 715-726)

Thus, the participants say that a therapist is not free to understand the difficulties as contextual and relational only but must also consider the need for diagnostic assessments. Therefore, a contextual understanding in child and adolescent mental health must always include the context in which the therapy is being conducted in addition to the families' lives.

5.2.3 Collaboration

Another skill that the participants emphasized in the interviews was collaboration. Collaboration means the mutual collaboration between the family and the systemic therapist and collaborative partners. I have divided the category "collaboration" into two micro-skills, namely, (1) collaboration with the family and the private network and (2) collaboration with the family and the professional network.

Collaboration with the family and the private network

The participants identified collaboration with users as essential in systemic therapy and described themselves as going further than sometimes expected to facilitate good collaborative processes. Collaborative challenges can place considerable additional stress and distress on the family. Therefore, mutual collaboration is facilitated, where family members are invited to explain how they perceive their difficulties and the therapist makes his/her knowledge available to them.

The participants emphasized that the referring services for BUP are Child Protection Services, psychologists, general practitioners and pedagogical-psychological services. Every referral is accompanied by information and descriptions of what type of help is required. The participants said that these descriptions do not always accord with the family's wishes and needs. The participants discussed many examples in which the referred patients and their families have been "obedient" to the referral, but it later emerged that they did not "dare" to

“stand up against it” and disagree with the descriptions of their difficulties and their needs. Accordingly, the participants viewed the referral as a way to invite family members to decide the direction of the therapy. In cases of disagreement between the family and the referring professional, the family’s request and goals are given precedence in the course of therapy.

I’m maybe a bit over the top in being concerned that it should be the family members who decide the direction, but I’ve got the most belief that change is possible if the family itself has ownership of the therapy process. (M1, 1663-1675)

Thus, a central principle that is described by all of the participants is that the family’s wishes and goals should guide the therapeutic process. As explained by Stein,

The course of therapy should be their project. They should feel ownership of the process, and we want them to walk along the way/discover the terrain themselves instead of being told where to walk. (S2, 191-201)

Another important topic to the participants was that the therapist must follow the family (“be where they are”, believe what they say and what they have experienced) and explore the family’s preferences, perspectives, wishes and theories of change (i.e., their previous suggestions for change). Although the therapist is viewed as an “ally” of the family, there is no indication that all of the tasks that the family “gives” should be followed uncritically by the therapist. One exception is when negligence is suspected or the suggested therapeutic approach is expected to be harmful to or inappropriate for the referred child. In addition, the participants indicated that another expectation could be that persons in therapy must be willing to reflect and tolerate reflections concerning their own role and contributions to their difficulties. This reflection and tolerance often involves a combination of both receiving support and being challenged.

With a starting point of offering user-involved therapy, little of the course of therapy is pre-planned. The therapy that is offered comes into being in the moment. Svein said, *Those times I plan therapy before the family arrives are the times I feel that I meet them most poorly* (S1, 1283-1287). The participants claim that systemic therapy is co-constructed and without always knowing the course of therapy. Regardless, the participants attempted to make assessments of which significant others (not necessarily biologically related) would be useful in participating in therapy. Although the decisions were given to the family, the therapists expected that the persons who were involved with the difficulties should participate in therapy. Nevertheless, “absent significant others” can be included in therapy through the use

of systemic questions (i.e., what would your deceased father say about this if he were present in the room?), although they are not present.

The therapist's collaboration with the family and other professionals

The participants said that collaboration with the family and other professionals is essential in systemic therapy, especially when many different collaborative partners are involved (e.g., school, Child Protection Services). The participants did not describe that they have a permanent structure for who is to participate among the collaborative partners; instead, they adjust participation on the basis of the needs of the family and the therapist. As Tuva said,

Instead of having a particular plan for who should participate among the cooperation partners, we do a continual assessment along the way with a basis in the themes and needs of the treatment course. (T1, 1069-1075)

The participants also described that to expand the reflections, they can work implicitly with the collaborative partners in the therapeutic room without their being present.

We also work therapeutically with external cooperation partners even though they aren't physically present in the room. For example, through asking the family/parents, What do you think Child Protection Services want to change for you, how can this happen, what do you believe would make them less concerned, and how can this be achieved in practice? (E1, 558-579)

Provided that there are no reasons for serious concern (i.e., that the therapists are required to report to Child Protection Services), the potential collaborative partners that should be invited to therapy is controlled by the family itself. The participants emphasized that although it has been necessary in individual cases to send reports to Child Protection Services, this is not synonymous with a break in the collaborative relationship with the family. Morten explained, *Sometimes, we have to report cases to Child Protection Services, but that doesn't mean necessarily that we can't continue to work with them (M1, 941-951)*. Instead, this report of concerns can often lead to expanded collaboration among the therapists, the family and Child Protection Services. Tuva said,

Even in cases that are reported to child protection, we wish to invite cooperation, preferably collaboration among ourselves, the family and child protection at the same time. We "don't let go" of the case necessarily if child protection has to get involved. (T1, 1212-1226)

The participants said that concerns regarding the care of the child are always discussed with the family before a report is sent to Child Protection Services. As noted above, contextual

factors, among other things, can contribute to possible misunderstandings of the individual or the family, which can make situations seem less serious in nature than first thought.

Therefore, drafts of these reports are always read together with the family before the therapist decides whether it should be sent. As expressed by Martin,

On one occasion, I wrote a report, went through it routinely with the parents and didn't send it when they came in with contributions that made me so uncertain in my concerns that I didn't send it. (M1, 1190-1203)

However, in cases of serious concerns, there is no doubt whether the report should be sent so that someone with formal authority (i.e., police, Child Protection Services) can regulate the level of conflict in a way that ensures the care of the child. The participants said that collaboration with other professionals involves contact on behalf of the non-referred patients in the family if this is initiated by the non-referred patient or if the therapist is concerned for a patient's life or health.

5.3 The systemic therapist's stance

An important competence of systemic therapy that the participants discussed is the therapist's stance. The therapeutic stance concerns the therapist's epistemological understandings, how he positions himself in his clinical work, and how he positions himself in terms of power relations in systemic therapy. I have divided this main competence into the three skills (1) the therapist's epistemological stance, (2) the therapist's position, and (3) power relations. The presented skills are all connected to ethical considerations. However, to be specific about the therapeutic elements and to avoid superficial descriptions, I have categorized them under the following overall competence: the systemic therapist's stance.

5.3.1 The therapist's epistemological stance

The participants' epistemological stance is operationalized in clinical practice in the following two micro-skills: (1) systemic and circular approach; and (2) non-pathologizing approach.

Systemic and circular approach

The participants defined their approach as both systemic and circular. They considered the family to be the referred patient, instead of the explicitly referred single individual. In this

way, the focus is changed from identifying individual difficulties as something “inside” the clients to patterns of interactions. Einar said:

Qualifying for help in BUP is achieved through descriptions of the problem in such a way that is adapted for the diagnostic paradigm while the help perhaps lies in a another understanding. (E2, 1697-1702)

In the participants’ view, difficulties are instead considered a common concern and “common enemy” of the family. Therefore, the participants grounded their understanding in the idea that the individualization of problems narrows their lives so that they can easily “bury” themselves in difficulties and experience themselves as guilty of the challenges that are faced by the entire family. Thus, any process of change with a focus on the “identified individual” will often be viewed as insurmountable. The participants said that by focusing on connections and emphasizing contextual factors, therapy will instead attempt to make visible how each individual affects one another and how the family system regulates itself. The participants also claimed that if one manages to make a systemic model of the family’s difficulties, this model can be presented and discussed, preferably with the family. A detailed circular model of understanding of the family’s difficulties can appear complex and insurmountable. Thus, the participants explicitly expressed that a small change to one part of the family system can be sufficient to change the entire system. Therapy can be viewed as a counterweight to an individualizing and personified understanding, and the smallest unit of a meaning-making system is considered to be a dyad (two people). The participants further described that families occasionally come with expectations that the therapist should “fix” and “repair” their “damaged” child. The participants understood this expectation as an expression of mental health problems’ historical focus on the identification of difficulties in the individual and medical explanation models. As expressed by Nora,

Mental health’s general individual focus can be confusing for families when they experience something different with us. Some of the parents who have a child who has been in for an individual examination expect that we should “repair” the child. (N1, 1250-1263)

Nora argued that if parents do not want a systemic approach, a limited individualistic focus can still be facilitated, although in a somewhat more “multifaceted” manner,

If we get a family that is in no way interested in a systemic understanding, we can take an individualistic perspective, but we will nevertheless facilitate a more multifaceted view of the difficulty/ies they have come in with. However, if the family’s demands become too different in relation to our systemic base, we refer the case on. (N2, 689-718)

The participants expressed that although a problem can be identified and assessed, this does not make it impossible to conduct systemic therapy. A systemic and circular understanding can, for example, take a point of departure in how they, as a family, should relate to one another, given the described difficulties or diagnosis.

Non-pathologizing approach

As employees of child and adolescent mental health institutions, all of the participants had comprehensive experience in conducting diagnostic assessments. However, in working with families in which the difficulties can be understood (completely or partially) as caused by problems that can be categorized in axis 5, traditional diagnostic assessments were described as often having little therapeutic value. As expressed by Einar,

Help for these people we work with is very little about curing some form of psychiatric illness. It is about helping them to live a good life in spite of the challenges that are along for the ride. (E2, 1712-1721)

The participants accordingly expressed a wish to liberate themselves from the diagnostic line of thought.

I have little use for assessments of children other than as functional descriptions. The point for me with a functional description is that it gives me information about how I should respond to the child. (R1, 454-463)

The participants said that when clients' difficulties are named in the diagnostic system, then the descriptions are often too generalized and difficult to recognize for the families. In the situations in which the therapists and the families consider a diagnostic assessment to be necessary, the participants indicated that the experience of the process of assessment impedes therapy. Several of the participants claimed that they think that both diagnostic assessments and treatment can occur in parallel. However, these participants said that organizational reasons, such as local deadlines for assessment and access to therapists with the necessary assessment competence, often make it difficult to achieve such parallel processes.

Although perhaps the child should undergo a diagnostic assessment, the participants emphasized that this does not exclude the opportunity for a systemic approach. The therapists' will then use this opportunity to make the "normal tools of diagnostic assessment" family-oriented by including them in the process of assessment. Receiving a diagnosis by itself does

not make anyone healthy; therefore, the participants described that they sought invitations from the family to discuss what type of help the family needed based on the given diagnosis. The implication is that a specific diagnosis seldom leads to a predefined therapeutic intervention (see category 4.2.1).

5.3.2 The therapist's position

The skill, “the therapist’s position” concerns how systemic therapists in child and adolescent mental health position themselves in their clinical work based on their epistemological stance (which is described in 5.3). “The therapist’s position” is divided into the following micro-skills (1) the “not-knowing” position, (2) reflections in regard to advising (3) structuring the therapeutic processes, (4) theoretical irreverence, (5) applause and praising, (6) a non-pathologizing view of the family and (7) the use of hypotheses.

The “not-knowing” position

The participants positioned themselves in a “not-knowing position” and referred to Anderson (2005), who emphasizes the client’s expertise, shared meaning making and an increased focus on dialogue. The participants expressed disbelief that instruction from an “expert” regarding their difficulties is useful. Instead, the need to create security and a good climate of cooperation is emphasized. As expressed by Martin, *My systemic conviction creates little faith in my own power of persuasion or instructing others* (M1, 986-994). Therefore, the participants view families as their own experts in their own lives. The therapist’s role is to help the families to address their own difficulties and to be loyal to their experience of the situation. As expressed by Tuva,

I am not invited to be the judge or find out what's right or wrong. (T1, 1,267-1,269) It would be a tragedy if I expressed that my thinking has to be followed or else it won't work out for you. (E2, 864-868)

Instead, the therapist asks for the family’s own perspectives (without taking the expert role in the family). Thus, the participants argue that the solution(s) to the families’ difficulties is to find in their history the previous attempts to find solutions. As Einar said,

There is a danger of isolation for the family members if they don't get to go into where they feel it's "burning" since they know a lot about what has put out the fire previously and that will probably also be helpful in the current situation. (E1, 796-780)

Although the families' own knowledge is preferred in therapy, there are situations in which families ask for "expert" knowledge and specialist competence. All of the participants expressed that although they do not possess any "recipes" for how people should live their lives, there can be situations in which specific advice may be called for. Typical examples that the participants discussed were when families describe that they are "stuck" and their repeated attempts at a solution have not led to a resolution. In this regard, the therapists said that they can share their "expert" knowledge and simultaneously emphasize that their advice should be considered one of many possible alternatives and opportunities for solutions (see more under section 5.2.2).

Reflected in regard to advising

All of the participants described that they initially wanted to avoid assuming an "advisor" position but that it is still necessary in some situations. As expressed by Nora, *Many families come to BUP and ask us to tell them what to do. Many are upset when I say that I don't have the answers* (N1, 306-308). The participants said that some clients' even request the therapist's professional knowledge so that they can choose which advice to follow. The systemic idea of translating advice into questions is described by Martin as appropriate (e.g., "*have you thought about?*", "*may it be the case that?*"), and in this way, it initiates a dialogue. Additionally, eventual expectations that the therapist should have the answers to their difficulties can in this manner "be answered" in the form of questions (e.g., "*if I had the answer, what would you want it to be?*").

The participants also discussed the situations in which families are in crisis when advice may lessen the crisis situation. In crisis situations, the participants claimed that therapy can be characterized as being more instrumental. Nevertheless, in most situations, advice should be initiated by the family because uninvited advice can easily be experienced as instructive, create responses of resistance and lead to a loss of interest in therapy. Often, the clients in these cases are experienced and are described as unmotivated and non-receptive to therapeutic treatment, which can be a sign that professional advice is not experienced as relevant. As expressed by Roar, *My experience is not that people are unmotivated but that the advice we give is too damn poor* (R1, 1062-1065). An expressed goal, according to the participants, is that advice should not be experienced as instructive.

*I am inspired by Maturana and think that instructive interaction is unfortunate.
People don't change because I tell them how things should be. But, people change*

perhaps because they get questions that make it so that they can hear themselves answer, which again can lead to the maps getting adjusted a little. (M1, 288-300)

With the therapist avoiding instructions and instead focusing on the families' own solutions, the family can experience ownership of the potential advice. In this way, family members can also experience control over their own lives.

Structuring the therapeutic processes

The participants asserted that it is their responsibility to ensure an appropriate structure in the therapy session. The structure's main purpose is to ensure that all the people who are present have the opportunity to be heard:

My job as therapist is to achieve “turn-taking” with those who come. Turn-taking is a way to achieve a therapeutic process in which they respond to one another’s responses. The simplest way to achieve a good turn-taking process is by me responding to something that the clients bring in and that increases the likelihood of them responding to me. (R1, 429-442)

Therefore, the participants always check whether the family will give them the mandate to structure the conversations to ensure that they do not get “stuck” in old and stalled communication patterns with little potential for change. As Martin explained,

I can certainly interrupt, but then I have to have a systemic perspective on it. Then, I can say that the mother is repetitive but that she is repetitive towards me. So, if I interrupt because it is a story I have already heard many times, I will acknowledge that I understand that this story is important for you, but can you help me understand what it is that I haven’t “heard”? (M2, 680- 703)

How the therapist will emphasize structuring the conversation depends on the extent to which “a changed structure” is a goal of therapy. As described by Einar, *The structure of the therapeutic process is not important if it isn’t what they have come here for/are struggling with* (E2, 145-148). Furthermore, Stein said, *we don’t take much control, there isn’t anyone who goes home to people and takes over either, so they have to be allowed to be themselves* (S1, 1251-1259). Thus, how the therapeutic context instead can be adapted to the clients' everyday situation must be assessed so that potential observations of interactions or proposed solutions can be adapted to their everyday lives.

However, the participants said that the need for structure is an evident part of the approach when there is chaos, high levels of conflict, or different reasons that make it necessary to protect the child's perspective. In these situations, the participants said that they are in charge of the therapeutic structure, for example, when it is necessary to interrupt the discussion. Stein explained:

I interrupt if I experience that the conversation appears to be taking advantage or is offensive, places unreasonable blame or negative qualities or if the children present are described in a hurtful or offensive manner. (S2, 848-868)

However, the participants described that there is usually little need for rigid structures. A "loose" structure can also provide much information regarding how the family is organized relative to who talks the most, who talks the least, who supports whom and how they communicate with one another.

Theoretical irreverence

Irreverence concerns moving to a position in which the therapist does not feel bound by the therapeutic model but instead uses the model as a flexible framework (Cecchin et al., 1992). The idea of irreverence also seems to be important to the participants, who described scepticism towards stringent theories that attempt to embrace human complexity. As Martin explained,

There is something reductionist about being able to arrive at a true and valid understanding of a phenomenon. For example, at a mechanic's workshop, it can be OK to arrive at the right way to do things, but in our work with persons with troubled relationships, it helps to think: "There's always another way." (M1, 153-173)

Accordingly, the participants emphasized an experience of systemic therapy that is not clearly defined in the literature. The participants described this lack of clarity as a potential theoretical strength because it gives them the flexibility and authority to be irreverent towards systemic theoretical elements that do not suit the family/therapeutic process. Therefore, a certain scepticism toward defining and limiting one's approach too much is important because there can be a danger of promoting reductionist thinking that cannot easily embrace human complexity. As described by Roar, *I have always been sceptical of social constructionism, as I feel it's reductionist to reduce everything to social constructions* (R1, 1264-1269). The participants simultaneously emphasized that there is a need for some theoretical guidelines so that the therapists, or the clients, do not become "lost" in all the complex work. However, a relational and contextual understanding seems to be fundamental for all of the participants,

but they are also open to the possibility that other perspectives in the course of therapy can be appropriate.

Applause and praising

The participants said that feedback from the therapist to the clients is important in therapy. However, they consider feedback, such as applause and praising, to be connected to the uneven power relationships between clients and therapists. The participants discussed the idea of applause and praising in terms of assuming a position in which they judge and evaluate the client's ideas, actions and behaviours. Therefore, the participants are aware of how any applause/praise of a client's activity/behaviour can be understood as a power assessment, which can promote a lower hierarchy for the client relative to the therapist. In addition, the use of applause/praise can lead to an unfortunate pressure of an expectation:

Geir Skagen [pseudonym] once taught me a lesson about this. He told me about a man that went over to his son and said: "I've seen you here at the pool several times now, and you're really good at diving". The son didn't dive for three years after that. It's one thing to experience the joy of diving; it's another thing to find out that it is watched and assessed. (R2, 1798-1820)

The therapists attempted to minimize the use of praise and instead presented themselves as acknowledging that people are viewed as "good enough" on their own without being rewarded based on achievement. A person's characteristics, not his or her actions, are the focus. However, the therapists described that there are cases in which the use of praise is experienced as natural and is difficult to avoid. One example is when a child in the therapy room discusses a concrete situation that he/she previously had handled differently and that the change in action led to a better result. The use of "applause and praising" on these occasions was also observed during the field observations. Nevertheless, the therapists described a goal of not using applause/praise as a strategic, therapeutic ingredient to "lead" the family toward a preferred solution.

A non-pathologizing view of the family

Through the observations in my fieldwork, I identified the use of positive connotation in therapy. The use of positive connotation was also confirmed in the qualitative interviews. This usage was often when the participants intended to avoid a non-pathologizing view of the family. Positive connotation was described by the participants as a "reflex" and a natural part of all therapeutic work. According to Einar, *Positive connotation is part of the vaccine*

against becoming buried in a problem and in relation to feeling hopelessness in the encounter with people's difficulties (E2, 1159-1165). Having a non-pathologizing way to describe or consider people and their challenges provides therapists an alternative view for new and possible understandings of the clients' difficulties. For example, a client's "described weaknesses" in some situations can be understood as strengths in other situations. As described by Einar, *Remember that the kids with anxiety are those with the greatest imagination. So, it isn't necessarily a truth that anxiety is purely negative* (E2, 1207-1212).

Additionally, according to Roar,

I can certainly relate to a person with anger as one of his characteristics, but following Michael White, I would also think that you and anger are a system composed of two parts. You as a person are part of a greater system such that your anger is only half of an interaction in which the other half can involve injustice. (R2, 1155-1171)

The participants also described that they use positive connotation when they ask clients questions at the level of intention. In this way, the therapists can address the clients' positive intentions, attitudes and values. A fundamental assumption regarding this approach is that the participants described that most people wish one another well. However, good intentions alone are insufficient to accept unacceptable behaviour. Thus, the therapists' understanding of intentions, or positive connotation, must not become descriptions that are exaggerated and false and hide a possible inadequacy. Stein said: *If one doesn't acknowledge the seriousness and only focuses on positive connotation and the like, there are many who won't experience that the level of severity gets heard* (S1, 1523-1526). Nevertheless, the participants emphasized that good intentions are worth exploring, for example, through questions such as "*What do you think lies behind this?*" In this manner, one can avoid good intentions being questioned and made suspicious.

The use of hypotheses

All of the participants said that they used hypotheses frequently, but their hypotheses are not as complex and refined as those that were emphasized by the Milan team (Selvini Palazzoli et al., 1978). Hypothesizing refers to the therapist's formulation of the client/family's difficulties based on the information that he is given (Selvini et al., 1980). Therefore, the therapists described that possible thoughts and ideas concerning the "nature" of the problem are presented in the form of undetailed "micro-hypotheses" that the family is asked to take a position on. In this way, the therapist avoids becoming enchanted with his/her own

constructions and blind to other possible understandings. As expressed by Einar, *If I don't achieve what I want with someone, this can be because I've ended up too much in an "idea" that I have the people in a different place from where they actually are* (E2, 1278-1284). Therefore, the participants explained that their hypotheses are presented as thoughts, not as well-founded facts, which, again, can contribute to the clients' ability to refute the hypotheses without feeling that they are rejecting the therapist's contribution.

5.3.3 Power relations

Another important topic that the participants discussed was power relations. They explained that power relations, between them and their clients, influence all areas of therapy. Therefore, power relations must be carefully considered throughout the course of therapy. In presenting the findings on power relations, I have chosen to divide *power relations* into four micro-skills that make it possible to concretize the participants' reflections on the different aspects of power. These are (1) avoiding shame and guilt, (2) creating a safe place to talk, (3) transparency, and (4) being appreciative.

Avoiding shame and guilt

The participants described that therapy that is based on individualistic psychological thinking has traditionally attempted to identify (diagnose) specific problems. Unfortunately, the process of identification has often led to a feeling of shame and guilt for the referred patient or the person who is identified as the one to blame for the difficulties in the family or the individual. The participants also described that there are many potential sources of offense in the wake of "problem talk". For example, the participants emphasized that interactional difficulties (in axis 5) are often understood by parents to be caused by a linear cause-and-effect understanding. The families' feelings of shame and guilt over their difficulties can lead to the "effect" that they have problems in viewing themselves as part of the possible solutions. Therefore, the parents can feel deprived of the opportunity to take responsibility. As described by Roar,

When families come to us, the symptoms are often explained by family interactions. Family interactions, in turn, are often understood causally from the parents' point of view and therefore contribute to increase the feeling of guilt and shame of the parents. My experience is, when parents have been "high" on shame and guilt, it becomes the main focus. When you increase the parents' feeling of shame and guilt, you also take from them the possibility of taking parental responsibility. (R2, 580-612)

To change this pattern, the participants emphasized the importance of having conversations that elicit an underlying belief in the family's strengths and potential for change. Therefore, the participants said that they express their faith in the family members' good intentions to facilitate an atmosphere that is not characterized by blame or the distribution of guilt.

Creating a safe place to talk

The participants emphasized the importance of creating a safe place to talk. For example, if people are offered conversations when they feel unsafe or afraid, they often respond in more defensive ways than in a changed modality. For good and appropriate therapeutic conversations to occur, the participants said that it is necessary for each individual to experience him/herself as secure in the therapeutic context. According to the participants, people who experience themselves as insecure or attacked do not have good opportunities to listen and actually hear what other people are saying, even when they are positioned in a listening position. As expressed by Martin, *You only listen when you are in a safe position* (M1, 941-942; M2, 1130-1132). Accordingly, the participants described that it is important that clients must be asked regularly regarding what is necessary for them to feel safe in the course of therapy. Examples that the participants discussed were contextual structural changes that must be addressed (see also point 5.2.2 and 5.6.2) such as arranging for divided conversations (i.e., the mother and the father by themselves). Through secure frameworks that make listening positions and reflections possible, one can thus come to a position to work with issues that the clients are not initially in a position to manage on their own.

Transparency

From both the interviews and the fieldwork observations, transparency was identified as a central element of the participants' practice. All participants emphasized the importance of not having too many inner presuppositions or inner evaluations that they, as therapists, are not reflexive towards or have discussed with the family. As expressed by Roar,

My experience has taught me that the families demand to have access to my knowledge. I try therefore always to tell them what I'm thinking. Then, it's up to the family to choose what they want to use. (R1, 776-787)

The participants said that an open, transparent therapist is the goal to ensure that there is no agenda of the therapist and that the parents/family has a freedom of choice regarding the agenda for the therapy. Additionally, being transparent involves sharing potential concerns. In

such cases, the therapist has the main responsibility to arrange conversations regarding the concerns so that the people who are concerned do not feel reduced. Einar said:

We have learned to say that whatever has happened or not, the suspicion that something has happened is so great that it is a problem for the therapeutic process in itself. Therefore, we then have to do the work of organizing things so that no new suspicions arise. (E1, 1358-1367)

The participants described themselves as being unable to work with the family in productive ways until certain concerns, i.e., the care of the child, are considered and discussed with the family. Provided that the therapist is consistent and transparent regarding his assessment (even reports of concerns), even serious concerns will not necessarily damage the therapeutic alliance. The participants also said that transparency involves expressing concerns in the cases in which treatment does not lead to the desired achievement of the goal of therapy, which must be discussed with the family. In this case, the participants said that it is crucial that the therapist share his possible thoughts and ideas about what is required to reach the goals of therapy and the possibility of change, for example, that specific persons should participate in the treatment course. However, the final decision lies with the family.

Being appreciative

Another important aspect of power relations that the participants discussed are being appreciative, which means that they always view clients as good people with good intentions. As expressed by Einar,

I often develop a logical understanding and appreciation for the people they are and the choices they have made when I see where their struggle comes from and how it perhaps has also existed for generations. (E1, 1181-1185)

The participants also said that for many clients, simply having the opportunity to talk to someone who does not criticize them but instead meets them respectfully with curiosity and listens to and confirms their experiences can have significant effects on their lives:

It takes time to learn to play the piano. But, it's damn true that it isn't everybody who has the chance to learn to play the piano, but they get asked nevertheless to play a piece by Schubert without having the first idea how. How should one relate to that? (E1, 1194-1205)

The participants emphasized both the significance of the therapists' acknowledgment of human processes and the importance and meaning of clients' effort to change. This emphasis improves the opportunity to "put things on the table". As Stein said,

In order to achieve change, one has to give a type of acknowledgement, “sow some seeds” that give hope for change. No matter how hopeless it looks, we as therapists have to express faith that change can happen no matter what. (S1, 1538-1550)

Although the focus is to acknowledge clients’ “battles with the problem”, potential concerns must be expressed to the family. Therefore, the participants preferred to use questions at the level of intention and honouring ceremonies so that the person will experience being respected and cared for, although interventions must be made.

5.4 Therapeutic processes

An important finding in my research relates to the process of therapy. The overarching competence of “therapeutic processes” is divided into three skills, namely, (1) child-centred family therapy, (2) feedback and evaluation, and (3) emotional expressions in therapy. *Child-centred interventions* are categorized by the participants as thoughtful focuses on developing creative and age-appropriate adaptations of the therapeutic approach. The participants described the feedback and evaluation of the therapeutic process as central. *Feedback and evaluation* describes the participants’ activity of gathering practice-near feedback from their clients to continuously adjust the treatment to follow the needs and wishes of the family. The category of *emotional expressions* describes how therapists relate to their clients’ and their own emotional feelings and expressions in the therapeutic process.

5.4.1 Child-centred family therapy

The participants described a continuous focus on providing child-centred interventions. However, the participants differed between their philosophical stance toward child-centred interventions and how interventions should be conducted. Therefore, I divided this category into two micro-skills (1) the child’s perspective and (2) creativity.

The child’s perspective

The participants emphasized that ensuring and organizing to hear the child’s voice is a fundamental premise of systemic therapy and the Norwegian Directorate of Health’s guidelines. The participants also describe a comprehensive focus on child-centred interventions, in addition to considering the child’s developmental stage (see also, 5.2.1 normative judgments). According to the participants, many children who are referred to BUP

are wrongly assessed as unmotivated for therapy often because the therapist's expectations are not adapted to the particular child. As expressed by Martin,

Many of the children aren't motivated in the first place and often answer, "I don't know". If I get an "I don't know" as an answer, I'm quiet and count slowly to 7 to myself. In half of the cases, I get an answer. They just needed to think a little bit. (M2, 414-432)

The participants emphasized that it is important to notice that even when a child says, "I don't care", "I don't know" and so forth, these comments can be an indication that the child has finally stopped taking their difficulties on his/her "young shoulders." Children are often masters at seeing and sensing signals, and they have a tendency to know far more than what their parents believe they know. Thus, even as they arrange for the child's voice to be heard in therapy, therapists must be attentive to the fact that the child can find it difficult to put their thoughts, feelings and experiences into words. One reason for this difficulty is that sharing thoughts and experiences can challenge a child's loyalty to his or her parents. The participants said that children's stories can be harrowing, and in many cases, it is difficult for parents to hear their children discussing them. Therefore, the participants underlined the importance of the parents being taken care of (for example, by contacting their treatment professionals in adult mental health and by "plugging in" family members) if the topics that the children present can especially impact the parents. The participants indicated that their loyalty always lies with the referred child and that interventions are made (if necessary) so that the child is not made responsible for the care of his or her parents. As expressed by Nora, *We have to avoid a situation in which the children are becoming responsible for their parents' choices* (N2, 394-398).

The participants described that a recurring dilemma in family therapy conversations is to assess how much children should know regarding the parents' understanding of the family's difficulties, the referred client and/or their own psychiatric difficulties. However, the participants emphasized that children's fantasies concerning the problems are often worse than reality. Because children know more than one likes to think, the participants said that a goal is to arrange for open conversations on difficult topics. Nora said:

Children often think it's good to hear their parents' stories with regard to psychiatric illness and other things because even though it can be difficult to hear, they have understood that something is wrong. Openness can therefore make the world more understandable. (N1, 535-543)

When children wonder about, for example, their parents' diagnoses, the participants said that it is possible to invite the responsible treatment professional (of the adult) to therapy if desired. However, the participants said that it is necessary to make continuous assessments concerning what information is to be shared by the external professional and whether the information that is to be shared is good for the children to hear or whether it may be harmful. As expressed by Stein,

I try to put myself in the place of the child to sense to what extent what the parents say is fine or if it would be harmful to the child. If the parents don't protect the child from potentially hurtful or damaging statements, I have to limit how freely they can speak. At the same time, I will be interested initially to see how far they actually go and how the child reacts. (S1, 980-1013)

In situations of high conflict, the emotional atmosphere and the conflicted tone can easily be understood as something that the child must immediately be protected from. However, these situations may represent a somewhat "normal" environment for the child in his or her everyday life situation:

If the level of conflict is well-known to the child, I don't get too agitated because, if the level of conflict is known in the family, it might be new to me, but for the child, it's just "another brick in the wall." (M1, 504-510)

The participants said that although high-conflict couples are not a described focus in child and adolescent mental health, they also work with these problems when appropriate. In these cases, the child's perspective and probable thoughts will be central and asked about in conversations in which the parents are present.

Creativity

Another topic that the participants discussed as central to therapeutic processes is creativity. All participants emphasized that children's and adolescents' expressions go beyond the use of words. Thus, systemic therapy requires therapists to facilitate creative ways of working that involve more than words. Tuva said:

Children can't be expected to contribute if they are only placed in a verbal context. Children "own more" of what they have said when it's said with modalities other than language. Our child expertise concerns organizing for communication that isn't exclusively verbally based. (T1, 1739-1763)

The participants emphasized creative approaches as crucial for children and adolescents to participate on their own terms and to capture their interest so that the therapeutic process does not become too boring. Accordingly, the participants noted many creative approaches, for

example, using “post-it notes”. On these notes, each person writes down three things that he/she wants more of in the family and three things that he/she wants less of. In this way, the therapist(s) can quickly become acquainted with the family, and the family members can become acquainted with one another’s points of view. After this exercise, all points are written down on the board, which creates a starting point for the coming dialogue. To ensure the parents’ participation, one of the parents, for example, can be responsible for writing the points on the board. Another possibility is to “open up” for the children to write the points. By actively using the board, information can emerge concerning sibling dynamics with regard to seeing who writes first, whether someone is excluded, and so forth. The post-it notes were also described as helpful in regard to structuring the therapy so that children do not become overwhelmed by all of the words, and this approach contributes to preventing the (often) talkative adults’ voices from becoming dominant. This method also gives children “ownership” of their own statements. As expressed by Tuva, *Our experience is that this [the post-it notes] is a way to give children an “ownership” relation to their own comments, which stops verbal expectations of them from becoming too great* (T1, 1717-1733). The participants also described using the post-it notes in a more ritual form to change the use of undesired language in the family. For example, ugly words that are used against the wishes of the family are written on the post-it notes. Thereafter, the notes are “crumpled” up and thrown in the rubbish. The rubbish bag is tied up, and all family members who were involved in this part of the problem collaboratively throw it out together.

Future dreaming is another creative intervention that was described by one of the participants. Future dreaming is described as a good supplement to discussing plans and short-term goals and how to reach them. As described by Martin,

Instead of talking about the future, we “go there” and talk about it, preferably in detail by using a number of sense modalities [such as how it looks, who is there, and what it smells like]. The advantage of doing such future dreams is that it is not possible to answer incorrectly as the events have not happened yet and everything is therefore possible. Dreams do not need to be realistic. Dreams can be exactly as one wants and can create conditions for another way of speaking about oneself, about life and one’s relationships. (M2, 1148-1170)

In my fieldwork observation notes, I wrote about this technique after observing how future dreaming was used:

The therapist uses a form of thought experiment in which the client is “taken forward in time”. The therapist then explains how he and the client will coincidentally meet somewhere. They complete a longer conversation following this that begins in the

future scenario. They talk among other things about how her world looks, how she is and what it is that led to the occurrence of all the positively described changes.

The participants said that future dreaming can open the ability to see hope for the future and the identification of several “roads” to travel to achieve one’s goals for the future. With this approach, the participants noted that parents are often impressed by their children’s creativity and often listen to their “future dreams” with respect and honour.

The children’s need to be engaged makes it necessary for the creative “toolbox” to be large. Stein said: *The therapy has to be “cool enough” if it’s to engage children and teenagers* (S2, 789-7989). The participants named several creative approaches that are occasionally used, such as the *use of “mirrored rooms”* [where available], *role-play, puppet theatre, a “jungle trip” in the gym* [if available], *metaphorical language and drawing/the drawing of cartoons*. Most of these approaches are self-explanatory. Nevertheless, I briefly describe how two of these methods (metaphorical/externalizing language and drawing) were used by the participants. The use of metaphorical and/or externalizing language regarding difficult topics can make it easier and safer for children because it does not linguistically identify problems with any particular family member and can contribute to creating distance between them and the problem. For example, Martin noted that *anxiety is often named as “the dark bogey man” and the like* (M2, 1208-1210). With the help of animal names, for example, it can also be easier for children to name difficulties that they otherwise do not have the language to describe. Similarly, drawing was also identified as an appropriate approach, for example, by drawing a cartoon series in which the next frame remains open (where what one wants to occur will be drawn). The “frame” can remain open until the next conversation in which the child is then asked to draw how things have gone since the last time. To the extent that this new drawing is consistent with the child/family’s previous wishes, the process can create a starting point for conversation.

5.4.2 Feedback and evaluation

All of the participants related that the skill, feedback and evaluation from the client(s) are necessary for the therapeutic work of change. In this connection, the participants repeatedly described being inspired by Miller and Duncan’s (2004) outcome rating scale (ORS) and session rating scale (SRS). However, according to the participants, client feedback is still mainly evaluated through the client’s answers to questions (that are posed at the end of each

session instead of using the ORS/SRS). Because the therapist can be viewed as the individual who is responsible for the therapeutic process of change, client feedback is necessary to ensure that the course of therapy is experienced as relevant with a basis in the clients' described goals. These goals are based on the original referral if it is consistent with the wishes of the family. If not, new goals are made based on the family's described needs and wishes. Therefore, feedback from the clients is gathered at the end of each session. As described by Martin,

I ask at the end of the sessions, has this been helpful, have we talked about what we should have, have I heard what you have said today, has the way we've worked been helpful, what could have been done differently. (M2, 886-900)

Relative to assessing the reaching of goals and the direction of therapy, the participants said that they give clients great power in defining what has been helpful. Therefore, therapy is to a small extent based on previously defined interventions but is adapted to the clients' wishes (within ethical guidelines) throughout the entire process. As described by Martin,

The therapy is more feedback-driven than manualized. The closest to a manualized approach is that I always, in conversations with one or two family members, ask about what the signs will be that we're moving in the right direction and how we'll know when we're finished and the like. (M1, 1808-1822)

If the feedback from the clients suggests that the goals are not being reached, then the participants stressed the importance of asking what the cause may be. Thus, the participants said that then they can share their own experiences of a lack of success over being unable to contribute to the desired change in therapy. This sharing is important because the participants considered themselves responsible for a therapeutic process that does not lead to the desired result.

When the treatment hasn't worked, this is experienced as a crisis for the treatment professional, and then, our cognition often gets narrowed down, and our affect becomes characterized by crisis, and then, one often tries more of what hasn't worked. More of the same leads to escalation. (R1, 1619-1628)

Another topic that the participants discussed was that the therapists must be conscious of "typical" reactions when results do not appear, and they must ensure that client feedback creates a starting point for a changed therapeutic direction. Therefore, the clients are invited into a dialogue regarding which changes they consider to be appropriate. Nevertheless, if the clients desire a linear approach (or a similar method that is considered to be contradictory to

the systemic approach), then the therapist will assist the family by referring them to the desired service, if possible.

5.4.3 Emotional expressions in therapy

As part of a therapeutic process, the participants discussed the skill, emotional expressions in therapy, which appear when difficult topics occasionally lead clients to emotional expressions (such as tears or crying) during the conversations. All of the participants expressed a continuous focus on the clients' emotional expressions because this focus is a potential "way into" identifying topics that are important for the client to discuss. However, the participants also emphasized how their emotions as therapists can influence their clients.

The participants described that a therapist should legitimate the family members' expressions through emotional attunement; simultaneously, the client should feel that he/she is verbally affirmed and acknowledged. Accordingly, therapists are considered an important emotional confirmer; however, therapists should be conscious that their emotionality is not the focus. Thus, emotional expressions should not be viewed as "noise" but as important information. Regardless, the extent and degree to which a therapist comments on emotional expressions are considered dependent on the therapist's knowledge of the client(s) and their assessment of the client(s) as being able to tolerate "going into" them. Therefore, the participants stressed the necessity of deciding early on in therapy with the family how the therapist should relate to the situation if strong feelings are expressed. As described by Nora,

If I see the emotional expressions for the first time or am uncertain about what this is an expression of, then I ask: do you want to name what it was that released this and/or is it OK that we continue? (N2, 21-29)

All of the participants described being concerned with the clients' emotional expressions and observed that if the therapy does not move people emotionally, it is in danger of being unable to create change. In this regard, a comment was also made that one participant often observed a changed and more nuanced level of reflection (especially in the parents) after they had been emotionally moved. Nevertheless, as a researcher, I observed very little focus on emotional expressions during my fieldwork. As described in the fieldwork notes,

It is remarkable that given all the times the participants in the interviews expressed great focus on naming clients' emotional expressions, I apparently don't see this during my field observations. Instead, the clients' emotional expressions seem to be passed over "in silence". It is possible though that the therapists express a form of

bodily emotional confirmation or other ways that I in my observer role don't notice.
(Fieldwork observation notes)

The focus that the therapists described and the distinct difference between it and my observations are presented in part 5.7, *A descriptive account of the fieldwork observations*. Thus, several of the participants described that they work just as much on the basis of their own emotions as with rationality. The participants also indicated that they name their own emotions in the therapeutic conversations. However, the participants were aware that they do not want the client to navigate the therapists' emotions, but they want to show through language that they are transparent and that they simultaneously "encompass" the clients' expressions.

5.5 Therapeutic practices

This finding concerns the identified therapeutic practices that the participants described. The main competence "therapeutic practices" consists of the participants' descriptions of several therapeutic practices that they use. I present these practices through the following four skills: (1) language practices; (2) narrative practices; (3) solution- and strength-focused practices; and (4) reflecting practices. The skill, *language practices* consists of the participants' descriptions of language-focused interventions relative to delivering a social constructionist-influenced therapeutic approach. *Narrative practices* contain descriptions of the participants' focus on narratives and outcomes. The skill about *solution-focused practices* is characterized by clinical descriptions of a resource- and solution-oriented therapeutic focus. *Reflexive practices* consist of therapeutic elements that are used to ensure that the utilized interventions and chosen solutions are reflected and nuanced.

5.5.1 Language practices

The skill, "language practices" presents how the participants use different language practices as part of their therapeutic approach. The category is divided into four micro-skills (1) negotiated language, (2) positive connotation and reframing, (3) metaphors, and (4) externalizing as a language and as a method.

Negotiated language

The participants said that one language practice that they used was negotiated language. The participants expressed that this practice concerns meaning as constructed in social interactions and negotiated through language. The use of a “disease language” of mental health and its somewhat difficult professional terminology is described by the participants as being potentially inappropriate with regard to creating an unnecessary distance between the therapist and the family. As expressed by Stein, *A medical/disease language can quickly become limiting and alienating* (S1, 284-290). Martin said relative to this that: *The problem starts when one tries to use the same language when one talks about a somatic disease as when one talks about interpersonal relationships* (M1, 2432-2436). Therefore, the participants attempted to use everyday language and the clients’ own words when talking with them. In addition, the families own language is sought in connection with the topics that are to be explored.

The shared meaning that is created through language is assessed by the participants as a meaningful process. Accordingly, therapeutic conversations significantly involve the arranging of good dialogues with a focus on the change-creating qualities of the family:

To create good dialogues between family members when someone is worried is demanding, because their language is usually not very phenomenological but more often characterized by a focus on things that confirm diagnoses. Then, it's important to try to turn the focus to concern what there might be about the other that could contribute to something that can be change-creating. (E2, 31-41)

Conversations that facilitate change also require that the therapist is conscious of the way in which the family discusses itself and its difficulties. Therefore, these conversations attempt to contribute to a reversed focus from the negative and are limited to facilitating conversations in which all family members are heard. Change facilitating conversations also promote the narratives that are open to life content that is built on recognition, self-preservation and self-confidence.

The participants said that in working with axis 5 problems, it is important not to “ignore the potential double” in the communication and thus go “into” the complexity and self-contradiction that are expressed. As explained by Roar in these two quotes,

If I see or experience double communication, then I'll mention it, but I will also take with me Maturana's thought about when people do as they do, it's because they can't do it differently. At each moment, when a person does something, then it's because you

are who you are in the moment, and in this sense, it's neither good nor bad. After the fact, one can look back to evaluate to what extent it was good or bad but not before then. (R2, 1596-1615)

What is difficult with double communication is that it's easily connected to pathology. However, with Bateson, it's connected as much to creativity, for example, in the case of the mad artist. (R2, 1560-1571)

The participants said that the “double in the message” is often considered a starting point to invite the family to a shared exploration of the expression of the message, how it is understood and the message that one wished to convey. Simultaneously, the understanding of the person as well-intentioned is upheld. Therefore, the potentially good intention is acknowledged by the participants while avoiding pathological explanations of the double message. Regardless, the participants acknowledged how difficult it can be for the people who are affected by double communication.

Positive connotation and reframing

This micro-skill has some obvious similarities with *Being appreciative*. Nevertheless, positive connotation concerns how the therapists position themselves regarding their understanding of humans and their difficulties. The micro-skill about “reframing”, however, places the therapists in a position of action. Reframing describes how the therapists’ position influences and is completed in clinical practice. For example, reframing can be accomplished through “parallel listening”. Parallel listening concerns listening for descriptions that can be positively reinforced. As expressed by Tuva,

I am always on the hunt for something to praise. Therefore, I listen “in parallel”: what is it they’re actually saying, out of what they’re saying, what can I positively reinforce, which other/preferred ways are there to understand this? (T2, 1129-1135)

As part of a helpful therapeutic conversation, the participants reformulate the difficulties, attempt to view them in different and more preferred ways, and look for strengths and possibilities where the family sees weaknesses and experiences itself as stuck. However, the therapist must “guard” against becoming uncritically positive because this can easily be experienced as naive and as not taking the family’s difficulties seriously. As described by Stein, *One should acknowledge but not reformulate into the unrecognizable. One should also not make the client “blind” to his own inadequacy* (S1, 810-816). Thus, serious descriptions or events should not be uncritically reformulated. Positive connotation is primarily used to

avoid inappropriate and pathologizing disease talk that identifies the difficulties in a person with a corresponding lack of power to change.

Metaphors

Through my field observations, I became aware that all of the participants used a dominantly metaphorical language in most of the circumstances in which the problem or the family's interaction is discussed. An example of this metaphorical language was when a family discussed its struggles and said, "It feels like we are on a boat about to overturn." In the interviews, metaphorical descriptions of problems were described by the participants as appropriate because they are often more easily linguistically manageable for clients. In this way, the metaphorical naming of the problem does not restrict the therapeutic conversation to painful and specific descriptions. If a therapist makes her own metaphors that are based on the family's difficulties and/or interactions, the participants said that it is important to use a language that is as close as possible to the family members' own ways of expressing themselves. Accordingly, the family's own linguistic expressions were described by the participants as always preferred, and a goal is to use the family's own metaphors if possible. As Nora explained, *If the clients come with their own metaphors, I'm aware of getting hold of them and using them further* (N2, 179-192). In this manner, the therapists' metaphors will represent the family and contribute to giving them "ownership" of the therapeutic process.

Externalizing as a language and as a method

In all of the therapeutic conversations that I observed during my fieldwork, externalizing (and metaphorical) language was consistently used when problems were discussed. Based on my fieldwork notes and analysis of the interviews, I can identify two different ways in which externalizing was applied, namely, (1) externalizing language and (2) externalizing as a method. The use of externalizing language was performed by the participants in the first conversation, regardless of the client's age, and it consistently referred to difficulties through externalization. As expressed by Martin,

I have internalized an externalizing way of speaking about problems. For example, as far as I know, the original reason you got in touch with child and adolescent mental health was that you'd gotten a type of eating disorder. (M2, 244-264)

The participants described that by using an externalizing language, they found that it became easier for the clients to discuss the problem because it was less guilt-inducing and the

therapist was not interested in finding a “scapegoat”. “It’s the problem that is the problem”. By using an externalizing language, it was also possible to use humour and irreverence on the nature of the problem without this being experienced as disrespectful to the client.

Externalizing as a method involves a more specific way to externalize how a therapist systematically interviews to locate the consequences of the problem, before the family members are thereafter invited to name the problem. The participants described that externalization is used to prevent the family from becoming infected by the destructive powers of the problem. Externalization was described by the participants as mainly being used in the work with young children and often to enable conversations regarding serious scenarios and conditions, for example, in the referred patient or relative to illness in the parents, without the condition or illness being placed “in” the person:

By externalizing psychiatric symptom profiles, we visualize quite a lot, especially in work with younger children. Often, drawing is used, and an example is that I ask a younger sibling to draw her big sister’s anorexia: how would the anorexia look, etc. (T1, 328-337)

By externalizing even severe problems, the participants claimed that difficulties are not so emotionally close and can therefore be experienced as more manageable. Externalization takes up much more “room” in the therapeutic intervention than if a therapist only used externalizing language. In externalizing language, the externalizing “flavour” of the words is simply one of many different therapeutic elements.

5.5.2 Narrative practices

The skill “narrative practices” evolved after I identified two different approaches to narratives by the participants. The participants emphasized the exploration of narratives as a way of creating preferable unique stories in which the family’s problem was not dominant. Simultaneously, the participants described that even they could share some of their own narratives with their clients to facilitate collaboration and equality in the therapeutic relationship. The skill “narrative practices” consists of two micro-skills, namely, (1) narratives and unique outcomes and (2) sharing narratives.

Narratives and unique outcomes

The participants described that the narratives of many of the referred patients and families are often characterized by uncertainty and inadequacy. Einar explained:

People in crisis become disturbed by meeting “the wall” of expectations about everything they were supposed to understand and master, and this makes them often doubt themselves, their resources, get angry and feel like failures. (E1, 822-832)

Although it is not a goal to change anyone's history, it is a goal to find ways for a person to live with it. The participants indicated that one objective is to obtain the narratives that describe unique outcomes. As Einar said, *in the work with the most difficult families, it is necessary to get hold of the “small weak” sentences that describe exceptions and what they've achieved* (E1, 105-111). In this regard, the issue of exceptions can be an entry into posing questions regarding action, intention and an identity plan to create more substantial and preferable exception stories. As described by Martin,

I am not supposed to be the one who sits and points and shows things, but I can ask questions that get the others to “hammer together” these individual exceptions into a more coherent exception story that says something about their goals, ideals, aims and intentions. (M2, 495-502)

The therapeutic process shows that the family's fixed problems have several potential solutions (by researching the unique outcomes) and also expands the space of available actions for the family. In this connection, through my field observations, I became aware that all of the therapists posed many questions regarding exceptions and that many exceptions were continuously described. Nevertheless, the exceptions appeared to be “followed up” very little by the therapists. This observation is further discussed in part 5.7, *A descriptive account of the fieldwork observations*.

The participants described a clear focus on narratives and simultaneously gave examples of how the client's problem-focused story is told repeatedly by the client or his/her family. Often, these stories are told without unique outcomes. The participants' theoretical understanding of the lack of unique outcomes is that the clients create an “opposition” to the perception that there are elements of their narratives that the therapist does not seem to have heard or perceived in a way that has meaning to them. In the cases in which the participants described being observant of the repeated, negative stories, they tend to note this to broaden their own understanding of the problem. As described by Martin, *What you say now, I've heard you say so many times. I understand that it's important for you, so you have to help me to understand what you're saying* (M1, 583-589).

Sharing narratives

To make the family's problems more manageable, the participants focus on reducing major concerns and/or lowering themselves from an expert position. The participants said that they occasionally use their own experiences and narratives when talking with clients. However, the participants were aware that they must not appear to be flawless or examples of the "perfect family life". Accordingly, the stories that they share with clients should preferably be halfway success stories that implicitly make the therapist equivalent to the family. As described by Stein, *by using stories from our own lives, you make way for an evening out of the relationship. We're all people with many of the same challenges and experiences* (S2, 1383-1388). The participants also make continuous assessments concerning the extent to which "sharing one's life" is viewed as having the potential for therapeutic change or whether the families own stories is the best starting point. If the participants share parts of their "own life", they are aware not to apply their own feelings to other people. Tuva said:

I don't want to apply my own feelings to others, but I can use my own emotional register to confirm that I was moved as well. Anyway, I don't embroider on my own feelings. (T2, 1488-1494)

A combination of the shared narratives of the participants, clients and families is often the starting point for the abovementioned challenges.

5.5.3 Solution- and strength-focused practice

All of the participants had a clear focus on the skill, *solutions and strengths* in all of the interviews and during my fieldwork observations. However, referrals to child and adolescent mental health are often characterized by problem descriptions and are less directed toward clients' resources, what they have achieved and what is important to them as a family. As expressed by Einar, *It is paradoxical that what treatment professionals want for the families is to be achieved through descriptions of how they've previously failed* (E1, 423-426).

Therefore, the therapists were not very interested in asking questions about the problem if the client did not desire it:

Unless the family is concerned with it, I'm not so interested in asking questions about the problem, its history, reasons, etc. The more solution-oriented part of me says that all facts belong to the problem, and the more we talk about the problem, the more sides of it get discovered and the bigger and more powerful it gets. (M2, 574-589)

With a resource-oriented focus, the therapists said that it is important to make realistic, surmountable goals for therapy. As described by Martin, *We are eager to bring the coping perspective into action but at the same time not create “a fable”* (M2, 477-481). Consequently, the participants were conscious of “capturing” possible positive changes in the interaction patterns of the family and facilitating dialogue that concerns finding strategies and suggestions for solutions other than the suggestions that the families have previously tried. Thus, the therapists punctuate family stories with a focus on solutions and strengths that can be expected to have the best potential for change.

5.5.4 Reflecting practice

Therapy as a reflexive practice was a skill, repeatedly emphasized by the participants. To safeguard a reflexive practice, the participants described both their own theoretical basis for being reflexive and different ways of exercising reflexivity in practice. The skill “reflecting practice” is accordingly divided into the following four micro-skills: (1) being a discussion partner; (2) acknowledging differences; (3) listening and reflecting positions; and (4) the use of a co-therapist.

Being a discussion partner

The participants described the families themselves as having the power to define which solutions they assess as appropriate (within ethical frameworks). It was also described as the therapists’ responsibility to account for potentially negative aspects that the clients’ choices could have so that the families could make nuanced and reflective choices. The participants offered themselves as discussion partners who not only confirm the person’s experiences but also challenge his thoughts and perspectives so that several sides of the same situation are revealed. As expressed by Stein,

Some people have grown up in a family culture in which the emotional and practical are so limited that it is difficult to think/see the possibility for anything else. (S1, 1128-1134)

As a discussion partner, the participants do not consider themselves to be in a position where they should define people’s actions as wrong. Instead, the participants use the clients’ and families’ own experience as starting points for discussions and reflections concerning how they can solve future challenges.

Acknowledging differences

The participants described themselves as attempting to be nuanced and reflective in regard to acknowledging other family members' diverging views of the same phenomenon. In this way, the participants described having a conscious connection to exploring family relationships with differences or disagreements. As described by Martin,

In some families, disagreement is a source of inspiration and enrichment, while in others, it can be a threat of dissolution. Therefore, I want to ask: "How is it with you, how do you see this differently, what relationship do you have to viewing things differently?" (M1, 1359-1379)

If the differences are considered irreconcilable or very divergent, then the participants indicated that one goal is to challenge the family members through dialogue to find ways to acknowledge and live with these differences, although they disagree. For example, questions such as the following can be used: "*If you, despite your disagreement with your father, were to try to see something positive in what he has said, what would that be?*" In this manner, differences and disagreements are facilitated so that they can be explained and understood although they cannot be shared.

Listening and reflecting positions

The participants described that good dialogue requires that "what is said needs to be heard by the desired recipient". Therefore, the participants facilitate listening and reflecting positions for clients in therapy. When it is necessary to structure the listening positions (for example, with the help of physical distance), this is assessed in each individual case. As described by Tuva,

When someone goes into a listening position, we mark this with them putting themselves slightly away from those who are to speak. We make a physical distance between those who are to listen and those who are to speak. After one has finished speaking, the co-therapist talks to those who've been in the listening position about what they've heard/been concerned with. (T1, 1965-1966)

The participants described it as particularly necessary to strictly structure the listening position when families or parents are in high conflict situations. In these cases, the participants are clear regarding who should speak, as well as when this person is expected to be in a listening position. The participants emphasized that it is not required that divorced parents in high conflict situations should talk to one another, but it is expected, at a minimum, that they should be able to speak with the therapist while the other listens. As Tuva said:

In those cases, in which there is much conflict and dysfunctional communication, we use the listening position a lot. That is, we concentrate not only on content but also on the form of the communication exchange. (T1, 1925-1893)

The participants emphasized that the focus of the therapeutic work does not need to concern the “specific” problem but can attempt to improve the family’s communication about the problem(s). Although clearly reflective positions (where the people who are listening are placed outside the circle) are frequently used, it is equally important to facilitate general listening and reflective conversations even without the use of particular listening positions. The participants said that the family is often invited to a conversation concerning what is a good framework for them so that listening positions can be performed. Through listening positions, family members can listen to one another’s experiences and ideas instead of going into a well-known argument and/or “standing on the barricades”. Listening and reflective conversations also pose demands on the therapist to tolerate silence for important messages to have room to emerge. As Martin explained,

It's when there are pauses in the conversation that the participants have the opportunity to listen to their inner dialogue. I also think that, when I can manage to keep my mouth shut, helpful and useful things come from the others that they've had the opportunity to talk about since I haven't been talking. (M2, 383-399)

With a starting point that is based on the goal of being transparent in their therapeutic approach, the participants describe the possibility of sharing their reflections after they sit in the listening positions. However, the families own reflections are considered the most important by all the participants.

The use of a co-therapist

To expand and nuance the family’s actions and reflections, the participants claimed that it is often an advantage to work with a co-therapist. Working with a co-therapist can also give clients opportunities that could otherwise be difficult to address with only one therapist, for example, if there is a wish to divide up the conversations (e.g., siblings, parents) (see the micro skill *working flexible with the family system*). The participants also described that the inclusion of the co-therapist is very important when there is high conflict. As Tuva said,

In high conflict cases, we're aware of always being two. When the conflict is tough, we have to be two in all the segments to ensure that we don't strengthen the conflict and end up going along with something destructive. (T1, 2321-2357)

The use of a co-therapist poses demands that the conversation is structured so that there is little doubt concerning who the “main” therapist is. The participants indicated that this structure ensures that the contributions of the co-therapist do not become too divergent and are not experienced as competitive. As expressed by Stein, *If the co-therapist is in possession of a specific competence, this can sometimes take up so much space that the main therapist's contributions get marginalized* (S2, 663-672). Consequently, the main therapist reserves the right to not follow the co-therapist’s ideas if he determines that these ideas can lead the family down a non-beneficial track. Thus, the participants stated that it is desirable for the co-therapist to contribute as the main therapist’s “sparring partner”, and he can also participate in the therapeutic conversation by asking questions and reflecting on some issue that a person becomes concerned with during the conversation. In addition, the co-therapist is often used as a participant on the reflecting team. As described by Stein,

Often, the co-therapist and the listening parent are put into a listening position in which they are then asked to reflect on what they have heard after the main therapist and the other parent have talked together. (S1, 645-650)

However, when a reflecting team is unavailable, the main and co-therapist can speak together as a reflecting team with a basis in the prior therapeutic conversation.

5.6 Session-specific competences

The participants also discussed some session-specific competences in systemic therapy. However, through the interviews and fieldwork observations, it became apparent that the competences in systemic family therapy are difficult to define beforehand as purely belonging to a specific period of the therapy course. Additionally, it emerged that each of the phases (initial, middle and ending sessions) had some aspects that seemed to be session-specific. Therefore, these aspects are divided into the three skills (1) initial sessions, (2) middle sessions, and (3) ending sessions.

5.6.1 Initial sessions

The “initial sessions” were described by the participants as consisting of several phases. The overall focus of the initial sessions is to safeguard the client/family’s integrity and ensure that there is a joint decision on the goal of therapy and the facilitation of a tailored therapy process that meets the demands and needs of the client/family. The skill “initial sessions” is divided

into three micro-skills, namely, (1) the becoming acquainted phase, (2) shared decisions on the therapeutic process, and (3) tailored therapy.

The becoming acquainted phase

The phase of becoming acquainted was described by the participants as consisting of introductory conversations. According to the participants, the introductory conversation(s) can be considered to be somewhat therapeutic conversations, but they function in many ways as a becoming acquainted phase that is characterized by the reciprocal exchange of information. The families are expected to share information about themselves, their challenges and family relationships. In this phase, the participants said that they share information regarding patient rights, the workplace context and frameworks, their relational and contextual emphases and their roles as therapists and social controllers. Subsequently, the family is given the opportunity to accept or decline further treatment. The introductory conversation(s) also helps to clarify the practical process of therapy concerning how the family organizes its life to participate in the therapeutic process (e.g., childcare, leave from work). Through the introductory conversations, the goal is for the family members to feel secure that their integrity are respected and that every individual's voice will be heard and acknowledged. As described by Stein,

In the beginning, the conversations are about building trust, faith and making frameworks that show that one can talk about everything and be heard and acknowledge one's thoughts and experiences. (S1, 1580-1586)

The participants described that early in the treatment, they want to determine who in the family has the most interest in attending therapy, the second most interest in attending therapy, and so forth. This assessment provides an impression of the family and each family member's intentions and eventual agreement regarding the extent to which therapy can be appropriate. According to the participants, often only the parents and the referred child participate in the introductory conversations before the therapist "expands" in collaboration with the family later in the therapy process.

Shared decisions on the therapeutic process

The participants described that a doctor, pedagogical-psychological service, psychologist or child protection institution refers all cases in child and adolescent mental health. In addition, cases can be referred internally among the different units in child and adolescent mental

health services. In the referral, the patient's difficulties are described. Often, the suspected reason for the difficulties is described, in addition to suggestions for therapeutic treatment. There are often great differences between the referent's wish for the family/client and what the family feels that they need help with. If the family does not agree with the referent's "service order" and its descriptions, it has little worth as a starting point for therapy. If the case is referred internally, then it is also most likely that a lack of results is the background for the referral. Accordingly, the participants emphasized the importance that additional treatment offer something different from what has previously not worked. The participants invite the family to a dialogue in which the referral is explored to create goals for the therapeutic treatment that are consistent with the family's wishes. If there is a major disagreement between the referent's "order" and the family's wishes, the family's wishes take "priority" because it is crucial that family members have ownership of their goals. However, if the client/family's wishes are too different from systemic therapy's epistemological starting point, the therapist begins a negotiation:

If the parents have a clear order, for example, advice and guidance, then we preferably try to expand this by including that we also look at the interaction in the family. We don't do pure information transmission. (T1, 1333-1342)

If the family's wishes diverge substantially from systemic therapy's epistemology, then the case is transferred to a unit where the family's wishes can be satisfied. There can also be internal disagreements in the family regarding what the goals should be for the therapy process. As noted above (*Acknowledging differences*), the participants stated that one therapeutic goal is to facilitate family members' acknowledgment of one another's wishes and perceptions. Thus, the family members are invited to a dialogue concerning how their different wishes can be included in a common "order", which is the extent to which they can agree on a central goal that can also be expected to have the power of change relative to their own goals. Once a shared goal has been agreed on, the family is asked regarding what a sign may be that the goal has been reached and that the therapy is nearing its end. The family's answer will subsequently be used as an indicator to assess where the family is in the therapy course.

Tailored therapy

The experience of the participants is that pre-planned therapy is not necessarily what best fits an individual family. At the beginning of the therapy process, the concrete approach is therefore tailored in collaboration with each family to optimize the treatment. As Einar said,

Tailoring is about when families come to us, we wonder together with them about how we can work together so that they can get help for what they came here for. Therefore, we make a treatment offer that is specifically adapted to the individual family. (E1, 243-251)

Although the participants are experienced therapists, the family is still considered to be in the best position to know what it needs. As described by Martin, *I am an old shoemaker who knows a lot about making shoes, but it's the client who knows if it fits the foot* (M1, 2275-2279). Tailoring is described by the participants as a factor not only in adapting the approach but also in considering the frequency and length of conversations and how the conversations should be conducted (within realizable frameworks). For the therapy to be tailored, the participants said that the therapeutic approach must also be evaluated regularly and that it is crucial for clients to regularly be given the opportunity to evaluate the form and direction of therapy. Einar explained:

We have an attitude that "the suit should be as they want it", and then, we have to watch out and adjust it so that it's not too small, wide or uncomfortable. It has to feel good, and to achieve this, we have to ask the entire way (E1, 280-290)

Although a “tailor-made” treatment was described as evident in all cases, it is performed differently in each individual case because families have different wishes concerning how they want to influence the treatment’s many elements. Therefore, tailoring is a taken-for-granted attitude in each individual case, if not a stringent methodical approach.

5.6.2 Middle sessions

The participants described the middle sessions as the working phase towards change in the therapeutic process and where many of the therapeutic competences are put into action. The category of “middle sessions” is presented as three micro-skills (1) the working phase, (2) parental activation and (3) working flexibly with the parts and the whole.

The working phase

After the introductory conversation(s) are conducted, the participants described that they move to the working phase in which the previously described therapeutic elements (some of the abovementioned competences) are put into action. The working phase normally has a clear focus on solutions and strengths. The participants described that this phase involves facilitating change-oriented conversations that have a starting point in the family and the

therapist's described goals. According to the participants, this phase appears to be more questioning and "laidback". Martin said:

I'm more "in charge" early in the therapy course, whereas the family leads more later. I'm then more laidback and even more questioning. Inspired by Michael White, I'm more decentred but influential in the midpoints of therapy. (M1, 1929-63)

The participants described that the therapist's role in the working phase is concerned with structuring and sorting the potentially many topics that arise so that the therapist does not lose focus on earlier, particular focus areas. As Einar said, *There's loads that happens that one can become concerned with, but is it relevant for what they've come here for (the service order)?* (E2, 62-66). It is not a goal that all previously described elements be used in the course of therapy; instead, the therapeutic stance of systemic therapy is pervasive in all phases of therapy.

The participants described that having a predefined time for the next conversation is important. In addition, who should attend the appointment is assessed in each individual case, which is described by Tuva:

Sometimes, we have "open" invitations to the next session, as neither we nor the family right now (for example, one month before the planned session) can know what will happen in the period in between and who then will be the correct person to talk with. (T1, 1460-1468)

The participants also described that they typically have more frequent meetings with the family in the working phase than in the ending sessions.

Parental activation

The participants explained that the parents of the referred child/children are mainly responsible for their children's care. Accordingly, it is crucial that the parents become aware of how important they are to their children's development. The participants were aware of mobilizing the resources in the adult system (parents and potentially "important others") to prevent the responsibility for change or the care of the parents from being placed on the children. As expressed by Stein, *The focus on the caregiver is the most potent in the aim of creating change* (S2, 1459-1463). Therefore, the participants emphasized that the parents must be made aware of the influence that their own lives (for example, the high-conflict

mother/father, mental illness, and an unstable love life) can have on their children. As Nora explained,

It is important to get hold of parents' thoughts about their own psychiatric difficulties and what thoughts they have on sharing this information with the rest of the family members. For example, what is it that blocks them in talking about it, etc.? We also want to get on with reflection with the parents around what consequences there can be for the child/children to know about their parent's psychiatric illness, for example, what fantasies can the child already have about it. (N1, 506-524)

The participants said that parents must be made aware of how a small change or openness regarding one of these areas can have considerable potential for greater change. In this way, the parents are enabled to mentalize how children's possible experiences and ideas regarding their parents' "life projects" can explain children's actions and/or ways of being.

Working flexibly with the family system

The participants discussed how flexible work with both individuals and their families is important. In the working phase, the participants emphasized that it is important to decide how they organize the therapeutic conversations. As Einar explained,

It's important initially to decide with the family who is to talk with whom and how. Everyone's presence can make people guarded with regard to talking about what they really want to talk about. (E2, 265-271)

Therefore, the need to divide conversations can be evident in certain periods in therapy. Einar said:

The extent to which we divide up the conversations with regard to child conversations, parent conversations, etc. is to a great extent about the family's incentives, even though we as therapists can also suggest it. At the same time, one has to consider whether what is said in the room is good for the children to hear. (E2, 247-259)

The participants also said that there could be practical reasons for not having the entire family in the same room because this can be re-traumatizing or practically impossible (for example, if one of the parents is in high conflict). As Stein argued,

With high-conflict cases, it happens that parents in an initial period can't be in the same room, and then we work individually with each one. But, even in high-conflict cases, it tends to be possible to have shared conversations. In the meantime, there can then often be a need for a tight structure. (S1, 594-607)

Additionally, the participants claimed that children do not initially need to participate in conversations concerning the parent system (e.g., disagreement about the children's upbringing, conflict in the couple's relationship). However, the participants emphasized that they are not afraid of allowing things to unfold in the room because the parent system can already be known to the child, and this unfolding provides the therapist with important observations. Martin said:

If the conflict level is well-known to the child, I don't get too agitated, because if the conflict level is known in the family, it's maybe new to me, but for the child, it's just "just another brick in the wall". (M1, 504-510)

How much the therapist will allow the conflict or the situation to play out in the room was described by the participants as dependent on how vulnerable the child/children are and/or the extent to which the child is consciously used to blame the other party for the difficulties that are identified in the referred child. As Einar explained,

If the child is consciously used so that the other party is to understand that they have the blame for the difficulties, then the child is placed in the middle of the firing line, and we want to avoid that. (E2, 539-545).

The child's wishes relative to dividing the conversations should also be met. The participants described that a common problem is that the child/children can feel that it is difficult to discuss sensitive topics if the parents are present. Through individual sessions or conversations with siblings, the therapist can facilitate an agreement concerning how they can take the children's message back to the parents/family when there is a basic expectation that the most information possible should be shared with the entire family, although at a later time. Thus, the therapists can also take responsibility to communicate the child's message.

The participants said that regardless, it is a goal that the greatest possible number of therapeutic conversations should be completed with the entire family present. This goal is defended on the basis of a desire for each individual family member's competence and resources to be revealed to the other family members. Each family member is also assessed by the participants as having a multiverse of exception stories and potential suggestions for solutions. The participants emphasized that if the child/children can also be a witness to the parents who relate to one another in a change-creating and appropriate manner, this can help the children to relax and feel safer. The participants said that such observation can also help the children to not shoulder the main responsibility for change.

5.6.3 Ending sessions

The skill “ending sessions” is based on the dialogues in regard to ending or continuing therapy, either with a changed direction or a changed therapeutic approach. I have divided the skill into two micro-skills (1) reviewing the achievement of the therapy goals and (2) negotiating the ending.

Reviewing the achievement of therapy goals

The participants said that when ending sessions, it was important to review the achievement of the goals of therapy that were addressed by the family members in the initial sessions. In this way, the family’s described goals of therapy and their descriptions of the signs that the goals are reached are used as indicators to assist the therapist in the process of ending therapy. If, on the basis of these factors, the therapist assesses that a family is nearing the conclusion of therapy, the family members are invited to a dialogue concerning the extent to which they have reached their goals. Martin explained:

In the concluding phases, we look back at the family’s original goals for the therapeutic process and ask them, for example: “How far have you come toward reaching your previously described goals?” (M2, 60-76)

In this phase, the participants described a clear focus on the positive changes that have been generated by the family members themselves to emphasize the perspective of coping with their difficulties.

We wish to expand their coping experiences when they move towards conclusion to make visible what they’ve achieved and the belief that they can cope and manage this themselves. Therefore, we want the family to relate the changes that they feel have occurred. (N1, 838-865)

The participants described that the family members are made aware of their own efforts and strategies for change, which can then contribute to generating their own solutions to future challenges.

Negotiating the ending

The participants said that if the agreed goals of therapy have been achieved, then they start to negotiate the ending of therapy. Additionally, in some cases, the families indicate that they do not feel that they have achieved their goals and that the problems have become worse and/or that for other reasons, they do not wish to continue therapy. If earlier attempts to adapt the therapy to the wishes of the family were made without results, or for other reasons, the family

does not wish to continue with the process of systemic therapy, the participants identified their responsibility to achieve a “tidy conclusion”. The participants said that they share information regarding different treatment alternatives and make themselves available to assist in a potential referral process if desirable.

The family itself is described by the participants as having the power to end therapy, but the therapist facilitates it to ensure that all family members’ perspectives are heard so that a reflective decision can be reached. Because difficulties have a tendency to reappear at different “transitions”, such as at the start of the school year or the conclusion of schooling, the family is often given some choices regarding how “absolute” the ending should be. Roar claimed:

With regard to ending therapy, we can do one of three things: we can end, we can set up a new session in six months or a year, or we can put the family on a list and they can telephone if necessary. (R1, 1288-1299)

The participants said that in the ending conversation, they are also interested in advice from the family members regarding whether they should counsel a family with similar difficulties. As described by Martin,

We tend to ask the family in the last meeting if they have any advice for us, if we should meet a family with similar problems as them later on; for example, what should we do differently? In this way, I use “finished” clients as consultants and also bring a little balance into the relationship. (M2, 197-208)

In this manner, according to the participants, the clients’ voices and a balanced power relationship in which the clients’ knowledge is valued are considered.

5.7 A descriptive account of the fieldwork observations

As part of developing a map of competences of systemic family therapy in child and adolescent mental health, I used fieldwork observations as part of this research project. The fieldwork observations were used as part of the GT sampling process to develop the follow-up interviews with the participants. A review of all my fieldwork observation notes shows that they were clearly useful in regard to developing the follow-up interviews with the therapists. I have not considered these notes to be sufficiently detailed and comprehensive to serve as empirical material on their own. However, in this section, I present some of my thoughts and

reflections on the fieldwork observations. I also present some of the questions that appeared from my observations and that were used to guide what I asked in the follow-up interviews.

In the first interview, all of the participants claimed that psychoeducation was not part of their approach and that they only used it if the clients requested it. However, one of my observations was that the therapists sometimes used psychoeducation, even when it was not requested by the clients. In my fieldwork observation notes, I wrote that one of my hypotheses was that the use of psychoeducation was because of the therapists' attempts to "take back" the structure of the conversation when it had become too unstructured and when the therapist seemed to feel that he/she had lost his/her role as the conversational leader of the therapy (i.e., if parents is blaming the child). Based on this observation, I asked some additional questions on this issue in the follow-up interviews, for example, "*What do you think about the use of psychoeducation?*" "*In which, if any, situations could psychoeducation be an appropriate approach?*" Another one of my hypotheses was that the therapists used psychoeducation when the "heat" in the conversations became high or when a conflict arose. By using psychoeducation, the therapists seemed to "take back control" over the conversation. Although the psychoeducation may have returned control to the therapists, it did not seem to "fit" the clients, because they seemed to be uninspired by it. This point is interesting because all of the participants claimed in both interviews that none of them wanted to be described as an expert, using psychoeducation or other normative interventions. The abovementioned stance of the therapist is also identified by the research of Stancombe and White (2005). Stancombe and White identified that therapists attempt to maintain the notion of a dialogical process, but were using rhetorical devices (such as changing the topic under discussion) when the conditions of the discussion were demanding. However, this seems to have the paradoxical effect of reinforcing the families feeling of not being heard, and therefore strengthened the demanding conditions (Patrika & Tseliou, 2015). Thus, the discrepancy between the participants' descriptions and my observations could also indicate that power and collaboration may not work in practice the same way that participant's claim it does in theory and that practitioners may assert their authority or take a more educational stance, wittingly or unwittingly. Also that they draw more on normative ideas than they would like to think. However, this is only my interpretation, and this point was not further explored. Therefore, it is possible that the clients found psychoeducation useful, despite my interpretation of my observations.

In an observer position, it also became visible to me that three of the therapists asked many questions, which generated many unique outcomes for the clients. A thorough focus on unique outcomes was also emphasized by all of the participants in the interviews. However, the therapists did not seem to explore the “unique outcomes” further. Therefore, I asked the three participants in the second interviews the following questions: *“How do you relate to potential unique outcomes?”* *“Which unique outcomes, if any, do you as a therapist consider to be worth following up?”* It is difficult to “pin down” what this is a “picture” of, and it is always easy to be the observer with no responsibility for the therapeutic process. Thus, the fieldwork observation could serve as an argument for the necessity of including a co-therapist who could ensure that the potential crucial moments in therapy (as unique outcomes) are being addressed. However, what is addressed in therapy is subjective and what we do in practice does not always match what we say in theory.

In the first interviews, all of the participants described an objective of working with the entire family together, if possible. However, four of the therapeutic conversations that I observed were conducted with only the parents, the children or an individual who was present. Thus, in the follow-up interviews, I asked the following: *“When, if ever, do you divide the therapeutic conversations into individuals, parents, siblings, the entire family or the like?”* *“When, if ever, do you consider it appropriate to talk with the parents without the children being present?”* In the follow-up interviews, the theme of meeting with the entire family was given “richer” descriptions. The failure to meet with the entire family was partly explained as not always appropriate because of high conflicts and similar factors. Nevertheless, I wonder whether several of the conversations could have been conducted with the entire family together, because all of the participants in the interviews emphasized the potential value of observing the communication and interactions of high-conflict families.

Several times in my fieldwork observation notes, I wrote that I experienced what I understood to be a lack of structure in the therapeutic conversations. Thus, it was necessary to be aware that my ideas concerning an appropriate structure of therapeutic conversations could be somewhat different from the ideas of my clients and the participants of this research. What I considered a lack of structure was especially evident in two conversations. During the interviews, the therapists said that in high-conflict cases, structured therapeutic sessions were very important but otherwise they were not. That is, according to the participants, structure was used only in high-conflict situations or if the lack of structure in the family was part of

the problem that the family wanted to address. I asked all of the participants in the second interviews the following:

“What thoughts do you have about structuring the therapeutic conversations? Which evaluations form the basis for how you choose to structure the conversations? How do you rate the need for structure based in the idea that all of the families you meet have their own agenda and history?”

In retrospect, I think that the lack of structure made the therapeutic sessions longer than what would have been necessary with a “tighter” structure. I also wonder whether more structured therapeutic sessions would have helped every family member to be heard and would have clarified what the other family members think about the areas that are being addressed in therapy. I hypothesize whether my experience of a lack of structure was implicitly considered an expression of the therapist’s attempt to make a symmetric relation regarding the aspects of power and/or being a non-expert. Thus, I asked the participants about how they positioned themselves regarding the power relations in therapy, i.e., *“How do you position yourself in regard to issues of power relations in therapy?”* My hypotheses concerning the lack of structure are only based on my fieldwork observations and experience as a systemic therapist.

In reviewing my fieldwork notes, I reflect that one person who I considered to be the theoretically “weakest” systemic therapist, based on the impression that was given in the interview, actually “stood out” as a strong, theoretically driven therapist during my fieldwork observations. By theoretically driven, I mean a therapist who is observed to use many well-known systemic elements, such as a focus on strengths and solutions, co-constructing, narratives, and a system focus. Because this research is a qualitative study with a somewhat small selection of therapists, one should be careful in drawing strong conclusions. However, this observation indicates that observation can also help add another layer to understanding practice and may not be fully accounted for in interviews.

In general, my fieldwork observation notes very much concern what I observed the therapists doing, e.g., using an externalizing language or using positive connotation. I also considered the therapeutic conversations, which I observed to be very theoretically driven. However, my fieldwork notes also describe what I did not observe the therapists doing, i.e., the manner in which they used unique outcomes. I considered that it was possible to “more clearly” punctuate the good strategies that the family members described in regard to mastering different situations, the manner in which the therapists said that they were concerned with the

client's emotions. All of these observations formed the basis of the second interviews with each therapist, which involved the following questions: "*How do you address potential emotional expressions in the therapeutic conversations?*" "*Considering the client/family's narratives, how do you position yourself regarding strengths and solutions?*"

My reflection regarding the follow-up interviews is that the therapists seemed to understand (according to my understanding based on their body language) that my questions in the second interviews were inspired by my observations. Therefore, the questions that I asked in the follow-up interviews could be understood by the therapists as a type of critique of them and their way of using/not using systemic ideas. This understanding may have had the result that the therapists were trying to "defend" the choices that they made in the therapeutic conversations that I observed. If this reflection is correct, then the descriptions in the map of competences could be more theoretically driven than the participants' "everyday" practice. In addition, systemic therapists within child and adolescent mental health are under scrutiny and are being asked to change their practice in favor of evidence based approaches. Therefore, it could have been interesting to use research for systemic therapists to engage in an open dialogue about reconciling systemic practice with legally binding requirements.

5.8 Summary

In this chapter, I presented a GT analysis of twelve interviews with six experienced systemic therapists. The first overarching competence from the GT analysis was *ethical and cultural awareness*. This competence is based on the participants' continual consideration of their role while always considering the ethical aspects of therapy and the different cultural and contextual understandings, possibilities and limitations. The second overarching competence, the *therapeutic stance*, consists of the descriptions of the participants' epistemological understanding, how their epistemological understanding positions them regarding therapeutic work and how they relate to the power relations in therapy. The third competence was *the therapeutic process*. This competence contains descriptions of the participants' focus on creating child-centred interventions. Here, the feedback and evaluation of the therapeutic process were described as central. The competence *the therapeutic process* also presents how the participants relate to both their clients and their own emotional expressions in the therapeutic process. The fourth overarching competence, *the therapeutic practice*, consists of the participants' descriptions of the different therapeutic practices that are used. The fifth

competence, *session-specific features*, presents a small selection of the therapeutic elements that can be used over the course of therapy.

Part two (2) was a descriptive account of the fieldwork observations. Although the fieldwork observations notes are insufficiently detailed to serve as empirical material on their own, I think that the fieldwork observations indicate some interesting points. Primarily, people do not always do in practice what they say in theory. This discrepancy could be considered a limitation of this research's findings, which draw heavily on interviews and what people say they do. However, as a systemic therapist, I have great respect for what people say they are doing, and I do not base my research on what I think people may think or might do. Nevertheless, my fieldwork notes indicate that the inclusion of an ethnographic element could have strengthened this research. An ethnographic element could have enabled me to ask more probing questions and given a more detailed observation study and yielded richer empirical material.

6 MAP OF COMPETENCES

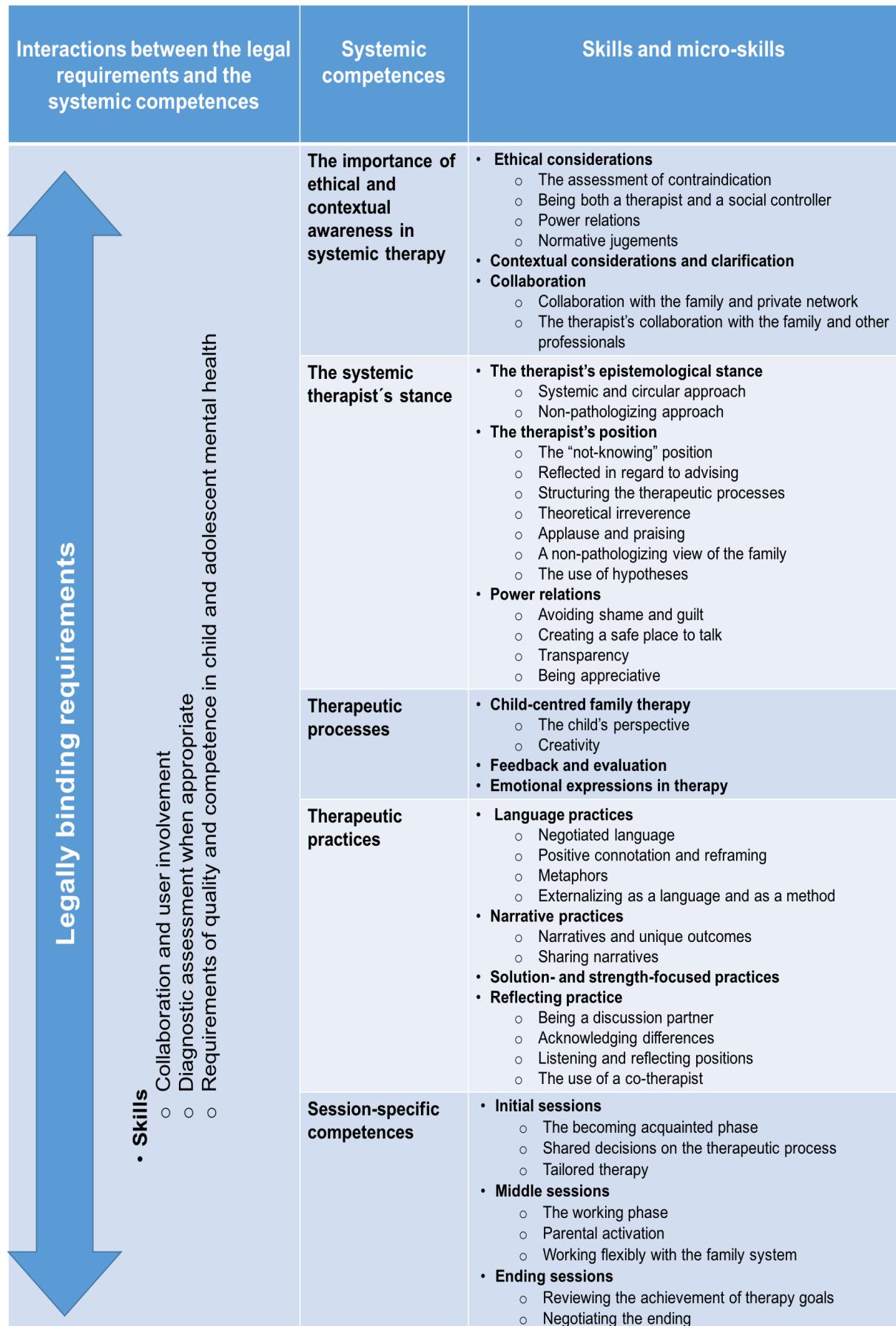
This study identifies a comprehensive and detailed outline of the systemic therapist competences in child and adolescent mental health that target the associated abnormal psychosocial situations (axis 5) in the multiaxial diagnostic system (WHO, 1996). In this chapter I have merged all the identified competences from the thematic analysis of the Norwegian Directorate of Health's guidelines (2008), the GT analysis of the interviews and fieldwork observations into a map of competences.

Following systemic ideas, the map of competences, shown in figure 1, on the next page, doesn't have a pre-defined beginning and end. However, I will argue that some of the competences are more likely to be used in specific phases of the therapeutic process (in the initial, working and ending phases). Instead, the map provides a comprehensive, detailed and flexible map of the competences a systemic therapist in child and adolescent mental health should cover in their work.

It is important to emphasize that the legal requirements overlap significantly with the systemic competency of 'the importance of ethical and contextual awareness in systemic therapy,' where collaboration and user involvement and the issues of normative judgments and power relations inherent in diagnosis are carefully negotiated. The interconnections are therefore negotiated throughout the therapeutic process to ensure collaboration and so diagnosis is not used as to exert power. This is discussed in chapter 7 in this thesis, especially in sections: *7.1 Interconnections between systemic therapy, organizational and legal contexts* (p. 141), *7.2 The importance of the epistemological stance of the systemic therapist* (p. 149), and *7.3 The therapists' competences in systemic family therapy* (p.156).

In this presentation, the identified overarching categories are named competences. The subcategories are named skills and the "sub-sub" categories are named micro-skills. The term "skills" and micro-skills refers to the overarching competences operationalized into detailed and practice oriented descriptions.

Figure 1. Map of systemic competences



7 DISCUSSION AND IMPLICATIONS

The overarching objective of this research is to identify a comprehensive and detailed outline of the competences of systemic therapy in child and adolescent mental health that target the associated abnormal psychosocial situations (axis 5) in the multiaxial diagnostic system (WHO, 1996). Based on the purpose and aims of this study, the research questions are as follows:

1. In the context of child and adolescent mental health, what are the different competences in a systemic family therapy approach that address the associated abnormal psychosocial situations?
2. What are the legally binding requirements in the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?
3. How does systemic family therapy interconnect with the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?

Although the three research questions are somewhat different, they are closely related. The identified legally binding requirements are the legal and political context in which systemic therapy is conducted in BUP. All therapists in BUP must consider these requirements. Thus, I discuss how the identified legally binding requirements "match" the participants' descriptions from the interviews. Through an analysis of the data, the following six main themes are identified: (1) the legally binding requirements in child and adolescent mental health; (2) the importance of ethical and contextual awareness in systemic therapy; (3) the systemic therapist's stance; (4) therapeutic processes; (5) therapeutic practices; and (6) session-specific competences.

Based on the purpose and objectives of this research, I structure the discussion around three somewhat different areas of systemic therapy in child and adolescent mental health. These themes are as follows:

- (1) Interconnections between systemic therapy, organizational and legal contexts
- (2) The importance of the epistemological stance of the systemic therapist; and
- (3) The meaning of systemic therapy competences.

First, I discuss these themes, and then, I discuss the study's implications for practice, training and supervision, present some questions for future research and my personal learning from this research process.

7.1 Interconnections between systemic therapy, organizational and legal contexts

An important topic that emerges from this research project concerns the interconnections between systemic therapy, the organizational and legal contexts of the Norwegian child and adolescent mental health care system. This topic is important because this is the formal context that frames and affects the work of systemic therapists. There is a critique in the mental health field that legally binding requirements may limit therapists' ability to work systemically in child and mental health care (Bertrando, 2009; Marrell & Koser, 2015). However, the findings from my research suggest that there is already an organizational and legal "backup" in the Norwegian Directorate of Health's (2008) guidelines that supports the idea that systemic therapy is an appropriate therapeutic approach in BUP.

Over the past ten years, mental health services have been characterized by a mode of governance that has placed great weight on efficacy and results (Ekeland et al., 2014). Thus, the requirements of review, control and documentation have also increased. The many legally binding requirements and recommendations of the Norwegian Directorate of Health (2008) in the field of child and adolescent mental health are one example of this increase. Historically, therapeutic work in mental health has been characterized by a certain degree of clinical judgment and flexibility (Grimen & Molander, 2008). Therefore, professional judgments have been viewed as a characteristic of professionalism (op.cit). It is important to mention that diagnosis is not totally objective and there are variations. Mental health is not a definitive science. A certain degree of professional judgment and flexibility is therefore a fundamental necessity in systemic and social constructionist therapy because they are concerned with how meaning is co-constructed in the therapeutic process instead of following specific diagnostic categories and pre-defined models of practice (Lock & Strong, 2014).

The many requirements of the Norwegian Directorate of Health (2008) and the need for a certain level of professional judgment in mental health can create tensions between the controlling institution and the practicing therapist. Accordingly, there is a certain opposition to the demand that therapists should be stewards of the requirements of the Norwegian

Direktoratet for Helse og Omsorg (2008) and should realize its policies while simultaneously meeting individuals and their families as unique and as having individual needs. This “balancing act” of roles necessarily involves some professional autonomy and discrimination. Based on my research, I have found that the participating therapists recognized that they must relate to the guidelines for child and adolescent mental health. Nevertheless, they experienced that the guidelines allow them to work in a systemic manner, with some concerns (i.e., that the referral often consists of pathologizing descriptions, with less focus on the family’s strengths and possibilities). However, all therapists in Norwegian child and adolescent mental health operate in organizational and legal contexts and with several legally binding requirements for the delivered therapeutic approach. Therefore, it is important to investigate the extent to which the requirements of the Norwegian Directorate of Health interconnect with systemic family therapy. Consequently, I claim that the therapists who want to work in a systemic manner in child and adolescent mental health care must have deep insights into these guidelines and see how these can be interpreted and applied to fit within a systemic frame.

Based on the analysis of the Norwegian Directorate of Health’s guidelines, I discuss this claim in the following section with two main themes as the starting point, namely, (1) collaboration and user involvement as central aspects of practice and (2) multiple epistemological views of diagnostic assessment.

7.1.1 Collaboration and user involvement as central aspects of practice

In mental health and family therapy, to take user involvement seriously and to create better services for the concerned clients, collaboration and user involvement have become a key perspective and central aspect of practice (Norwegian Directorate of Health, 2008). In my study, collaboration and user involvement are identified as central themes in the Norwegian Directorate of Health’s (2008) guidelines. The core of this partnership is professionals’ competence in working together through listening, taking service users seriously and making decisions regarding treatment through joint discussions (Ness, 2014a, 2014b). Nevertheless, the academic research has revealed a lack of focus on collaboration and user involvement in Norwegian child and adolescent mental health services (The Norwegian Knowledge Centre for Health Services, 2008). This lack of focus on collaboration may be because of the positivist and medical discourses that have emerged in health care in the interwar period from 1918 to 1939 and that continues to have great importance (Hårtveit & Jensen, 2008). Essential in the positivistic and medical discourses is that the relations among “cause and effect”,

rationality, neoliberal ideas, measurement and quantifiability are central to understand and solve human problems and to organize therapeutic treatments (op.cit). Neoliberalistic ideas can be generally described as a broad-based political and intellectual movement to advance the market as the most efficient mechanism for organizing virtually all aspects of human/social life, with the consequence that the patient is considered a consumer (Esposito & Perez, 2014). In my research, the institutionalisation of neoliberalistic ideas in the mental healthcare system expect professionals to account for one's actions through different sorts of performance measures, opposed to the traditional system of responsibility under the trust of authorization and/or professionalism (Høstmælingen, 2014; Sugarman, 2015). A positivistic and medically-based therapist takes a deterministic view of humans in which internal and external factors, such as genetic heritage, are considered to be determinative of who you are as a human being. Based on a positivistic and medical model of understanding, the therapeutic treatment seeks to uncover "the truth" regarding the underlying cause of the problem. Therefore, the client/family members' own ideas concerning their difficulties, the difficulties' impact on the family system, the family's own proposed solutions and the ability to solve these difficulties through a collaborative relationship (with the therapist) are not considered to be true and quantifiable knowledge. The families own knowledge is not emphasized, and collaboration is less important.

Marrell and Koser (2015) argue that it is debatable the extent to which it is necessary or "correct" that neoliberal ideas should regulate therapeutic work with complex human systems that are always undergoing change and are difficult to define. Thus, Sundelin (2013) emphasizes that in the field of systemic therapy, there is a critical scepticism towards neoliberal ideas that control and delimit the therapeutic approach. However, I argue that it is reasonable to assume that certain forms of documentation and administration are necessary and appropriate to ensure that the legal safety of clients is protected. Stratton et al. (2009) consider this matter in their work on constructing an adherence protocol that is based on the Leeds manual (Pote et al., 2000). One of the adherence items in the protocol is a description of proscribed practices. Pote et al. (2000) also develop a "session-specific checklist" to ensure that not only the therapeutic elements but also the rights of the client are covered. Therefore, systemic therapy can be said to have used neoliberal ideas (to some extent) over a period of many years. However, I emphasize that this usage also allows for a certain degree of professional judgment. Professional judgment is also advocated in the Norwegian Directorate of Health's (2008) guidelines.

There is a focus on collaboration and user involvement throughout the Norwegian Directorate of Health's (2008) guidelines. In my thematic analysis of the guidelines (Norwegian Directorate of Health, 2008), collaboration and user involvement are identified as both central and legally binding requirements in therapy. Therefore, the guidelines should be considered to be postmodern, and reality should be considered to be socially constructed through interactions, language and culture (Jørgensen & Philips, 1999). According to the Norwegian Directorate of Health's (2008) guidelines, the search for "objective and quantifiable truths" no longer seems to be considered sufficient for therapy. Thus, the inclusion of collaboration and user involvement is considered to be a central aspect of therapeutic practice in Norwegian mental health.

From a systemic perspective, collaboration and user involvement are subjective concepts concerning practice and must be negotiated in every meeting with the families who are seeking help (Anderson & Gehart, 2007). My participants also emphasized this point. They described that collaboration and user involvement were made possible through dialogical and empathetic conversations that begin with talking with the families about their everyday life contexts and then negotiating methods to work together from there. This process involves negotiating the goals for the therapy and co-constructing new possible meanings, opportunities and solutions to the family's challenges. Therefore, the focus on user involvement in mental health care seems to be "expanded" in systemic family therapy and the participants' descriptions in this research. In addition to starting with collaborating and negotiating with the family's ideas, wishes and goals for therapy, therapists also must be conscious that the family's own statements and expressions are also influenced by the therapist's presence and attitudes and the contexts in which these conversations occur (Hoffman, 1990, 2002). In systemic therapy, there is a clear expectation for therapists to be self-reflexive with how they influence meaning making in therapy (Pote et al., 2000). Meanings must be understood as being co-constructed in collaboration between the client and the therapist and the context they operate in. Accordingly, the therapeutic process is viewed as co-constructed through collaborative relationships and dialogical practices (Anderson, 2012; Pote et al., 2003; Stratton et al., 2009). Thus, the bases of systemic therapy and the practices of the participants in this research takes user involvement further than is required in the guidelines and acknowledges that the presence and powerful role of the therapist influence both the collaboration and the therapeutic process (von Foerster, 1982).

Systemic therapy's theoretical basis and my findings from the interviews support the idea that the client's own understanding of his/her life situation should create the foundation for the solutions to the problems of the family. This strategy follows the guidelines of the Norwegian Directorate of Health (2008) and places systemic therapy in a strong position in terms of being able to put this into practice. Therefore, I argue that the guidelines must be viewed, interpreted and applied in a broader scope than only employing neoliberal ideas in ways that are considered incompatible with or too different from the theoretical perspective of systemic therapy. Paradoxically, systemic therapists could take a strong position on collaboration, but the focus on diagnoses causes them to feel they need to take up or exert a position of power/social control rather than both / and.

7.1.2 Multiple epistemological views of diagnostic assessment

A central theme in the guidelines is the use of diagnostic assessments. Examination and diagnosis have traditionally been explained in terms of the individualization of problems, with little focus on context and other potentially contributing factors (Brinkmann & Petersen, 2015; Ekeland, 2014). Although the focus of the guidelines on examination and diagnosis is considerable, the language that is used in the guidelines reveals that there are no irreconcilable differences between the guidelines and systemic family therapy. For example, it is explicitly stated in the guidelines that the extent to which diagnostic assessment is appropriate should only be *assessed* (Norwegian Directorate of Health, 2008). Therefore, the user's status in child and adolescent mental health is not synonymous with the performance of an examination with a resulting diagnosis. Thus, users are given a large degree of definitional power regarding how an examination should be performed and what type of treatment should be initiated. However, many of the participants seemed to believe that they were expected to conduct diagnostic assessments, in each individual case. I consider this to be build on a dichotomy and/or expectations in their organisational contexts that apply the guidelines in a distorted way, which has been applicable because of the field of mental health's increasing focus on diagnoses and disorder- specific treatments. Nevertheless, the distinction between the participants' beliefs and the stated requirements in the guidelines (that diagnostic assessments should only be considered) represent a significant difference. Systemic therapists in BUP are therefore allowed (and actually legally bound) to consider the need for diagnostic assessments as collaborative decisions, between the interdisciplinary team and the clients. A collaborative process of decision facilitates the possibilities for a number of systemic

competences related to the competence *collaboration* to be put into action (e.g., the skills and micro-skills related to the overarching competence *collaboration* in the map of competences, fig 1, chapter 6).

The focus in systemic family therapy on relations, strengths, solutions and positive connotations in any case makes it possible for diagnostic assessments (axis 1-5) to be performed without contributing individualistic and pathologizing descriptions of people. Instead, one can collect narratives that do not confirm the problem (the diagnosis) alone, and that direct focus to how the individual's/family's thoughts about potential diagnoses can influence their lives and relations at the same time as one challenges the way in which diagnoses are made and used within BUP.

The participants explained that every referral to child and adolescent mental health services is accompanied by information and descriptions of which type of help is required. Thus, the participants described that the descriptions from the referral do not always accord with the family's own wishes and needs. The referral is also often characterized by requirements for diagnostic assessments and negative and pathologizing descriptions and has less focus on the family's strengths and possibilities. Consequently, the participants stated that one goal is to invite the family members to a collaboration. In this collaboration, the family decides the direction and aim of the therapy (i.e., "be where they are", believe what they say and what they have experienced) and their preferences, perspectives, wishes and theories of change (i.e., their previous suggestions for change) are explored.

In contrast to an individualistic biomedical explanation, systemic therapy therefore gives *precedence* to a relational and social constructionist understanding of the problems and difficulties of individuals and families. Systemic family therapy's theoretical perspective creates an opening for an understanding that people's difficulties are best understood and worked with through relationships and contexts (Pote et al., 2000; Stratton et al., 2009). Similarly, Maturana and Varela (1987/1988) argue that a person is a biological creature and that our biology forms our cognition, which, in turn, forms our meaning creation (what we do and do not perceive). Pote et al. (2000) describe that epistemological *ideas* from constructivism regarding meaning creation also occur through biological processes. In certain cases, these constructivist ideas can be included in the treatment process (Pote et al., 2000). However, there is a danger though that these ideas can be used in a reductionistic way. For

example, that there are differences across cultures in the way that mental illness are constructed. These ideas therefore need to be carefully considered. Thus, it can be useful for systemic therapists to include different epistemological positions, such as constructivism, in parts of the treatment (Stratton et al., 2009). One example can be when a family requests a biomedical diagnostic assessment of their child. However, the participants in this research described that although the child should undergo a biomedical diagnostic assessment, the opportunity for a systemic approach is not excluded.

Thus, the participants emphasize that «traditional» investigation/diagnosing does not necessarily lead to negative consequences for those involved. Viewed therapeutically, a diagnosis can also contribute to the removal of guilt and/or shame, or serve the aim of distinguishing significant abnormality from expected development (for example in the case of autism) (Rimehaug & Helmersberg, 1995). According to the way in which our society is currently organized, a specific diagnosis can release the right to specific treatments, medicines or helping aids (for example anti-psychotic medication, or talking books in school). Depriving a child or youth of a diagnosis that can help them to understanding, reconciliation, coping and potentially useful aids or interventions therefore can also be understood as an expression of therapeutic paternalism and misuse of power (op.cit). However, the participants described the diagnostic process as an opportunity to make the traditional diagnostic assessment tool as family-oriented as possible by including family members in the process. Therefore, the participants in this research claimed that concerning diagnostic assessments in BUP, it is important that therapists are aware of and use multiple epistemological understandings. A multi epistemological stance can help therapists to see beyond the biomedical perspectives of psychiatric diagnoses, assessment and contribute to a multifaceted and complex picture of people's (also contextually-based) problems and difficulties. In this way, systemic therapy can be an important contributor to ensure that the intentions and requirements of the (2008) guidelines are realized.

My research project shows that the openness in the guidelines to different treatment forms can be understood as being consistent with systemic family therapy's ideas about a multiverse of possible approaches, with diagnostic assessment being viewed as one possible approach among several others. Systemic family therapy's focus on relationships, strengths, solutions and positive connotations allow opportunities for traditional diagnostic examinations (axis 1-5) without necessarily being viewed as individualistic and pathologizing descriptions of

clients. Instead, in systemic family therapy, therapists collect narratives that do not by themselves confirm the problem (the diagnosis) but instead direct their therapeutic focus towards how the individual's/family's thoughts about potential diagnoses can influence their lives and relationships. Additionally, therapists can challenge the manner in which the diagnosis is viewed and applied within child and adolescent mental health. However, a systemic family therapist with a moderate social constructionist understanding would not exclude axis 5 diagnostics (or indeed, diagnostics in general) as potentially useful knowledge, provided that the coded categories are not viewed as objective truths about the person and his/her context but instead as one of many (or overlapping) potential stories. Nevertheless, the labelling of the different categories in axis 5 (e.g., abnormal intrafamilial relationship, abnormal qualities of upbringing) and some of the linguistic formulations in the Norwegian Directorate of Health's guidelines (2008), challenge systemic family therapy's theoretical premise of being appreciative and using non-pathologizing descriptions of the family system (Pote et al., 2000). A non-pathologizing view of the family was also described by the participants as a "reflex" and a natural part of all of their therapeutic work in the antidote against becoming buried in problem descriptions. Systemic family therapy contributes the use of positive connotation, the systemic surveying of the family's strengths/solutions and negotiating the meanings of the categories between the therapist and the client to ensure a non-pathologizing systemic perspective, even in the assessment work. Through the identification of the family's strengths and previous solutions to so-called "stuck" problems, the opportunity to revise the family's narratives is also opened up. A central idea within narrative therapy is that people's lives are richer than many of the stories that are told by or about people's behaviour and identities (White, 2007). Therefore, it can be experienced as a paradox that the stories within psychiatry are typically formulated through pathological aspects or through psychiatric diagnoses (op.cit). Thus, these stories can often become dominant descriptions of persons that excludes those aspects of life that are not described through the diagnostic system (White, 2007). Therefore, systemic family therapy can be an important contribution with regard to facilitating that the preferred story is given greater space without excluding other types of potentially necessary information. The participants also claim that the facilitation of the preferred story allows for a more appropriate process of shared meaning making through collaboration. There are therefore few reasons to assume that an understanding of the world as composed of circular, complex causality is inconsistent with the intentions and requirements of the (2008) guidelines.

Based on my study, I argue that the Norwegian Directorate of Health's legally binding requirements for a "holistic" assessment of users' psychosocial conditions and specialized services opens for the specialist competence of family therapists on relational and contextual conditions to be used in diagnostic assessments. Especially when the difficulties are categorized within axis 5, associated psychosocial situations. With a starting point in a systemic understanding, it is therefore somewhat paradoxical that the stories within the psychological health services usually are formulated through pathological aspects, or through psychiatric diagnoses (White, 2007). These stories often become the dominant description of the persons involved and exclude those aspects of life that are not described through the diagnostic system (*Ibid*). Systemic family therapy can therefore be an important contributor to ensuring that the preferred story is given a place, without the exclusion of other potentially necessary information.

7.2 The importance of the epistemological stance of the systemic therapist

Another central topic that emerged from my research project concerns the importance of the therapist's epistemological stance. Although the aim of this research was to identify a comprehensive and detailed outline of competences for systemic therapy, the participants claimed that the therapist's epistemological stance is of greater importance than the specific therapeutic elements. Therefore, the importance of epistemology seems evident. The importance of epistemology is discussed in the following themes: (1) multiple epistemological perspectives; (2) social constructionism – the therapist as a co-expert; (3) constructivism – knowledge as provisional; and (4) critical realism – an answer to the disillusionment concerning therapists' need for autonomy.

7.2.1 Multiple epistemological perspectives

Although systemic therapy is primarily described from the perspective of social constructionism (Pote et al., 2000), the participants in my study expressed a general scepticism towards all stringent theories that attempt to embrace human complexity because there can be a danger of promoting reductionist thinking. It is important to note that the participants' scepticism in relation to theories was directed towards relating to only one epistemological position. Based on my study, the participants' epistemological stance was identified as multifaceted, consisting of social constructionism, critical realism and constructivism. I think that there are several reasons why. One of these reasons is the social

constructionist idea that everything can be deconstructed, which I do not think is actually accurate (Lorås, 2016a) because it is impossible for people to know what is real, but we must realize that there is something that is unreal. As expressed by Eco (2012) in another way, *we cannot say what is right, but all of us can tell what is wrong* (p. 105). I think the same reflections are relevant regarding families. We cannot say how “right” family interaction is, but we can say when there are unhealthy family interactions, for example, discipline that is so inconsistent within/between parents that a predictable response to the child’s misbehaviour is lacking (WHO, 1996). I agree with Pocock (2013), who states that if one follows strong social constructionism, for example, that of Gergen (1998), who claims that social constructionism is “ontologically mute”, to an extreme extent, then one is unable to criticize family interactions at all. According to my findings, the participants argued that they occasionally take up normative positions or relate to so-called normative knowledge, such as developmental psychology and what gives children and young people healthy opportunities for their development, which is inconsistent with a strong social constructionist stance. From this perspective, even the axis 5 category is to some extent considered normative knowledge because it somewhat defines unhealthy family interactions (e.g., abnormal intrafamilial relationships, abnormal qualities of upbringing).

It could be argued that the multi epistemological stance that my research is suggesting for “post systemic” therapy differs significantly from earlier theories and forms of systemic family therapy (Selvini Palazzoli et al., 1978; MacKinnon & Miller, 1987). However, Cecchin (1987) suggest that systemic therapy require constant creative elaborations and radical reconstructions, and claim that we should never fall in love with our hypothesis. Based in Cecchins ideas, the incorporation of a multi epistemological stance could be considered as appropriate. I also consider it as necessary and appropriate considering the fact that many therapists are required to carry out therapeutic tasks, such as diagnostic assessments and biological surveys. For example, within the context of BUP, therapists are required to conduct diagnostic assessment if it’s considered as appropriate and wished for by the client (Norwegian Directorate of Health, 2008). These tasks could be considered as contrary in regard to the therapists’ personal domain of aesthetic (Maturana 1995). The domain of aesthetics refers to wherein we take up a moral position in relation to what we consider as acceptable (Lang, Little & Lang, 1990). Or as emphasized by Bateson (1979, p 87):
“Epistemology is always personal. The point of the probe is always in the heart of the

explorer”. Nevertheless, as therapists, we do not work in a “vacuum” and everything exists in communication and is based on feedback. We therefore need to consider the context where the therapeutic work is carried out (i.e., child and adolescent mental health). This could be associated with Maturanas (1985) domain of production, which refers to the possibilities and limitations in the context where the therapist carries out his tasks (Lang, Little & Cronen, 1990). I therefore consider both Cecchins suggestions of creative elaborations and radical reconstructions (1987) and Maturans domains of aesthetics and productions as important to understand and facilitate a therapeutic practice within the complex framework of therapeutic practice, such as BUP. A complex framework where both the therapists integrity (domain of aesthetics) at the same time as the therapists contextual awareness and responsibility (domain of production) is considered. I also consider Maturanas domain of explanations as essential in regard to the support of a multi- epistemological stance. This is because the domain of explanations is about questions and questioning and the idea of a multi-verse (rather than a uni-verse) is given precedence (Lang, Little & Cronen, 1990). The domain of explanations therefore support both Cecchins ideas of creativity and reconstructions within the systemic paradigm (1987) and this research idea of considering “post systemic” therapy as consisting of a multi epistemological stance.

The Norwegian Directorate of Health (2008) also poses specific guidelines about competence that go much further than merely conducting dialogical conversations, such as diagnostic assessment, evaluation, supervision and research. A central idea in systemic therapy concerns being reflexive regarding power and power relations and therefore not providing advice or sharing specific “expert” knowledge beyond the dialogical (Stratton et al., 2009). Thus, I claim that this idea does not promote change if the client desires something different. Instead, I understand systemic therapy to be concerned with co-construction and that the therapist and the client together co-create meaning through dialogue. Nevertheless, in this co-constructed process, because of the nature of her role, the therapist is viewed as the person with the greatest responsibility (Karlsson & Oterholt, 2015). This is supported by the fact that, in relation to those seeking help, therapists are in a position in which they can decide what type of help should be given and at what time. The issues of power were also an important topic for the participants in this research. The participants described power relations as influencing all areas of therapy, and they said that they needed to be carefully considered throughout the course of therapy. Therefore, the participants were reflexive regarding how their role as both a

therapist and a social controller affects their clients and the stories being told/not told. Thus, power relations are an omnipresent and integrated part of all relations within mental health care. In this connection, Foucault (1973) claims that *power is everywhere: not because it embraces everything, but because it comes from everywhere* (p. 93). Following Foucault, power is not located in one person alone but instead should be viewed as being integrated in all people's social expression and as present wherever people move and meet. Therefore, it is less interesting to discuss how one can "get rid of" power. Instead, the focus for systemic therapists should be on being sensitive to how power influences the relationships of which one is part. Therefore, in the practice of systemic therapy, it can be relevant to explore the concepts of "power over" and "power with" (Miller & Stiver, 1997). "Power over" relations concern how one professional, on behalf of a system, can "force" persons to decide ways in which to live. "Power with" relations concern relationships in which power is shared between the parties and choices are made in collaboration (shared decision-making) (Drake et al., 2010), which can also mean that professionals collaborate in ways that make it possible for persons to see that they can make their own choices (supported decision-making) (Pathare & Shields, 2012). By being sensitive and critical towards power relations in this manner, power becomes "talked into being" and negotiated (Bird, 2004; Roy-Chowdhury, 2006). In such a negotiated dialogue, the participants claim that there can also be cases in which people wish that the therapist(s) make choices on their behalf. Therefore, the participants emphasize a "supported decision-making process" in which one can share the power and achieve genuine and useful collaboration, consisting of a multifaceted epistemological stance. Thus, the multifaceted needs of human beings and the Norwegian Directorate of Health's (2008) legally binding requirements (e.g., regarding therapists' competences) seem to validate the need for a multifaceted epistemological perspective.

7.2.2 Social constructionism – the therapist as a co-expert

Based on this research, I wish to argue that systemic therapists should be regarded as a co-expert who acknowledges each family member's understandings as being equally important but who contributes with his/her profession-specific knowledge if it is requested by the clients (Rimehaug & Helmersberg, 1995). The importance of the term "co-expert" can be compared to the notion of therapy as co-constructed (Fruggeri, 1994). The co-expert facilitates a view of the problem both from her own and from each family member's position while acknowledging her own influence on the therapeutic process. This is also consistent with the legally binding requirements of the Norwegian Directorate of Health (2008). However, none

of the participants in the research project used the word co-expert. Nevertheless, I claim that the term co-expert summarizes the manner in which the participants discussed their ways of working because they opened up to give advice (expert knowledge) when clients asked for it or when the family was in a crisis and it may be necessary to think alternatively, if only for a short period. As part of co-expert knowledge, the therapists could also share with their clients their own experiences of needing advice and expert knowledge when they had found themselves in similar situations. However, the participants explicitly expressed that their shared narratives must not appear to be flawless or as examples of the “perfect family life”. Therefore, the stories that are shared are preferably half-successful stories that acknowledge humans’ struggles and dilemmas and implicitly facilitate a more symmetrical relationship with the family.

7.2.3 Constructivism – knowledge as provisional

For several decades, constructivism has been noted as one of systemic therapy’s epistemological points of departure (Jensen, 2008; Jensen & Ulleberg, 2011). Regardless, this integration appears to be built on dichotomies in which constructivism’s focus on biological processes has been marginalized and, instead, its ideas have been viewed as identical to social constructionism and its almost exclusive focus on language and discourse (Jensen, 2008). However, constructivism and social constructionism should not be viewed as competing epistemologies because of their shared focus on meaning-making processes (McNamee, 2004). I claim that it is time to discuss whether constructivism, with its extended focus on other significant aspects of life, such as the internal, cognitive processes of individuals, should be included and acknowledged as part of the epistemological basis of systemic therapy instead of only as the idea of social constructionist epistemological purity (Pocock, 2013). Knowledge about internal, cognitive processes is also described as one of the therapists’ expected competences in the Norwegian Directorate of Health’s (2008) guidelines (i.e., basic knowledge about normal development and lopsided development), and it is described by the participants as one of the areas that must be considered, especially regarding the client’s development.

The focus on inner and cognitive processes can be argued to be based on a linear understanding (Schjødt & Egeland, 1993). However, I argue that it is important that therapists are concerned with both the linear and circular models of understandings to understand the development and maintenance of human problems, which is also one of the legally binding

requirements in the Norwegian Directorate of Health's (2008, p 56) guidelines. All of the participants noted that they had experience with individual clients who wanted diagnostic assessments. Therefore, the participants were not critical of relating to biology or diagnostic assessments per se (repeatedly referring to Maturana), but they were critical of all knowledge that claimed to be objective truth, with the result of generalizable understandings and approaches. However, the participants discussed how many clients frequently disagreed with their previous diagnoses. Instead, the participants highlighted some clients who had experienced their diagnoses as wrong and/or who were assessed on a deficient basis. Families' suffering is often imbued with feelings of guilt (Patrike and Tseliou, 2015). These research participants also described repeated examples in which clients had experienced receiving a diagnosis as a valuable contribution in regard to removing shame and guilt (i.e., in the case of mental retardation) (Rimehaug & Helmersberg, 1995). In this manner, the actual result of receiving a diagnosis can have the paradoxical effect of removing guilt and shame and creating a distance between the individual and the problem, which is the same result that one attempts to achieve through externalizing conversations from narrative therapy (White, 2007). Simultaneously, in contemporary society, a diagnosis can grant rights (e.g., assistant teachers, access to treatment) (Sundet, 2015). Diagnostic assessment is not in opposition to systemic therapy's epistemological basis. Instead, I am sceptical of the use of diagnostic knowledge, understood here as objective and true knowledge. I do not consider the ICD or the DSM diagnostic manuals as false per se, but I consider them to be constructions that are not useful when they are taken as "a Bible." Thus, it is possible to use diagnostic assessments within a systemic framework by using diagnostic tools as "guides and maps" rather than as instructive manuals. In this case, it is important to include the family's "significant others" as part of the empirical material for an eventual diagnostic conference.

7.2.4 Critical realism – an answer to the disillusionment concerning therapists' need for autonomy

Critical realist ideas became apparent through the participants when they discussed therapeutic autonomy and professional judgment, in addition to an expressed desire for delimited interventions. On one hand, the participants emphasized an experience of systemic therapy as unclearly defined in the literature, in which the theoretical descriptions almost exclusively consisted of epistemological considerations. However, the participants partly hailed this as a theoretical strength because its flexibility made systemic therapy simultaneously fit every context and create an opening for the therapist's creativity. On the

other hand, the participants claimed that the difficulties in “pinning down” systemic therapy’s competences made it easy to become lost in the complex process towards change. Therefore, the participants expressed a desire for clearer descriptions of the many competences that a systemic therapist is expected to cover in his work. The participants defended this desire with the idea that, provided that the descriptions of the competences are not exaggeratedly stringent, then they could be helpful in ensuring that the therapist did not “wander off” into the confusing and complex landscape. Therefore, I add a critical realist element to systemic therapy theory and practice. In critical realism, there is a belief that all scientific work must be based on informed opinions about what actually exists within the current area of study and the basic properties of this form of existence (Davidsen, 2004), although it is never possible to predict the outcome of interventions. The critical realist directs our attention towards understandings and explorations of the tendencies identified (e.g., the identified competences in my study). Therefore, critical realism is polemical regarding positivism and shares with positivism the positive concern with developing knowledge (Cruickshank, 2011). It stands in contrast to social constructionism, which embraces relativism and scepticism in the attempt to delegitimize knowledge claims by exposing them as symptoms of underlying discursive power relations (op.cit). Therefore, the inclusion of critical realism in systemic epistemology can be helpful. However, I claim that this inclusion should be done with some concerns about its traditional view on objectivism and as post-positivistic. Clarke (2001) argues that critical realism is positioned as “post-positivistic” and that it strives to understand *how* and *why* human difficulties occur. Although moderate social constructionism and critical realism can seem incompatible, the difference is not necessarily that substantial. The reason is there are two different positions regarding objectivism in critical realism: “traditional” objectivism and moderate objectivism (Layder, 1998). “Traditional” objectivism seeks to uncover the “truth” and infallible knowledge. Thus, moderate objectivism (moderate critical realism in the continuum) is more aligned with social constructionism and considers reality as being composed of both subjective and objective aspects and that both aspects mutually influence and require one another (Andersen, 2007). Therefore, the critical realist “assumption” of knowledge as something more tangible than in social constructionism is consistent with the dominant understanding of psychiatric symptoms, unhealthy family interactions and child development described in the Norwegian Directorate of Health’s (2008) guidelines and as described by my participants.

Therefore, critical realism is in all probability a more acceptable epistemological position, both organizationally and legally, for decision makers, who have great influence in Norwegian child and adolescent mental health care. The systemic therapists who include critical realist ideas acknowledge taking a position in relation to knowledge. Although my research participants do not use the phrase critical realism, I consider the manner in which they position themselves regarding knowledge to be a critical realist stance. This is in opposition to the “both and stance” in social constructionism, which offers a safe container for the tension between the different perspectives offered, those of family members and our own as therapists (Pocock, 2013). The critical realism-inspired systemic therapist acknowledges taking a position as an expert in the therapeutic process, with professional knowledge regarding unhealthy family interactions and child development, but simultaneously, he is humble about what he knows and is open to other possibilities. The multi-epistemological systemic therapist knows that he will never reach the proper reality of the family (Lorås, 2016a). Therefore, critical realist ideas do not seem to exclude social constructionist ideas because they share an experience of the world as a place where it is difficult (if not impossible) to achieve true objective knowledge (Pilgrim, 2000). Thus, the inclusion of critical realist ideas is a response to and supports the participants’ wishes for some precise descriptions of the systemic competences that they are expected to cover or that may be valuable in working within child and adolescent mental health.

7.3 The therapists’ competences in systemic family therapy

Poor specifications of systemic interventions make it easy to become lost in the multitude of definitions of what constitutes the systemic family therapy interventions assessed, if the intervention is defined at all (Asen, 2002). Therefore, a certain amount of therapeutic guidelines and requirements for documentation and administration are both necessary and appropriate. The map of competences proposes some flexible guidelines for systemic therapy that targets the psychosocial difficulties that are categorized as the associated abnormal psychosocial situations in the Norwegian child and adolescent mental health care system.

However, in the beginning of this research project I thought of the concept of competences as a collection of session specific and clearly defined systemic elements. Thus, I learned quite early in the research process that the systemic therapist I was interviewing and observing was much more epistemology/ or philosophically driven (even if they rarely used the word

epistemology), than they were emphasizing a competence based therapy. I was therefore led into the exploration of several epistemological positions, in order to identify the epistemological basis of my participants' descriptions and practice. The concept of competences therefore evolved for me with an expanded focus on how the different epistemological positions influence therapy. Nevertheless, the theoretical foundation of epistemology makes the descriptions more theoretical and philosophically driven, than some of the identified and more easily specified competences (i.e., narratives and unique outcome). Thus, competences or techniques out of context can give us the idea that we are acting on people, which is counter to the epistemological position that we are mutually learning and co-constructing. The participants throughout focus on the philosophical aspects of therapy therefore gave me the permission and confidence to both include and describe competences, which were difficult to delimit, such as *systemic and circular* and *non-pathologizing*.

The map of competences offered, therefore does not claim to represent a "blueprint" for how systemic therapy should be performed. Nevertheless, the use of "systemic maps" is somewhat debated. The discussion regarding the use of the "map of competences" is centred on the following themes: (1) maps as a basis for structured but flexible systemic therapy, (2) the map of competences as a guide: the therapist as the translator of knowledge into practice, and (3) the map of competences of systemic therapy: a flexible and irreverent framework.

7.3.1 Maps as a basis for structured but flexible systemic therapy

Historically, systemic therapists' resistance to competences and manuals has been significant (Sundelin, 2013). However, the participants in this research expressed a desire for clear descriptions/maps (provided that they are not exaggeratedly stringent) of the many competences that a systemic therapist is expected to cover in his work. Some of the criticism manuals and "collections" of competences has been their tendency to privilege the more easily specified and measureable aspects (i.e., whether circular questions were used) and their lower level of reliance on therapy process research from clinical contexts (Pote et al., 2003). A main goal of such manuals/competences also seems to be to reduce the amount of therapist variance. Therefore, the use of manuals and competences has been criticized for oversimplifying "everyday practice", restricting creativity and provoking resistance from therapists (Silverman, 1996). In this context, everyday practice means the clinical daily practice of systemic family therapists in child and adolescent mental health.

From the systemic paradigm, competences mean the documentation and description of the fundamental elements of systemic therapy (Northey, 2011) that are expected to be mastered by systemic therapists (Stratton et al., 2011). Nevertheless, the social constructionist epistemological stances of systemic therapy reject the understanding that a “correct” method of successful therapy exists (Gergen, 2015). With a basis in social constructionist ideas, it is easy to understand the criticism of that which is easily measurable that apparently seeks to “uncover” reality. Accordingly, Maturana (1978) claims that instructive interactions are an illusion. The notion of instructive interactions is based on his idea that a system will only respond in its own way to any interaction it may have. Therefore, concrete directions, advice and problem solving are considered therapeutic errors (Leyland, 1988). If it is not to lose its identity, a family system can only undergo changes that are determined by its own organization (op.cit). Therefore, instructive interaction is not to be expected to possess the potential for change without the risk of the family members’ loss of identity. Nevertheless, techniques and principles are spelled out with varying degrees of specificity in different collections of competences, i.e., Tomm and Wrights’ (1979) skills and competences for family therapists, or in manuals, i.e., the coping cat from CBT (Kendall et al., 2006).

On the other hand, quality assurance in mental health has increased the requirements for standardized procedures. A considerable amount of research also documents the efficacy of these methods of treatment for a variety of disorders (i.e., anxiety, depression) (Manassis, 2009). Based on my research, I consider the degree of “instructive interactions” to be that which decides the extent to which the map of competences maintains the central epistemological tenets of systemic therapy within social constructionism. Regardless, systemic therapy can be said to have made some sort of a compromise and have (to some extent) made use of neoliberal ideas over several decades, i.e., the Leeds manual (Pote et al., 2000). However, the Leeds manual is only instructive to a small extent.

7.3.2 The map of competences as a guide: the therapist as the translator of knowledge into practice

As presented in the findings chapter, the map of competences is intended to help, guide and support systemic therapists’ practice in child and adolescent mental health. The map of competences is created based on the identified systemic elements from 12 interviews with six experienced systemic therapists and, to some extent, fieldwork observations. I have also included the legally binding requirements of the Norwegian Directorate of Health (2008). The

map of competences presents some flexible guidelines for systemic therapists that require an independently operating therapist working within a given “semi-”structured process.

Therefore, I propose that the therapist should use his/her professional knowledge and judgment when using the map of competences in his/her therapeutic work. This proposal is also consistent with my participants’ wish for some clear but flexible maps, provided that they are not exaggeratedly stringent. To facilitate the independently operating therapist in relation to the use of the map of competences, I find three of Aristotle’s intellectual attitudes towards the knowledge of “reality” to be useful: *fronesis*, *episteme* and *techne* (Wivestad, 2002).

Aristotle’s intellectual attitudes are important because he included human beings’ personality (*fronesis*) and equally juxtaposed it to techniques (*techne*) (i.e., the map of competences). He also argues for the need for a multifaceted epistemological (*episteme*) grounding.

Aristotle claimed that *fronesis* was one of several intellectual attitudes that were helpful in relation to uncovering “reality” (op.cit). *Fronesis* concerns the notion that people’s wisdom and practice related to knowledge provide them with compassion for and insight into what is good for the person, both in general and in specific situations. Aristotle emphasized that the wise person is not merely clever or learned but must also use common sense and seek advice on his own (Gadamer, 1988; Wivestad, 2002). Therefore, the concept of *fronesis* can be consistent with my study’s approach because the map of competences is mainly built on participants’ descriptions of their systemic approach, which is grounded in their self-reflexivity. I also consider the notion of *fronesis* as synonymous of the use of self as basis for therapeutic relationship, which much of the evidence based practice literature leaves out in favour of the focus on techniques.

The map of competences and the inclusion of multiple epistemological stances (social constructionism, constructivism and critical realism) are also in agreement with Aristotle’s ideas of knowledge, *episteme*. *Episteme* should be understood as a basis for epistemology (Wivestad, 2002). Aristotle challenged the use of the concept of *episteme* and created an opening for multiple epistemological understandings of “true” knowledge. In this regard, Aristotle used the notion of *techne*. *Techne* is directed towards the derivation of knowledge and is expressed through oral or written didactic statements. Didactic statements concern the assumptions that a person has about what is necessary to create a solid foundation, for example, to build a solid wall or the creation of a good therapeutic relationship (op.cit). Therefore, Aristotle’s term *techne* relates to the map of competences because the competences

are to be viewed as written descriptions of what can be assumed to be contributions to building a solid systemic foundation for therapy. I emphasize that Aristotle makes clear that the “foundation” is not to be viewed as a static “recipe” but that the wise therapist (in this case) simultaneously must seek counsel with him/herself (op.cit). This can also be understood as a critique of how traditional, rigid evidence-based practice is understood and used. Because of the support provided by my research, I emphasize that knowledge should be considered an interaction between the three intellectual attitudes of techne, fronesis and episteme, to borrow Aristotle’s terms. I consider the interaction between techne, fronesis and episteme to represent my research participants’ view on systemic therapy. I also consider the interaction process to provide a more sophisticated understanding than evidence-based practice, which to a greater extent focuses on techniques. Knowledge as a co-constructed process is also more consistent with the postmodern understanding of knowledge as socially created, which is also supported by the participants in this research and the Norwegian Directorate of Health’s (2008) guidelines, which hailed the necessity of a multifaceted therapeutic approach in which the therapists’ own judgments, user involvement through collaboration and therapeutic competences stand in a relationship of mutuality to one another.

7.3.3 The map of competences in systemic therapy: a flexible and irreverent framework

The findings in my study highlight my participants’ descriptions of the unprecise definitions of systemic therapy as a potential weakness. Simultaneously, the participants hailed systemic therapy’s flexibility as a potential theoretical strength because it gives therapists the flexibility and authority to be irreverent towards systemic theoretical elements that do not seem to suit the family/therapeutic process. Irreverence, according to Cecchin, Lane and Ray’s (1992) descriptions, concerns moving into a position in which the therapist does not feel bound by the therapeutic model but instead uses the model as a flexible framework. Therefore, Cecchin et al. (1992) propose that the therapist should never become completely seduced by one model and emphasize that the therapist needs to know something (i.e., a therapeutic model or approach) very well before he can be considered able to be irreverent towards it, as they claim: “*You should be conversant with the literature of different therapeutic perspectives and be an ‘expert’ in at least one of them*” (Cecchin et al., 1992, p.8). Therefore, I consider the map of competences as a tool and a framework to assist and guide the process of becoming an “expert” and having theoretical and practical knowledge about systemic therapy, adapted to the context of child and adolescent mental health. Nevertheless, the term “expert” is a somewhat negatively charged word in systemic psychotherapy (Anderson, 2005), which has

to do with the understanding of therapy as being concerned with the exploration of meaning systems through conversation instead of the use of some preliminary ideas (Anderson, 1995). However, not even the “not-knowing position” of Anderson (2005) claims that the therapist is “not-knowing” but instead emphasizes a therapist who is humble about what he/she knows. Therefore, the therapist’s contributions are presented in a manner that conveys a tentative posture and portrays respect and openness to the client (Anderson, 1995) but consists of some specific techniques (i.e., inviting the client’s curiosity and having inner conversations to respond in a manner that invites dialogue). Therefore, as emphasized by Andersen (2005), the use of “expert” in my research means that the therapist is expected to have “expert” knowledge of the theoretical and practical elements of systemic therapy but is humble about her own knowledge.

Although systemic therapists and the participants in my study described the flexibility of systemic therapy as a potential theoretical strength, there is no implication that systemic therapy cannot accommodate or may benefit from some predefined limits. My participants also emphasized this point. Thus, the theoretical basis of systemic therapy does not exclude such predefined limitations, provided that the client is considered a co-expert and the client’s needs guide the therapeutic process (Rimehaug & Helmersberg, 1995). The research of Wampold and Imel (2015) also supports the importance of the therapist’s being competent in specific disciplines and relational skills to adapt the therapy to the client’s needs. The map of competences consists of the fundamental elements of systemic therapy, without neglecting the therapist’s own professional judgments. Therefore, the map of competences is intended to be used as a “tool for delivering consistent practice”, consistent with Wampold and Imel’s (2015) research. I hope the map of competences will also be a useful pedagogic tool to ensure that therapists in training are prepared to work with families (under live supervision) but can also be a contribution to safeguard clients in receiving adequate treatment, even by trainees (Figley & Nelson, 1989). The need for supervision (among others) is to ensure that the trainees (or others) do not use the map of competences as a “blueprint” for how therapy should be conducted, with the therapist deciding on behalf of the clients which intervention is best suited to their problem (McLeod & Sundet, 2015).

7.4 Closing reflections

Systemic therapy has a considerable and comprehensive theoretical foundation. However, all therapeutic approaches in the Norwegian child and adolescent mental health system are subject to the legally binding requirements of the Norwegian Directorate of Health (2008). Therefore, systemic therapy's theoretical foundation is not sufficient if therapy is to be practiced in the context of Norwegian child and adolescent mental health work. The guidelines have to be considered clear directives, and they must be included as part of the therapeutic approach. I argue, the legally binding requirements of the Norwegian Directorate of Health (2008) do not appear to break with the theoretical perspective of systemic family therapy, although their wording and their inclusion of inner biological processes challenge the systemic ideas of using a non-pathologizing language. The social constructionist epistemological position in which meaning is negotiated in language through social interaction also makes it possible for the somewhat negatively charged naming of categories to serve as a starting point for negotiations.

Based on my findings, Batesons ideas of systems and social constructionism are still the most relevant. However, I argue that it is also important to include constructivism and critical realism in the systemic epistemology. By this, I mean that to acknowledge only a Batesonian and social constructionist epistemological level as the foundation for systemic therapists' understandings of human systems is, in my view, insufficient regarding the Norwegian Directorate of Health's (2008) legally binding requirements and the complexity of human systems. Thus, I consider Batesonian and social constructionist ideas as not sufficient to be the single epistemological stance for grasping the complexity in child and adolescent mental health. On the one hand, social constructionism is important to ensure co-constructed therapy and to not be reductionist about human complexity. On the other hand, social constructionist ideas that everything can be deconstructed are not useful (Lorås, 2016a). For example, although systemic therapists cannot define what the "correct" family interactions are, instead, they can say that family violence is wrong and illegal (op.cit). Thus, the social constructionist idea that everything can be deconstructed and re-constructed is not actually useful while working with vulnerable children and adolescents living under adverse conditions. Nor is it correct because, in practice, systemic therapists make choices between competing constructions, both those of the family that we either support or at some point hope to see explored/or challenged and the therapist's own competing ideas of what is going on. The systemic therapist's 'both-and' stance is supported by a philosophical stance of social

constructionism, but the systemic therapist's "either/or" practices seem to be a hidden but well-documented dichotomy (Pocock, 2013). However, the inclusion of *moderate* social constructionism in systemic therapy epistemology seems necessary to ensure a tentative stance towards so-called "objective" knowledge. This inclusion creates an opening for a co-constructed therapeutic process and avoids limiting the possibilities of a person or a family.

I think it is now time to also include constructivism and its specific focus on internal and cognitive processes as part of systemic epistemology for systemic therapeutic practice. I consider the inclusion of constructivism to be necessary to acknowledge the Norwegian Directorate of Health's legally binding requirements that therapists have a basic knowledge of internal and cognitive processes. This issue was also emphasized by all of the participants as one of the areas that must be considered, especially regarding clients' development.

A moderate objectivistic variant of critical realism (moderate critical realism in the continuum) aims to reconcile the idea that many features in human interactions need to be understood on the basis of the participants' intentions and subjective understanding. Within moderate critical realism, the notion of positivism is rejected. However, moderate critical realism does not deny that some aspects of the social world have some similarities with the natural sciences. Therefore, moderate critical realists claim that some social phenomena (i.e., unhealthy family interactions) should be considered in terms of somewhat normative or objective knowledge and should be treated differently from so-called constructions (Andersen, 2007). Thus, the position of moderate critical realism seems to correspond better with mental health's focus on diagnostic assessments and its idea regarding knowledge (i.e., axis 5 categories) and specialized services (Lorås, 2016b; The Norwegian Directorate of Health, 2008). Nevertheless, to practice a therapy influenced by moderate critical realism, systemic therapists must take a stance regarding how they position themselves in relation to somewhat "semi-objective" knowledge, for example, the axis 5 categories. Otherwise, systemic therapists are in danger of offering a covert version of social constructionism that only borrows the name of "moderate critical realism" to seemingly have considered the legally binding requirements of the Norwegian Directorate of Health (2008). I consider such a covert approach to be in danger of presenting systemic therapy as being even more indistinct than it is already today. Therefore, I argue that it is necessary for systemic therapists in child and adolescent mental health to take a multi-epistemological stance that consists of Batesonian ideas of systems, moderate social constructionism, constructivism and moderate

critical realism. For example, from a multi-epistemological stance, a diagnosis can be useful for identifying abnormal or unhelpful behaviours (which are contextually defined), but that these are dynamic and relational and subject to change and therefore not just identified with the individual's biology but as patterns.

The inclusion of moderate critical realism in systemic therapy can serve as a valuable contribution to therapists' antagonism towards positioning themselves as knowledge and research-based therapists, a fear that is ravaging the systemic field. I argue that, if systemic therapists base their epistemology in Batesonians ideas of systems, moderate social constructionism, constructivism and critical realism, then an opening is created for a more nuanced and useful stance in relation to research than that which systemic therapists have today. In this manner, research can be viewed as useful for practice, and vice versa. The inclusion of moderate critical realism entails that research is important for improving practice, provided that practice also informs research, which is also important within the discourse of evidence-based practice and RCT studies (Barkham et al., 2010). From a critical realist perspective, Carter and New (2004) argue that there is a need for interpretative and hermeneutic research methodologies and RCT studies within the field of mental health (Carter & New, 2004). It is important to note that, within the Norwegian Directorate of Health's (2008) guidelines, evidence-based practice based on RCT studies was only noted once. Thus, I believe that, in an optimally new edition of the guidelines, the focus on research will be significant.

The participants in my study praised the flexibility of systemic therapy but also desired clearer guidelines regarding which systemic competences they were expected to deliver so that they would not become lost in the complex work. Therefore, a certain degree of therapeutic guidelines and a demand for documentation and administration are viewed as necessary and appropriate to ensure that people receive good therapeutic service and to ensure the protection of their rights (Rimehaug & Helmersberg, 1995). Thus, my research offers a "map of competences" for systemic therapists in child and adolescent mental health who target the psychosocial difficulties that are categorized as associated abnormal psychosocial situations. The map of competences consists of the legally binding requirements (Norwegian Directorate of Health, 2008) and flexible guidelines consisting of the fundamental elements of systemic therapy, simultaneously with explicit descriptions of the therapists' authority to be irreverent towards systemic theoretical elements that do not seem to suit the family/therapeutic process. Thus, from my research, the map of competences offers an

available language for systemic therapy that is adapted to child and adolescent mental health. Therefore, this map can be viewed as a point of reference for systemic therapists within the child and adolescent mental health field.

7.5 Implications for practice, training and supervision

The map of competences targets the difficulties categorized within axis 5 in the WHO's (1996) multiaxial diagnostic system. However, research has historically been directed towards the difficulties categorized within the ICD and DSM diagnostic systems, such as anxiety and depression. Therefore, my research contributes to an under-researched domain in systemic psychotherapy and child and adolescent mental health. The necessity of this research becomes evident because children and adolescents are also being referred to BUP institutions when there is the suspicion that their difficulties the result of contextual and/or family issues (Norsk Forening for barn og unges psykiske helse, 2016) and not more individual psychiatric diagnoses. Therefore, the map of competences is a contribution to all clients for whom the family's psychosocial situation is considered the best starting point in the process of change. Because 16% of the clients in Norwegian child and adolescent mental health receive an axis 5 diagnosis and that this number is considered to be significantly under-reported (Sintef, 2016) the potential for the map of competences is significant.

The field of mental health is increasingly becoming a subject for political debate and with an increasing degree of control from forerunners, such as the Norwegian Directorate of Health (Nielsen, 2002). The inclusion of the legally binding requirements in the map of competences, presented in this thesis, is therefore a valuable and rare contribution in order to include the organizational and legal context within systemic therapy and safeguard that the requirements are being adhered to. The map of competences can therefore serve as part of a "bridge-building" process towards a greater inclusion of systemic ideas in the field of mental health. At the same time, the map of competences is offering an available language for systemic therapy that is adapted to child and adolescent mental health.

My research also has implications for the teaching, training and supervision of students in systemic therapy. As a teacher and clinical supervisor of family therapy students, my experience is that many students experience systemic therapy's theoretical background as vague and "hard to grasp". The map of competences can be a valuable contribution to

educational institutions and supervisors in order to offer a more unified version of systemic therapy, at the same time as the therapists' need for flexibility is adhered to. In this way, the map of competences both acknowledge and challenge the supervisees or students' effort, at the same time as helping the supervisor/teacher of being comfortable to constructively challenge him/her.

The level of detailed descriptions of systemic competences provides the possibility for the supervisor to explore the supervisee's use of specific systemic competences (i.e., the use of applause and praising, irreverence the use of hypotheses etc.). In this way one can work with the systemic competences at a more specific level of detail, if desired, than the more "traditional" way of considering systemic therapy in more general terms.

7.6 Questions for future research

Upon completing this study, four interesting questions for future research emerged. The first (1) regards the research methodology. As part of the Grounded Theory sampling process, I used fieldwork observations to develop the follow-up interviews with the participants. An interesting observation was that primarily therapists do not always do in practice what they say in theory. By conducting an ethnographic study, it would have been interesting to examine the extent to which therapists do in practice what they say they do. (2) The map of competences is a result of this research. Therefore, it would have been interesting to research the effect of relying on the map of competences in therapists targeting axis 5. (3) Additionally, it would be interesting to test the effect of the map of competences on disorders categorized within axis 1, such as anxiety and depression. Fourth (4), the map of competences offers a therapeutic approach to the difficulties categorized within axis 5 in child and adolescent mental health (BUP). Therefore, it would have been interesting to interview clients and their families (with difficulties categorized within axis 5) who received therapeutic treatments in BUP based on the map of competences to examine their experiences with this "model".

7.7 Personal learning from the research

Remaining fresh, as a family therapist, often requires the learning of new ideas and practices. For my part, conducting this research project was "the perfect match". The research project

led me, among other things, into the exploration of several epistemological positions. This was really an exciting and demanding process. Partly because the descriptions of epistemology varied a lot, according to which author I chose to follow. As an example, Per Jensen (2008) has used the word constructivism to describe both social constructionism and constructivism, while for example Sheila McNamee (2004) makes a clear distinction (at the same time as presenting similarities), following to a large extent the constructivist descriptions of George Kelly (1955). Aiming to give a clear and comprehensive account of the systemic competencies, I chose to present social constructionism and constructivism as two separate (but not competing) epistemological positions. However, the somewhat “chaotic” and misleading labeling of the epistemological positions contributed greatly to critical awareness and new knowledge.

I also learned a lot about myself as a systemic practitioner while being a researcher. One of the things that were “pointed out” was that I found it hard to rely on an interview template. I think this is because of my experience as a systemic therapist and my desire to “be where the client” is, follow them and not a pre-defined template. However, this improved as both my research supervisor and the research literature (Burck, 2005) recommended that I be more open to “what happens” in the conversation rather than strictly follow the interview guide. This also improved the later interviews.

This research has given me a more reflexive stance with regard to how my presence affects the participants. This became especially clear to me when I was looking in my research diary and found some descriptions of my experience of being restless and impatient when I thought the therapy was lacking in structure. What I consider the most interesting aspect is my written reflection that this (the lack of structure) did not seem to affect the clients. I also learned a lot from my use of fieldwork observations, which I think was really helpful, in combination with grounded theory. The use of fieldwork observations also helped me gain a broader understanding of the participating therapists’ practice. Thus, it was really helpful as part of my sampling process and improved my follow-up interviews. The inclusion of fieldwork observations also showed that we do not always do what we say we do, and that what the participants say they do is considered by the researcher to be something different. The social constructionist idea of facilitating meaning making processes through dialogue (in this occasion the follow-up interview who were partly based on my observations) was therefore pivotal, and had the paradoxical effect of safeguarding the data material.

8 CONCLUDING REMARKS

The overarching aim of this research project was to identify a comprehensive and detailed outline of the systemic therapist competences in child and adolescent mental health that target the associated abnormal psychosocial situations (axis 5) in the multiaxial diagnostic system (WHO, 1996). Based on the purpose and aim of this study, the research questions were the following.

1. In the context of child and adolescent mental health, what are the different competences in a systemic family therapy approach that address the associated abnormal psychosocial situations?
2. What are the legally binding requirements in the Norwegian Directorate of Health's (2008) guidelines for child and adolescent mental health?
3. How does systemic family therapy interconnect with the Norwegian Directorate of Health's guidelines for child and adolescent mental health?

This research is based on twelve qualitative in-depth interviews with six experienced systemic family therapists, as well as fieldwork observations of therapeutic conversations and the Norwegian Directorate of Health's (2008) guidelines.

The research findings were compiled into a *map of competences* that targets the difficulties that are categorized as associated abnormal psychosocial situations (axis 5) in the multiaxial diagnostic system of the WHO (1996). The map of competence is not meant to serve as a rigid and linear map of when each described systemic competence intend to be used. In addition, I have called it the map of competence, instead of a manual. This is because a map, following systemic ideas, doesn't have a beginning and an end, but instead provide important systemic therapeutic competences in child and adolescent mental health.

The map of competences is intended to contribute to how therapists in mental health can use systemic therapy when working with families' psychosocial situations. This research has shown that the requirements in the Norwegian Directorate of Health's guidelines (2008) for "holistic" assessment of patients' psychosocial conditions, interconnect with systemic therapy. In addition, systemic competences can be a valuable contribution to the training of systemic therapists in educational institutions and for clinical supervision. Therefore, researching the legally binding requirements in BUP relative to systemic therapy competences can contribute to a greater inclusion of systemic ideas in the field of mental health.

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APPENDIX 1 REQUEST FOR PARTICIPATION THERAPISTS

Inquiry about participation in the research project: “Development of a manual in systemic family therapy for child and adolescent psychiatry”

Therapist version

PART A

Background and aim

This inquiry concerns participation in interviews in which the aim is to develop a manual of systemic family therapy for difficulties categorized as psychosocial factors, axis 5/ ICD-10 (WHO 2008). At the present time, it seems appropriate to interview six systemic therapists. Even though gender is not the subject of the research, I will ensure that both men and women are represented among the informants.

The questions we will discuss with you concern how you define systemic family therapy's different elements in work with difficulties classified as psychosocial factors within the family / axis 5. After the introductory interview, the research project will have an ethnographic element in which field notes will be made during observation of therapeutic practice. The focus of the field work will be the therapist's choice of techniques, and not on patients' statements/expressions. If the field notes provide new information or create new questions it will be desirable to conduct a follow-up interview, if you as a participant give your consent. For practical reasons (such as travel time and logistics, etc.) a follow-up interview will be conducted directly following completion of the field work/observation of therapeutic practice; that is to say, three to four days following the first interview.

Those of you who have been invited to participate must have substantial clinical experience. Experienced therapists are defined in this project as those with more than 15 years' experience with systemic family therapy within child and adolescent psychiatry.

What does the study involve?

In order to illustrate experiences, we wish to conduct one to two interviews with you in the course of approximately one week. If you consent, the interview will be audio- recorded to allow for transcription. The interviews will be conducted in the course of January – December 2014. The project leader for the study is Per Lennart Lorås; the main supervisor is Dr Rabia Malik, and the secondary supervisor is Dr Ottar Ness. Those responsible for the conduction of the interviews are Per Lennart Lorås and Dr Ottar Ness.

What will happen to information about yourself

All data will be treated confidentially and in a responsible manner in accordance with the Law for personal/confidential information and following the guidelines provided by the Data Inspectorate. This includes the researchers having professional confidentiality in relation to all personal information gathered. The data material will be anonymized and deleted when the research project is concluded, no later than 31. 12.2017. The research results will be published in the form of a monograph as well as in national and international academic journals and conferences.

Voluntary participation

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without giving a reason. If you wish to participate, please sign the

consent form on the last page. If you wish to withdraw or have questions about the study, or generally want more information about the research project you can contact Per Lennart Lorås, tlf. 98 42 21 13 or e-mail: pelloraa@online.no.

PART B

Confidentiality

The information stored about you will only be used as described in the aim of the study. All information will be handled without name or birth number or other directly identifying information.

The Regional Committee for Medical Research Ethics, Mid-Norway has approved the study.

Communication of material and information to others

It is only the undersigned who has access to the information and can trace it back to you. It will not be possible to identify you in the results of the study when these are published.

Right to review and deletion of information about yourself

If you agree to participate in the study, you have the right to review the information registered about you. You have the further right to have corrected any mistakes in the information we have registered about you. If you withdraw from the study, you can demand to have deleted any of the information gathered unless this information has already been used in the analyses or in scientific publications.

Information about the outcome of the study

As a participant you have the right to information about the outcome of the study.

If you wish to participate, we ask you to sign the consent form and include a stamped return envelope. When we have received this you will be contacted by the project leader.

Kind regards,

Per Lennart Lorås, MFSP

Child and Adolescent Family Unit- Levanger, Norway

Doctoral student at East London University/ Tavistock Clinic

Tlf 47 98422113

Levanger, 22.08.13

Consent to participation in the study

I am willing to participate in the study

(Signed by the project participant, date)

I confirm that I have provided information about the study

Per Lennart Lorås, MFSP

Child and Adolescent Family Unit- Levanger, Norway

Doctoral student at East London University/ Tavistock Clinic

Tlf +47 98422113

APPENDIX 2 REQUEST FOR PARTICIPATION CHILDREN

Invitation to participate in a research project: development of guidelines for work with “communication difficulties in the family”

Child version, 7-12 years

PART A

Background and aim

This is written to inform you about a research project that has the aim of developing guidelines for work with communication difficulties in the family (Health Directorate 2008). I will conduct the project and will be present passively as an observer in some of the conversations you and/or your family members participate in. My focus will only be on what the therapist says and does, and not on you or your family members.

Voluntary participation

Participation in the project is voluntary. You can therefore withdraw from the project at any time and without telling me or others anything about why. If you wish to participate, you must write your name on the statement of consent at the back of this document. If you agree to participate, you can later on withdraw your consent without this having consequences for the help you or your family receive. If you later wish to withdraw or have questions about the project, or want to know more you can contact me, Per Lennart Lorås at tlf. 98 42 21 13 or e-mail: pellora@online.no

PART B

Confidentiality

As the focus is on what the therapist says and does, I will not store information about you or your family members. The project has been approved by the Regional Committee for Medical Research Ethics, Mid-Norway.

Communication of material and information to others

It is only I (Per Lennart Lorås) who has access to the material from the conversations. It will not be possible for others to find out who has participated in the conversations when the results of the project are published.

References:

Health Directorate, (2008). *Multiaksial klassifikasjon I psykisk helsevern for barn og unge (BUP). Akse 5. Avvikende psykososiale forhold inkludert definisjoner og diagnostiske retningslinjer. Multi-axial classification in psychological health care of children and youth (BUP). Axis 5. Abnormal psychosocial relations including definition and diagnostic guidelines.*

Best regards

Per Lennart Lorås, MFSP

Child and Adolescent Family Unit- Levanger, Norway

Doctoral student at East London University/ Tavistock Clinic

Tlf 47 98422113

Levanger, 26.10.13

Consent to participation in the study

I am willing to participate in the study

(Signed by the project participant, date)

I confirm that I have provided information about the study

*Per Lennart Lorås, MFSP
Child and Adolescent Family Unit- Levanger, Norway
Doctoral student at East London University/ Tavistock Clinic
Tlf +47 98422113*

APPENDIX 3 REQUEST FOR PARTICIPATION ADOLESCENTS

Invitation to participate in a research project: development of guidelines for work with «communication difficulties in the family»

Youth version, 12-16 years

PART A

Background and aim

This is written to inform you about a research project that has the aim of developing guidelines for work with communication difficulties in families (Health Directorate, 2008). I would like to be present during some of the conversations you have with the therapist in order to see how the therapist «works» with you. I will therefore concentrate my attention on what the therapist says and does, and not on you or the others in your family, and I will be a passive observer in the room.

Voluntary participation

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without giving any reasons. If you want to participate, you sign the statement of consent on the last page. If you agree to participate, you can later on withdraw your consent without this affecting your treatment. If you later wish to withdraw or have questions about the study, or want more information in general about the research project, you can contact Per Lennart Lorås, tlf. 98 42 21 13 or e-mail: pelloraa@online.no

PART B

Confidentiality

As I will concentrate on what the therapist says and does, I will not store any information about you or your family members. The Regional Committee for Medical Ethics, Mid-Norway has approved the study.

Communication of material and information to others

The undersigned has sole access to the recorded material from the therapeutic conversations. It will not be possible to identify you or your family members in the results of the study when I later write or speak about the project.

Right to knowledge and deletion of personal information

If you agree to participate in the study, you have the right to knowledge about which pieces of personal information have been registered. You have the further right to have corrected any errors in the information we have registered. If you withdraw from the study, you can ask to have the collected information deleted as long as this information has not already been used in analysis or written about in a professional journal or the like.

Information about the results of the study

You as participant have the right to access to the results of the study.

If you wish to participate, we ask you to sign the statement of consent and send it in the reply envelope in the post or give it to the undersigned or another cooperation partner at the start of the therapy session.

References:

Health Directorate, (2008). Multiaxial classification in psychological health care for children and youth (BUP). Axis 5. Abnormal psychosocial conditions including definitions and diagnostic guidelines.

Best regards,

Per Lennart Lorås, MFSP

Child and Adolescent Family Unit- Levanger, Norway

Doctoral student at East London University/ Tavistock Clinic

Tlf 47 98422113

Bergen, 03.11.14

Consent to participation in the study

I am willing to participate in the study

(Signed by the project participant, date)

I confirm that I have provided information about the study

Per Lennart Lorås, MFSP

Child and Adolescent Family Unit- Levanger, Norway

Doctoral student at East London University/ Tavistock Clinic

Tlf +47 98422113

APPENDIX 4 REQUEST FOR PARTICIPATION PARENTS

**Invitation to participate in the research project:
“Development of a manual in systemic family therapy for child and youth psychiatry»**

Parental version

PART A

Background and aim

This invitation concerns participation in a research project in which the aim is to develop a manual in systemic family therapy for work with psychosocial difficulties in the family / axis 5.

In the multiaxial classification system, the difficulties are described as abnormal relations within the family, psychological disturbance, abnormal development or disability in the child's closest family, inadequate or disturbed communication, abnormal aspects of upbringing, abnormal environment, acute life events, social stress factors, chronic interpersonal stress factors in connection with schoolwork and/or stress-producing events/conditions that are a result of the child's own disturbance/functional disability (Health Directorate, 2008).

The focus of the field work will be exclusively on the therapist's choice of interventions in encounters with the user(s) and not the referred user's statements/expressions. By field work is meant that the undersigned will be a passive observer during the conversations between the user and the therapist.

Voluntary participation

Participation in the study is voluntary. You can at any time and without providing a reason withdraw your consent to participate in the study. If you wish to participate, you should sign the statement of consent on the last page. If you agree to participate, you can later withdraw your consent without this affecting your treatment. If you later on wish to withdraw your consent or have questions about the study, you can contact Per Lennart Lorås, tlf. 98 42 21 13 or e-mail: pelloraa@online.no

PART B

Confidentiality

As the focus is on the therapeutic choices, no patient-related information will be stored. The Regional Committee for Medical Research Ethics, Mid-Norway has approved the study.

Communication of material and information to others

The undersigned has sole access to the transcribed material from the therapeutic conversations. It will not be possible to identify you or your family members in the results of the study when these are published.

Right to knowledge and deletion of personal information

If you agree to participate in the study, you have the right to knowledge of personal information that has been registered. You have the further right to have corrected any errors in the information we have registered. If you withdraw from the study, you can ask to have the collected information deleted unless the information has already been used in analysis or in scientific publications.

Information about the results of the study

You as participant have the right of access to the study results.

If you wish to participate, we ask you to sign the statement of consent and post it in the stamped response envelope / or give this to the undersigned or the cooperation partners at the start of the therapy.

References:

Health Directorate, (2008). *Multiaksial klassifikasjon I psykisk helsevern for barn og unge (BUP). Akse 5. Avvikende psykososiale forhold inkludert definisjoner og diagnostiske retningslinjer.*

Yours sincerely

Per Lennart Lorås, MFSP

Child and Adolescent Family Unit- Levanger, Norway

Doctoral student at East London University/ Tavistock Clinic

Tlf 47 98422113

Bergen, 03.11.14

Consent to participation in the study

I am willing to participate in the study

(Signed by the project participant, date)

I confirm that I have provided information about the study

Per Lennart Lorås, MFSP

Child and Adolescent Family Unit- Levanger, Norway

Doctoral student at East London University/ Tavistock Clinic

Tlf +47 98422113

APPENDIX 5 REK NORWAY



Region:	Executive Officer:	Telephone:	Date:	Reference:
REK midt	Ramunas Kazakauskas	73597509	05.11.2013	2013/1551/REK midt

To Whom It May Concern

Project title: Dveloping a systemic family therapy manual , for inadequate or disturbed communication within the family/axis 5 diagnosis (ICD-10)

Principal investigator: Per Lennart Lorås

Confirmation

The Regional Committees for medical and health research ethics, Central Norway, evaluated the project "Utvikling av en systemisk familieterapeutisk manual, for inadekvat og forstyrret kommunikasjon innen familien" ("Dveloping a systemic family therapy manual , for inadequate or disturbed communication within the family/ax is 5 diagnosis (ICD-10)") in its meeting on 20. September 2013. The project was approved with minor revisions on 5. November 2013.

Sincerely

Siri Forsmo
Dr.med.
Deputy Head, REC Central Norway

Ramunas Kazakauskas
Higher Executive Officer

APPENDIX 6 ETHICAL DECISION UEL, UK

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa

Quality Assurance and Enhancement



17 September 2014

Dear Per Lennart Loras,

Project Title:	"Developing a systematic family therapy manual, for inadequate or disturbed communication within the family / axis 5 diagnosis (ICD-10)"
Researcher(s):	Per Lennart Loras
Principal Investigator:	Dr Charlotte Burck

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered on **Tuesday 16th September 2014**.

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
Child and adolescent family unit, Norway	Dr Charlotte Burck

Docklands Campus, University Way, London E16 2RD
Tel: +44 (0)20 8223 3322 Fax: +44 (0)20 8223 3394 MINICOM 020 8223 2853
Email: r.carter@uel.ac.uk





Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
UREC Application Form	1.0	7 March 2014
Participant Information Sheet (Parent)	1.0	7 March 2014
Consent Form (Parents)	1.0	7 March 2014
Participant Information Sheet (Child)	1.0	7 March 2014
Consent Form (Child)	1.0	7 March 2014
Participant Information Sheet (Therapists)	1.0	7 March 2014
Consent Form (Therapists)	1.0	7 March 2014
Interview questions	1.0	7 March 2014

Approval is given on the understanding that the [UEL Code of Good Practice in Research](#) is adhered to.

Please ensure you retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Neville Punchard'.

Professor Neville Punchard
Chair
University Research Ethics Committee (UREC)
Email: researchethics@uel.ac.uk

Docklands Campus, University Way, London E16 2RD
Tel: +44 (0)20 8223 3322 Fax: +44 (0)20 8223 3394 MINICOM 020 8223 2853
Email: r.carter@uel.ac.uk



APPENDIX 7 INTERVIEW GUIDE

Research project: “Development of a manual of systemic family therapy for child and youth psychiatry”

TOPIC GUIDE

The questions I will focus upon in the interviews are:

- a. What is your educational background?
- b. What is your experience with systemic family therapy in child and youth psychiatry?
 - How do you define systemic family therapy?
 - Can you give any examples?
 - Which specific elements do you use in work with difficulties categorized as abnormal psychosocial relations (axis 5?)
 - Can you give some examples?
 - How would you describe the client(s)'s contributions (user influence) and the 'place' this has in the therapy?
 - Can you give any examples?
 - To what extent are potential cooperation partners 'activated' in your work (child protection service, health sister, etc.)
 - Can you give some examples of how this is 'organized'
 - How do you relate to parents/other carepersons for the referred child with their own psychiatric diagnoses or significant difficulties?
 - Are there some, and if so, which cases do you view systemic family therapy as 'contraindicated'
 - What characterizes good systemic family therapy for work with psychosocial relations?
 - Can you give some examples?
 - Which 'ideas'/theoretical elements would you say the therapy is built upon/are the most prominent?
 - How are these 'ideas' put into practice?
 - What is (if it is possible to define) 'the main idea'?
 - To what extent would you describe the therapy to be 'manual-based/or adapted on the basis of 'what happens in the room (there and then)'?'
 - Can you give some examples?
 - Can you describe a 'normal' therapy conversation with a basis in the difficulties connected with psychosocial relationships?
 - Who is present?
 - How are you as a team organized?
 - In what way/to what extent does one relate to assessments with regard to reports/investigations?
 - If something is to be investigated how is this done?
 - Interdisciplinary?
 - What importance is given to contextual factors?
 - To what extent do possible 'additional diagnoses' have significance for the therapy offered? What importance is given to the diagnosis(es)?
 - Can you give some examples?

- Does the therapy course have specific ‘characteristics’ at the start, the middle sessions and the concluding treatment sessions?
 - In what way? Examples?
- How conclusive / what assessments form the basis for the point of conclusion / that is to say: when does one conclude the therapy course?
 - Who makes the decision to conclude?
- What, if anything makes systemic family therapy work difficult in child and youth psychiatry?
 - In what way? Examples?
- What, if any other therapeutic traditions do you ‘build’ your work upon?
 - If so, what is the reason that systemic family therapy is assessed as ‘enough’ alone?
- What do you think about the future of systemic family therapy in child and youth psychiatry?
- What (if any) are systemic family therapy’s challenges, possible deficiencies for the future in child and youth psychiatry?

APPENDIX 8 FIELDWORK NOTES EXAMPLE

Fieldwork observation notes (in Norwegian)

Nora is the main therapist, Tuva is co' therapist 19.11.14

The discussion between Nora and Tuva before the therapy starts:

The case has been with BUP for more than half a year and more than 10 conversations have been conducted. Mother has had a serious depression approximately 3 years previously. Abuse in childhood has emerged, something that has made the whole family constellation become «torn apart». The therapists clarify the goal of the session, clarify with relation to Christmas and its organization. The therapists say that they expect that both father and mother (they are divorced) and the daughters of 15 (the referred patient) and 19 years to participate in the day's therapeutic conversation. The therapists clarify between themselves what will not be talked about with regard to the children's wishes from previous conversations. Tuva says in this introductory clarification round between the therapists that she feels the children have been given too much responsibility. The therapists speak about the father needing to be «more in the running» when mother has a difficult period. Father is described by both Nora and Tuva as avoidant. Nora says that she has previously received a mandate from 'the girls' to share some of their comments.

Question for the follow up interview: *what is the reason that few of the many conversations appear to have been conducted with the whole family?*

Tuva is concerned that non-normal situations demand extraordinary interventions (ref. to their custody situation), that function well ordinarily though they are now viewed as «exceptional circumstances».

Observations of the therapists' choice of «techniques/elements» in the therapists' conversations with the parents:

The main therapist begins by saying that she is aware that the youths (15 and 19 years) feel it is difficult to be together in this way. The eldest daughter cries when this is said. The therapist asks if it is all right to continue. Gets a weak/low yes as answer.

Question for the follow up interview: *How do you relate to emotional expressions in the room?*

The conversation continues with Nora retelling from the previous conversation (what the girls wanted to be shared) and with a basis in this what the goal is for today's conversation. The therapists use a great deal of time to clarify the structure of the day's session. Tuva suggests that they begin together (the family), but that they conclude by speaking with the parents alone.

Question for the follow up interview: *When should one talk with the parents without the children present?*

The therapist suggests the day's «start» theme, but the family is asked if it sounds all right. Continue with a basis in the practical «tasks» - planning the referred girl's birthday. The therapist uses the metaphor «a changed family map» in order to describe how the family has changed after the recent events.

Question for the follow up interview: *When do you use metaphors in therapy and why?*

I observe strong emotional expressions in both mother and eldest daughter that remain unacknowledged. When Tuva «takes the floor» there appears to be extended use of positive connotation. Tuva uses her own family as examples.

Question for the follow up interview: *When do you use your own experiences/own life as part of the therapy? And Can you say something about what assessments you made in the therapy with regard to how much/little you could challenge mother and her expressions (for example her statement to the girls: you don't care about me)?*

There was much discussion regarding arrangements / potential arrangements for Christmas, but little was concretized clearly.

Question for the follow up interview: *When should one/can one concretize arrangements/suggestions completely explicitly?*

The therapists appear to «withdraw» noticeably often when mother shows strong emotional expressions after Nora says that the children cannot be responsible for mother needing

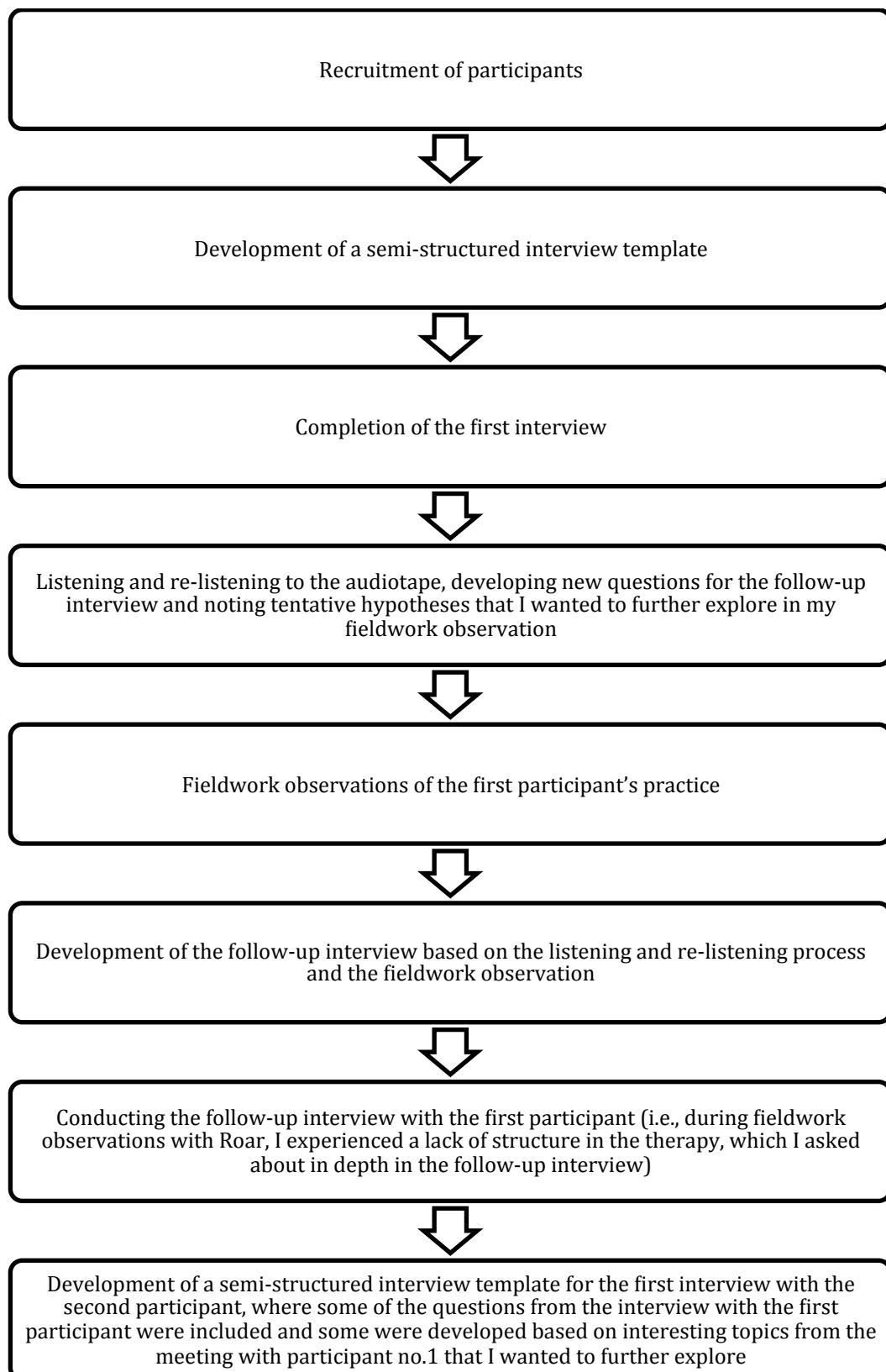
company. Appears that Nora's to an extent normative linguistic expressions became «too strong» for mother, and that the therapists therefore withdrew what they said. Tuva then used diverse psychological expressions and defended the choice in the observation that this appears connected to her psychiatric disturbance (wrong thoughts and the like – a certain form of psychoeducation). Both the therapists began as well to speak to a noticeable extent without involving the parents and/or the children after the strong emotional and linguistic expression came from mother. When the conversation is nearing its end, the therapist asks the girls if we have talked about what was important for them.

APPENDIX 9 EXAMPLE OF INITIAL AND FOCUSED CODING

	Interview nr. 2 Roar	Initial	Focused
1	I: Now it's this interview number		
2	two. In the conversation we had		
3	today, now, and that...and that		
4	you said a little about that you	Divided up the	
5	did as well otherwise, you talked	conversation, something	Family therapy, also with
6	about..so..so we divided it up a	with the parents and	Individuals, and parts of
7	little bit. We had something	something with the family	the system (R2,5-8)
8	about parents, something about	together	
9	the whole family together. And		
10	you said as well earlier today		
11	something about that you also do		
12	individual conversations and	Often there are more	Often more individual therapy
13	different things.	individual conversations	later in the process (R2,13-15)
14	P: Yes	done farther out in the	
15	I: Preferably more individual	course	
16	farther out in the course of		
17	therapy. But can you say a bit		
18	about the choices that lie at the		
19	base for when you speak		
20	together, when you divide it up,		
21	why you divide it up and how do		
22	you divide it as well?		
23	P: it's an exciting question,	I work as much on intuition	Intuition as essential as
24	because I said something as well	as rationality	rationality (R2,22-26)
25	before about that I, in a way,		
26	work the same... perhaps a lot on		
27	intuition as I do on rationality, if		
28	I can put it like that.		
29	I: yes		
30	P: So that if I'm thinking about		
31	this concrete conversation, then I		
32	know that we've agreed that we	Work on how to have the	The family's best is the focus
33	will meet the whole family to	best possible situation in the	(R2,31-32)
34	work with the issue which is:	family	
35	How to have the best possible		
36	situation in the family? And that		
37	focus has been such that we..we		
38	haven't had a problem focus as		
39	such, but we've said that... that		
40	many things are good, many		
41	things one can work with to		
42	make it even better.		
43	I: yes..	Should we do what we've	The family decide whether we
44	P: As well I'd made a list that I'd	decided?	should follow the previously
45	worked out with them before.		decided plan for therapy
46	And then I start as well...as		(R2,42-44)
47	well... such tha the rationale then		
48	is that, after asking them as well:		
49	should we do what we've		
50	decided?		
51	I: yes..		

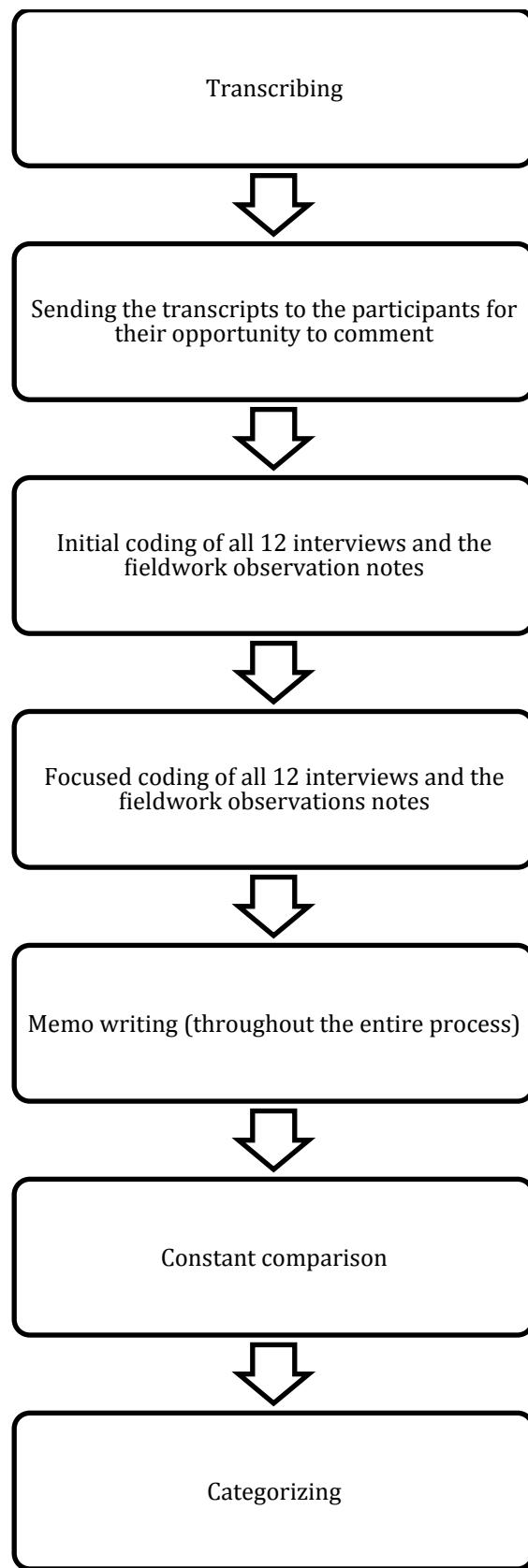
52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95	<p>P: then we begin there. But then .. so .. and especially with this family here where there were two children, especially the one who's also for that matter a picture of hyperactivity, I mean. you hear how fast she talks.</p> <p>I: very often and very much.</p> <p>P: yes, and fast.</p> <p>I: very fast, yes.</p> <p>P: very fast. And a sister who in a way responds, so that I know that when to have my sensory apparatus on the whole family, then I begin as well ..</p> <p>I: yes.</p> <p>P:.. so that I don't know how it looks from the outside, but then I have in a way to try to hold myself to what I've decided to do, and that we've decided, namely to explore XXX is afterwards) issue confusion?</p> <p>I: yes.</p> <p>P: at the same time as I have to relate to these here girls who then shift attention all the time because they.. that's of course why they've had ADHD diagnoses both of them.</p> <p>I: yes.</p> <p>P: and the one perhaps has more ADD. And that's what I mean about function descriptions. So that then.. Also of course I feel, after awhile as we work with this about confusion, that I'm beginning to lose these girls. I mean I can't get them to join anything.. What Michael White</p>	<p>I notice that also my own sensory apparatus gets «overstimulated» in conversation with this family and the hyperactive child</p> <p>They shift attention often</p> <p>I can't get them to join what Michael White would call stancetaking to the issue/problem</p> <p>I struggled with their attention disorder in such a way that I had the need to divide the conversations up so that the other family members could have a</p>	<p>Even the therapists own sensory apparatus gets "overstimulated" in therapeutic conversations with families/individuals of high activity or noise (R2,57-58)</p> <p>Need to relate to individuals who shift attention often (R2,67-69)</p> <p>How the individual function in their every day life inform how i meet them in therapy have a turn (R2,74)</p>
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APPENDIX 10 SAMPLING PROCESS FLOWCHART



The same procedures was conducted with all six participants

APPENDIX 11 DATA ANALYSIS FLOWCHART



APPENDIX 12 FLOWCHART OF THE BUILDING/MERGING OF THE MASTER CATEGORIES

In these flowcharts (Table 1 and 2), I lay out an example of the building and merging of two of the six master categories: (1) *The importance of ethical and contextual awareness in systemic therapy* and (2) *Session-specific competences*.

Table 1.

Text transcripts	Initial Coding	Focused Coding
<p>So, that if I'm thinking about this concrete conversation, then I know that we've agreed that we will meet the whole family to work with the issue which is: How to have the best possible situation in the family? And that focus has been such that we haven't had a problem focus as such, but we've said that many things are good, many things one can work with to make it even better. As well I'd made a list that I'd worked out with them before. And then I start as well such the rationale then is that, after asking them as well: should we do what we've decided? Then we begin there.</p>	<p>Work on how to have the best possible situation in the family</p> <p>Should we do what we decided earlier</p>	<p>The family's best is the focus</p> <p>The family decide whether we should follow the previously decided plan for therapy</p>

Table 2.

Focused codes	Sub-categories	Master categories
The family's best is the focus	Power relations	The Importance of ethical and contextual awareness in systemic therapy
The family decide whether we should follow the previously decided plan for therapy	Tailored therapy	Session-specific competences

