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COLLABORATION: FAMILY AND THERAPIST PERSPECTIVES OF HELPFUL THERAPY

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

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

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

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

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[Correction added after online publication 9/30/09: The Gehart and Lucas reference on p. 14 was incorrectly listed as being from the Journal of Family Psychology, and should have been listed as from the Journal of Family Psychotherapy.]

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

THE STUDY

Context

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

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

Participants

Four therapists (Table 1) and 10 families with 10 mothers, 5 fathers, and 11 children (Table 2), in total 30 persons, were interviewed. Table 1 depicts gender, age, years of experience, and profession of the therapists. Table 2 depicts family size, who was interviewed, their status at the time of interview, and who the therapists were. All the families and therapists were ethnic Norwegians. The families were recruited by the therapists. The criteria for inclusion were both two-parent and single-parent families, and both active and terminated treatments. All families asked agreed to participate. The families were supplied with both verbal and written information about the study, and the researcher contacted the family after they had given their consent for participation.

The author/researcher contacted the consenting families by phone and the parents were given the choice of an individual interview or an interview as a family. In addition, they were asked if they wanted their children present. If so, the parents asked them to participate. All the

Table 1
Therapists

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

Table 2
Families

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

[a]Therapist X stopped working at the Family Unit before project start.

families chose a family interview except one of which only the mother wanted to participate, not the father and child. In one family, circumstances prohibited the participation of the children, and one mother did not want her child to participate. In seven of the families, the children were present. The participation of the children varied from full active participation in the interview to leaving the main part of the interview to their parents.

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

Data Collection

A grounded theory analysis was performed. Data was collected through one interview session with each therapist and family, lasting from 1 hr to almost 2 hr depending on the time

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

Analysis

This study employed modifications of grounded theory (Glaser & Strauss, 1968) by Rennie, Phillips, and Quartaro (1988) and Hill, Thompson, and Williams (1997). The interviews were organized into texts composed of statements that constituted blocks of data (Hill et al., 1997) or meaning units (Rennie et al., 1988). The meaning units were organized into a preliminary structure according to common themes differentiating topic areas that formed different domains. The following domains formed an initial organization of the material: manner of therapeutic work, effects of therapeutic work, understandings of therapeutic work, and a domain for themes not related to the research question. The next step was to abstract core ideas (e.g., the "essence" of statements) within each domain (Hill et al., 1997). A total of 110 core ideas were formulated from the therapist interviews and 577 from the family interviews. These core ideas were compared within and across cases to create categories. Two levels of categories were chosen: category and subcategory (Nerdrum & Rønnestad, 2002). The following provides an example:

> *I: To confront something in the moment. It sounds as if you have experiences with that. Could you tell me more about how that was experienced?*
>
> *F: It gave you the opportunity to have a real situation where you could be given supervision or you could be given affirmation that what you were doing was right in a difficult situation and at the same time the therapists were experiencing how difficult our daily life could be.*

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

The present study had a defined target group: four therapists and families who fit the selection criteria described above. Processes for identifying the experiences of such a predefined group as described by Hill et al. (1997) have been followed. Hill et al. (1997) did not use theoretical sampling (Glaser & Strauss, 1968). Instead, they defined the sample and "collect(ed) all the data using the same protocol to ensure constancy of response within a homogeneous sample of participants rather than alternating between data gathering and data analysis" (Hill et al., 1997, p. 521).

Saturation (Glaser & Strauss, 1968) or stability of findings (Hill et al., 1997) is reached if "new cases do not change the results" (Hill et al., 1997, p. 552). In a process in which 12–15

cases are collected, a preliminary analysis of 8–12 is completed, and "if the remaining cases do not change the results substantially, the findings can be considered to be stable" (Hill et al., 1997, p. 553). The therapist interviews were fixed (there were no others to interview), so the question of saturation did not apply. A preliminary analysis was completed with eight families. The next two interviews did not supply new categories and saturation was assumed.

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

RESULTS

The Therapists' Perspective

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

"To get a taste of it" pointed to therapists' use of opportunities to have similar experiences as the service users. It was specified by the following subcategories: sharing experiences, participating, attaining mutual definitions, and blurring the differences. Experiences of sharing concerned therapists being "in their shoes" and getting "a little taste of it" (T.A.).[1] Through their close work with the families, therapists described how they often experienced being in the same situation as the families in that they felt helpless in getting through to the children. The therapists also experienced that it was helpful for the families "to see other persons struggle with these problems" (T.A.). There was "a mutual touching, you were touched yourself and they were not unaffected by the way they were being met by us" (T.A.).

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

Table 3
Therapeutic Work: The Therapist Perspective

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

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

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

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

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

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

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

Over several years, the therapists had developed a variety of techniques from which to draw. Typically mentioned in this study were the flip chart and chart pens as tools for visualizing and memorizing material; the use of specific, more or less manualized forms of therapy like Barkley's parental training (Barkley, 1997) and narrative practice (White, 2007); tools used across specific methods such as the Genogram (McGoldrick, Gerson, & Shellenberger, 1999) and the Family Dialogue Set (Balmbra, 2006); role-play, puppet theatre, games, the making of videos, the use of photo albums, and play were also part of this toolbox. Lastly, the Session Rating Scale and the Outcome Rating Scale (Miller & Duncan, 2004) were used to monitor process and outcome.

Traditionally, pathology has been the focus of mental health. This focus is suggested in therapists' view of a service user as being "without nuance" or "lacking nuances." The

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

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

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

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

The Families' Perspective

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

All the families were represented with statements and meaning units in the three main categories. There was variation in the preferences and needs of the various families. In the following, "all families" means all 10 families, "most families" means eight or nine of the 10 families, and "some families" means six or seven of the 10 families (Table 4).

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

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

Giving and receiving feedback were significant activities for most of the families, and although giving feedback to the therapists was confirmed as important, the main concern was to get feedback from the therapists: "(M)aybe what was missed was more feedback if I did it correctly. . . . Am I doing it right or could I have done it differently?" (F10). Some family members said that the therapist could have supplied more feedback about negative aspects of family interactions. Key words were "state," "be direct," and "be concrete." The focus should be on errors, but in a friendly and nondegrading manner.

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

Table 4
Therapeutic Work: The Family Perspective

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

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

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

Having many possibilities was important for all the families. This concerned where, when, how long, how, and with whom to work. This family unit had the opportunity to go outside the traditional time span and treatment contexts, an element valued by all the families. To stay at the unit gave "a kind of breathing space" (F5). Families emphasized the opportunity for the participation of the extended professional network and the extended family. To involve kin was "healthy in most connections because they were touched by (the problem) also and they were a great part of the lives of the children" (F9). Organization of the therapeutic work also included separating the family into subgroups, which allowed parents to work alone knowing that the children were attended to. The most important context outside the family was the school. Establishing good collaborative relations with the school was a central agenda for all the families.

Understanding through participation was valued by most of the families. Participation in situations similar to those of the family context was often characterized by experiences of failure, both on behalf of the service users and the therapists. The key word was "sharing experiences": "You do not have to drown in order to be a life guard, but you must take in through your thinking what drowning involves" (F5). Participation did not mean to have exactly the same experience, but for therapists to put themselves in the place of the family. Families viewed understanding through therapist participation as happening in the immediacy of the moment, showing itself nonverbally on the part of the therapist, and was received as an embodied experience by family members: "I only needed to look at him (the therapist), and (I knew) he just knew" (F6).

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

The personal conduct of therapists was vital in generating a collaborative relationship. To be quiet, patient, friendly, easy to talk with, nonjudgmental, humane, and above all, to have a sense of humor made therapists "easy to collaborate with" (F4). Sincerity combined with lack of prejudice toward the family was of utmost importance. Prejudice was connected to "knowing better than" and taking a top-down position toward the family: "(The therapists) apologized . . . and I was heard. I thought it was good that they admitted a mistake because . . . often we get the feeling . . . that authorities don't make mistakes. They came down to our level" (F10).

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

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

DISCUSSION

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

Similarities of Perspectives

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

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

Differences Between Perspectives

The differences between these two perspectives enrich the three concepts. Conversation is enriched by the difference in focus concerning the use of feedback. The therapists were committed to the idea of monitoring their work and adjusting it according to feedback about process and outcome.[2] The families acknowledged this, but gave a strong message that they needed

more feedback from the therapists on negative aspects of their own interactions within the family. The therapists were experienced as supportive and this made their focus on such negative aspects safe and secure. Training within the language-oriented therapies (Flaskas, 2002) emphasizes skepticism toward labeling the family as "problematic" and positive connotations are promoted (Selvini Palazzoli, 1978). The message from the families was that therapists did not have to be afraid of focusing on the negative as long as this was within the boundaries of "the helpful relationship" depicted here. This obviously suggests that the families' previous experiences with social services were not perceived in a "helpful relationship" context.

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

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

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

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

Implications

The concept of *relationship* in this study parallels the findings of Norcross (2002), but also suggests some expansions that should be given attention in clinical work, training, and

research. It reflects the importance of the therapeutic alliance (Horvath & Bedi, 2002) and self-disclosure (Hill & Knox, 2002) and highlights the importance of privileging and following the perspective of the client. One expansion of the concept of relationship is the role of the therapist in taking an active part in resolving conflicts between the family and other parts of the health care system, social services, and school system in a manner that resurrects both the honor of the family and collaboration with these services. This implies the expansion of therapist training to include skills in conflict management and an active role for the therapist as supportive agent of the family. Research into what kinds of skills and knowledge are needed in such situations is therefore recommended. This issue also invites further research into detrimental results of therapeutic activity and helping behaviors of the helping systems at large.

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

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

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

Above there is identified a possibility of having to deal with aspects that might be experienced by therapists as oppositional. Potentially opposing processes are included within the concept of *participation*. The linguistically and collaboratively oriented therapies (Andersen, 1991; Anderson & Gehart, 2007; White, 2007) that have inspired this unit have a troublesome and skeptical relationship with technical aspects of therapy. Andersen stated: "Therapy is not a technique. It is a way for the 'therapist' to engage in client relationships" (1993, p. 305). The fear is that use of techniques and tools turns it into an instrumental relationship, where the family members become objects of scrutiny, with the objectification of persons and relationships as the result. The families in this study expected therapists to be skilful, have knowledge, and use it. What therapists might fear as detrimental to a helpful relationship was taken for granted by the families in this study. For them it was a matter of course that therapists used what they knew and that they shared it. To be able to do this is a necessary aim of training, and also invites research on the collaborative use of specialist knowledge within the therapeutic relationship.

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

Context for Changes

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

CONCLUSION

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

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