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The First Meeting at Child and Adolescent Psychiatry

MONICA HARTZELL

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Abstract
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Children and parents who visited child and adolescent psychiatry (CAP) for the first time were interviewed in the presence of their therapists about the first meeting. The interview was intended to make the attendants describe in their own words what the meeting was like for them. The interview was repeated after six months to get complementary information. Research assistants, reflectors, helped the interviewer to prevent from bias and to hold on to the theme.

The grounded theory approach was utilised in papers I, II, and III, and qualitative content analysis was used in paper IV.

Children appreciated the therapist being in an active as well as in a more passive but alert position, moving between asking adjusted questions and including the parents. The therapists' skill of listening was also important to them.

For the parents, it was important what happened between their child and the therapists. They questioned their own role and presence. Also, they focused on the plan for the meeting and for the coming process. Certain things that happened in the dialogue were useful after the meeting. The results indicate that what was helpful was connected to family therapy matters rather than psychiatric ones.

The therapists balanced between a psychiatric and a family therapeutic position, and it was a dilemma for them how to best fulfil their assignment in the organisation as they perceived it.

Two competing discourses were found in the first meeting; *Structuring*, which stood for structure, planning and expertise, while *Collaboration* represented negotiations of how to work together, empowerment and emotional aspects. The *Structuring* discourse tended to dominate. Both discourses consisted of valuable elements that needed to be included to ensure that the atmosphere would not be too strict or too flexible.

The findings are tentative because of the lack of studies to compare to, and because of the few interviews made.

Monica Hartzell, Child and Adolescent Psychiatry, Akademiska sjukhuset, Uppsala University, SE-75185 Uppsala, Sweden

To my father who talked with me about the big things
To my mother who talks with me about the at first sight little things
To my children who keep talking with me about the new things

Min själ älskar så de främmande orden

Min själ älskar så de främmande orden
som hade den inget språk –
och så är det:
Mitt språk är ofött, det är i tillblivelse
Det är inte hackmat av alla de gamla språken
Ord parat med ord
ger ord med ny mening
Nytt ord.

My soul loves so the extraneous words

My soul loves so the extraneous words
as had it no language -
and so it is:
My language is unborn, it is in coming
It is not mishmash of all the old languages
Word paired with word
gives word with new meaning
New word.

Gunnar Ekelöf, 1967 (Swedish poet, 1907-1968), transl. MH

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I   What Children Feel About Their First Encounter with Child and Adolescent Psychiatry. *Contemporary Family Therapy, 31*(3), 177-192

II   Parents' Perception of Their First Encounter with Child and Adolescent Psychiatry. *Contemporary Family Therapy*, *32*(3), 273-289

III   Therapists' Views of the First Meeting at Child and Adolescent Psychiatry. Submitted for publication.

IV   Structuring and Collaboration – Balancing Discourses in the First Meeting at Child and Adolescent Psychiatry. Submitted for publication.

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Contents

Introduction

The thesis focuses on what happens during the first encounter at child and adolescent psychiatry (CAP), an organisation intended for children up to 18 years of age, as described by the attendants. Children, parents and therapists were informants in research interviews intended to get a deeper understanding of what it is like to be part of such a first consultation. It adheres to the first occasion when children and parents sit together, at least some of the time, with one or two employees in the staff at CAP.

The occasion could have different names depending on what one wants to stress as important. It can be called a meeting or an encounter if the important thing is that a couple of people meet each other, or called a visit if it is seen as there are visitors coming to a place where others are hosts or hostesses. If called a consultation the expert aspect is lifted, and if it is defined as a conversation, the dialogue is in focus. In the thesis, the words meeting or consultation will be used mostly.

A medical perspective versus a contextual one

The meeting in focus takes place in CAP, a medical speciality, and therefore included in a field where a medical view of peoples' difficulties, may they be physical, mental or both, is prevalent. The medical model follows the linear sequence of 1.collecting data, 2.diagnosing, and 3.finding an appropriate treatment. The diagnosis and treatment can be re-evaluated if new information arises. The medical model implies a (natural) scientific, positivistic approach to human suffering. Techniques being used are more or less standardised, and are inserted and conducted by a therapist who follows the standard (Sandell, 2006). An alternative to the medical perspective is the contextual model presented by Wampold (2001), which instead emphasises the importance of the context and the atmosphere connected to treatment, paired with how the patients value the therapeutic process. Jensen (2006) describes the contextual model as including elements of 1.the emotional relationship (the therapeutic alliance is a part of this), 2.the client's belief in the treatment and in the therapist's ability to help, and 3.both parties' acceptance of the same rationale of the present problems. The medical model and the contextual model are connected to different meta-theories, and

subsequently they focus on different aspects and in research they give answers to different kinds of questions.

Psychotherapeutic influences have a place in psychiatry, but since some psychotherapeutic approaches are close to the contextual model, consequently they have difficulties to do themselves justice in the psychiatric context (Wampold, 2007). The two perspectives might not necessarily clash, but the dominance of the medical model could bring some therapists' actions and attitudes into the background. The practice of psychotherapy in managed care (in the US) is imposed by the medical model, and as a result therapists are not free to deliver treatment that they deem to be optimal (ibid). Within Swedish psychiatry one can trace the same tendencies. Sjöström (2000) asserts that psychiatry has taken the responsibility to handle mental difficulties and sufferings. He means that psychiatry insists the patients should be compliant and adjust to its demands. It claims the most severe sufferings, which hinder alternative treatment (ibid.).

Carlhed (2007) in a Swedish study found that all the older forms of organisations for education and training, mental health, health care, and social services constitute powerful forces, which still influence the way the welfare state organises also today. If included, the medical doxa was the dominant one, and could execute symbolic power in the practice of any organisation (ibid.). As mentioned, CAP professionals are put to conduct certain assignments. First, they must make the family, or rather the child, a client for this organisation, i. e. construct a client (Johansson 1993), in this case construct a child psychiatric case appropriate for the organisation and with an identified patient, or the family is requested to turn to another organisation. If the case is accepted, the personnel should conduct the assignment to make an assessment in the first meeting (Gillberg 1990, Lewis 2002, Rutter & Taylor 2002). Also, therapists should ensure that the family members return (ibid.). As mentioned, the professionals have limited degrees of freedom, and must adjust to the demands which are present in the organisation. The culture and the written and unwritten rules regarding what a first meeting should be like, leaves to the professionals to be obedient to these rules, as they perceive them, or to make own decisions on how to act. In any case, the professionals have within their power to direct family members or collaborate with them in varying degrees.

The power of discourses

Discourse is defined as a certain way of talking about and understanding the surrounding world and activities in it (Winther Jörgensen & Philips). It has to do with perspectives, ways of thinking and arguing connected to a certain field and puts limits to what is meaningful and acceptable to say and do. A person is seldom aware of which discourses influence her or him. Discourses

affect positioning and expressing, and that is why discourses are crucial in human collaboration and interaction. Cameron (2002, p. 145) points out, that *"talk is always designed by those who produce it for the context in which it occurs."* In every discourse there are social voices which could be contradictory, and people host different social voices in unique combinations. Discourses are created and changeable in interaction with different social voices inside or between discourses (ibid.). Discourse breaks, for example when a taboo is broken and a subject becomes possible to speak about, social and relational changes can occur. Linell (2007) argues that discourse theory does not necessarily lead to discourse analysis or discourse studies, but can be useful when reflecting on or discussing a phenomenon. Discourses and the connected social voices influence people who come to visit CAP, as well as therapists working there. In the context of CAP competing discourses and social voices could decide the discourse order and be serious challenges for therapists when building alliances to family members.

Psychiatry and the development of bureaucracy

As the Swedish welfare state developed, starting in the late 19th century, psychiatry as part of medicine was influenced by Weber's ideas of bureaucracy. Like other organisations it was built upon ideas of rationality and effectiveness and implied hierarchy, work division and sets of rules to achieve coordination and control (Johansson, 2007). Contact with clients or patients should be carried out by some workers, street-level-bureaucrats (sw. gräsrotsbyråkrater, ibid.), and decisions and manuals were made by others, administrators. The organisations' clients were involved very little in the decision process. The organisation had a legal authority, built into the system. The client-relation had a double character; it meant both contact between human beings and contact between organisation and client. Both parties had to adjust to this fact. Although meant to be effective, Blau & Meyer (ibid.) suggests it is an empirical question whether modern bureaucracy is effective or not and how well necessary innovations can occur in the organisation.

Staff members in psychiatry today are the ones who work in direct contact with patients, and could be comparable to street-level-bureaucrats. Therefore they are limited by the organisation and by the prevailing views of the administrators, principals and bosses who gives prerequisites for the work. Thus, some of the knowledge and skills which employees bring into the organisation will not always be welcome.

The diagnostic interview

In the guide-lines of hand-books of CAP, the first occasion when children and parents meet with the CAP staff is considered to be a diagnostic interview (Rutter & Taylor, 2002). The clinician has the assignment to collect comprehensive information about the child, its development, family history etc. It is meant to lead to an assessment, and later to a diagnosis. Cox (1994) says the clinician needs to be flexible to gain information, and let the persons start telling where they choose to start themselves. Others have meant that diagnostic interviews should be structured (Martin & Volkmar 2007) and manuals might be helpful. It is described as important to build trust and confidence to make family members share information and also to want to come back (Cox, 1994). The first meeting could be the beginning of a longer contact. By the end of the meeting, there should be a conclusion or comment from the clinician about further assessment or treatment. Interviewing the whole family is recommended as it gives extra information (Jenkins, 1994); although authors in Martin and Volkmar's edited book (2007) focus on separate interviews with children and parents.

How to conduct first meetings in psychotherapy

Experienced clinicians of psychotherapy have described how to do and what to think of when meeting clients in psychotherapy or psychosocial settings for the first time (Bryant, 1984; Sterlin, 1980; Tomm, 1992). It has been pronounced and discussed what skills a therapist needs to be able to carry out a successful first interview (Heller, 1987; Paterson, Williams, Grauf-Grounds, and Chamow, 1998; Weber, McKeever, and McDaniel, 1985), as well as how to present suitable questions (Cabie & Fride, 1980) and who to invite (Sveaass & Reichelt, 2001). The process of joining the family and to find a way of being together with them, especially fitting them, has been marked (Minuchin, 1993). Flexibility and spontaneity has been seen as key elements when building a contact with a family (Haley, 1980). Using simple words, being clear about why you meet and focusing on the child have been pronounced by others (Wilson, 1998). The first meeting has been seen as especially critical (Coleman, 1995), and can be predictive of the following process (Odell & Campbell, 1998). In therapeutic relationships many authors talk about the first 10 or 15 minutes as crucial, even in a long-term setting (Bachelor & Horvath 2002, Odell & Quinn, 1998).

The first meeting – certain possibilities

Stating that the first meeting is of great importance, we get on a sidetrack into the precious moments of the birth of a child. In research on infants and their mothers (Macfarlane, 1978) it is stated, that the potential of starting to build the attachment between them is high in this first hour. Researchers do not say, though, that it is not possible to connect to a child also later, but this meeting soon after birth contains certain possibilities as there usually is openness from all three parties child, mother and father.

When a family comes for the first time to a CAP setting, they are "newborn" in the sense that they come to a place they have never been before, they have gone through suffering of some kind, they are unknowing of the rules and procedures, they don't know what to expect or what is expected from them. Different from a newborn, which has a very limited experience of human meetings, the family members have varying experience of previous meetings and expectations of what might happen. From attachment theory, we know that infants have a social capacity, that make them active agents in building attachment bonds (Maehle, 2002) just like any human being. Transmitted to the first meeting in psychotherapy or CAP it could imply that family members of all ages contribute to create attachment, everyone in her or his way. Therapists could make use of those talents, which of course are in their repertoire as well, when they take the lead to achieve a good atmosphere and a working alliance with child and parent. The attachment between the family and the therapist would be valuable in the future process.

Sorting and perceiving what is communicated in meetings

In a first meeting, there is an intense communication verbally and bodily, and of course more complex when several people are gathered. Watzlawick, Beavin & Jackson (1967), mean that a therapist is bombarded with 10 000 bits of information a second. Apparently, we are not able to receive everything of what is conveyed. Our limitations of what we can let in and what we can keep in mind are due to our perceptual system and our work memory (Christiansson, 2002). The capacity we dispose is further influenced by psychological factors like pre-understanding and prejudices. If we expect to collect data, our attention is directed to facts. If our intention is to facilitate dialogue, our attention in listening is on how we and the family members relate to each other In addition, categorisation of the ones we meet give ideas of how we should act even before we meet them. As therapists we have a lot to win in the contact with children and parents if we scrutinize our pre-understanding and watch out for not yet reflected actions

and attitudes in our work (Andersen, 1992). Meeting the clients with openness and sensitivity would make it more likely to create a fruitful and beneficial collaboration. The opposite, being insensitive and rigid could be the basis for creating iatrogenous injuries, i.e. injuries caused by treatment. According to Andersson, Grevelius, and Salamon (1990) and Salamon (1993) such injuries hinder the therapeutic process and have to be dealt with before any therapeutic progress is possible. Sprenkle, Davis, and Lebow (2009) believe that therapies with a poor beginning can recover, "but this is likely to happen only if the aberrant issues in the alliance are assessed and addressed."

Psychotherapy and Family therapy.

The European Association for Psychotherapy defines psychotherapy in the following way:

1. The practice of psychotherapy is the comprehensive, conscious and planned treatment of psychosocial, psychosomatic and behavioural disturbances or states of suffering with scientific psychotherapeutic methods, through an interaction between one or more persons being treated, and one or more psychotherapists, with the aim of relieving disturbing attitudes to change, and to promote the maturation, development and health of the treated person. It requires both a general and a specific training/education.
2. The independent practice of psychotherapy consists of autonomous, responsible enactment of the capacities described in paragraph 1; independent of whether the activity is in free practice or institutional work.

Psychotherapy consists of a wide range of methods and approaches, like cognitive behavior therapy, existential therapy, psycho-dynamic therapy, art therapy, and family therapy to mention a few. These "schools" also have their varieties, and they all develop as knowledge is increased and alternative practices are proven more helpful. Some approaches are easier to apply to the medical model and quantitative research designs are preferred. Cognitive behavior therapy (CBT) is an example of an approach which can be evaluated in randomized clinical studies (RCT), where standards can be under control. Strictly controlled studies have been questioned for not being possible to generalize into ordinary clinical settings. The results in those studies come in terms of group data and tested hypotheses, and do not give knowledge of improvement in the unique sets of problems which characterises individuals or families in clinical practice (Kazdin, 2006). Wampold (2001) found in meta-studies of different forms of psychotherapy,

that psychotherapy definitely is effective, and that it is not possible to discern any special form of psychotherapy as being more successful than the other. What works was "common factors" (ibid.) associated with every form of psychotherapy. A good therapeutic alliance, assessed by the client, was one necessary factor. The therapist per se and her or his attitude to the present method were other examples. If the therapist had faith in the method it was more successful. The common factors approach has gained influence in the discussion of effective methods, and has been criticized (e.g. Sexton & Ridley, 2004) for being generalizing and unspecific. Sprenkle, Davis & Lebow (2009), though, has continued to develop the approach in the field of couple and family therapy.

Kazdin (2004) remarks that in the context CAP a big challenge is to work with both children and adults, also at the same time. Consequently, it is a dilemma that in most forms of psychotherapy there is an individual perspective of the clients. This is the case also from the medical point of view. Family therapy seems to be the only form of psychotherapy which works with interaction and relations in real time with the persons concerned. Connected to the first meeting, family therapy in its different varieties has knowledge and approved practice to offer CAP, which is a crucial reason for raising family therapy more than other forms of psychotherapy in the thesis.

Considering the first meeting from a psychotherapeutic or more specifically from a family psychotherapy angle, this occasion might have therapeutic qualities due to the process itself, where the clinician or therapist is as involved as the family members.

Family therapy

Like other psychotherapeutic approaches, family therapy is a divergent field with an internal debate. It has a common interest of offering ways of thinking and acting when working psychotherapeutically with children and parents for a change to the better, making it useful in CAP. The family is the context where meaning is created and maintained, which makes it a suitable entity to work with. Alternatively, others have asserted that it is more beneficial to meet the ones who are engaged in a problem; not just the family. It could be family members, but also others, like relatives, friends, and professionals. Efforts to sum up what family therapy is and has been since its birth have been made for example by Hårtveit and Jensen (2005). Different issues has been discussed in this field; the limitation of meeting nobody but the family and always the whole family, the therapist's role, and the opinion of how to regard patterns and structures within the family, the structuring of the sessions; all this has been focused on. There have been different views of what is and what causes problems and how to get rid of

them. The biggest differences of opinion are probably between the structural and what could be called the collaborative or dialogical approaches.

The structural approach

The structural school is often represented by Minuchin. For him, the delimited entity "the family" is what is interesting and important (Minuchin & Fishman, 1990, Minuchin & Nicols, 1992). Bonds and structures are scrutinized and weighed, and a lot of the therapists' assignment is to help family members to change and correct the relations into a favourable balance. The therapist is active and often directive. He or she takes the role of being an expert. Problems disappear when the relations between the family members are improved and the system parts come into balance with each other, for example when the borders between child and adults are made clear and are re-established. Closely attached to the structural approach, a diagnosis system meant to diagnose families was developed, which could relatively easy connect to a psychiatric perspective of regarding problems – with a cause and a solution, that is, with a linear outlook.

Collaborative/dialogical family therapy

In Sweden, the collaborative or dialogical family therapy has often been named "språksystemisk" ["language systemic"], indicating that a lot of what is happening between people is connected to verbal and non-verbal language. Stressing the language part of therapy too much might jeopardise perception of what happens in the dialogue and how clients and therapist act. Seen from the "language systemic" perspective, the problem will resolve as the system of people who has become engaged in it, not necessarily the family, communicates, have conversations about it. Anderson (1997) writes that together we create meaning by using language, which consists of pronounced and unpronounced conversations and interactions with each other and inside ourselves. The inner dialogue (Andersen, 2003) is developed by the outer dialogue going on with other persons within the system. When several voices are heard, the better it is (Seikkula, Arnkil & Eriksson, 2003). It becomes a plural creation of senses and meanings, built on the influence of many meanings, polyphony. The therapist's function then is to facilitate for as many voices as possible to be heard. More voices mean more perspectives on what is going on, and it also paves the way for more alternatives also in action. Some voices might be inhibited or silenced, which might hinder freedom of action or speech for those in the system. The use of reflectors or reflecting processes in therapeutic meetings enhances the possibilities of being able to and to dare to put forward more views in outer

or inner dialogues (Eliassen & Seikkula, 2006, Anderson & Jensen, 2007). Anderson (1997) talks about a " not-knowing position", an attitude which means that the therapist, without leaving the expertise of being the one who leads the conversation and takes responsibility for what is possible in the situation, stays unconditionally open to what the client presents or narrates. Later this concept has been developed by Seikkula (2008) and called "tolerance for uncertainty." The therapist helps the family to formulate what they want to receive by the therapeutic contact and in what way it could be done. In such a co-creation (Andersen, 2003) every attending person is given space, and gets the opportunity to let her or his voice be heard. (Seikkula, 2008). Family members have their own tempo, their own way of expressing themselves and their own level of not too small and not to big challenges leading to change. They should, Andersen (2003) means, be met in this during the meeting. Language, and the way each and everyone uses it might, according to Anderson and Goolishian (1992) be a key element in blockings and despair. Especially when there are children in the room it is important what meaning everybody puts into the words, and to what extent children really understand what the adults are talking about.

The collaborative or dialogical approach is closely connected to narrative therapy and also to social constructivist perspectives. To help every person to put down their thoughts and emotions, their narrative, in words in the presence of others, can be seen as in itself therapeutic (Lundby, 1998). Telling your narrative means a possibility and an opportunity to formulate yourself in a way that can make others understand. It also gives an opportunity to listen to yourself as well as to listen to other peoples' reactions on your story. In turn, your story might change, or necessarily has to change, as a consequence of that (Morgan, 2004). A social constructivist view implies that every person has an understanding of the surrounding world that is their own, formed in the interplay with others (Gergen & Gergen, 2004). Listening to how other people describe their perspective can thus give new insights and challenges (Anderson, 1997). From this follows, that the therapist, to facilitate change or progress has to have an open mind and not be locked up in hypotheses or pre-understandings, or take sides (Anderson & Goolishian, 1992). It is unavoidable to get involved in the family or network, to have hypotheses and to hold a position of power in relation to the clients. That is why it is important in the position as a therapist to handle the situation in an ethically acceptable way, and to consider these facts.

Ethical considerations in therapy

A big question in the context of therapy is the ethical stands you make as a therapist, and what ethics you choose to follow. Henriksen & Vetlesen

(2001) argues that being a moral subject means practicing care as well as showing respect. They include both emotion and cognition in the ability to take responsibility for another human being. Two prominent philosophers worth mentioning are Lögstrup (1993), who emphasizes the responsibility connected to the therapeutic situation, which literally means that the client puts her or his life in the hands of the therapist. Furthermore, we feel what others feel, because being human is to be interdependent. Also this must be recognised by therapists as it implies that because of my position as a therapist, me and my client are not equal, but there will be interplay of power between me and the other, which has to be handled delicately. As a therapist I can hurt and be hurt. Still, Lögstrup asserts (ibid.), I can never take over the independence or the responsibility for another human being. Secondly, Levinas (Hand, 2005), puts forward the way a face in front of me awakes my urge to help; that is what a face does, also my own. The uncovered face communicates without words (Henriksen & Vetlesen, 2001). It gives my existence and my freedom someone to be there for – someone in distress. It is more of an emotional urge than a cognitive one, and it emanates rather from the other than from me, according to Levinas (Peperzak, Critchley, & Bernasconi 1996). With this perspective, one could run the risk that an asymmetric relation could emerge where the party who needs help ends up in an inferior position. It becomes important to regard a person not only as weak and in need, but as a person with resources on other levels. Also, as a therapist, I have to deal with the fact that there are more bare faces to take into consideration; the first not less important than the second one (ibid.). In first meetings at CAP there are usually several people to relate to. The way in which the therapist handles children's presence and balances the interplay with their nearest relatives are examples of crucial ethical questions.

A third perspective is presented by Bauman (Henriksen & Vetlesen, 2001). He relates to the rules and regulations in institutions and puts forward the problem which occurs when the individual follows them too strictly and thereby disclaims her or his personal responsibility and ethical stance. At its worst, in for example CAP, it could be expected to lead to therapists being insensitive or even cruel and family members getting iatrogenous injuries (Andersson, Grevelius & Salamon, 1990; Salamon, 1993).

How to know what is helpful

What is successful in psychotherapy, that is, what leads to positive changes? In this context, "common factors" have been noticed in a variety of psychotherapy branches. These factors were for example the therapists own belief in their own form of therapy, and the way they manage to convey this to their clients (Hubble, Duncan & Miller, 2002, Philips & Holmqvist,

2009). The therapeutic method seems to be less important than for example being in a dialogue with the clients, and to receive their polyphonic reality (Seikkula et al, 2003). Bakhtin (1988) goes so far as to say that destroying the dialogue is to destroy the person. What is important as a therapist in the first meeting, as Seikkula (2008) found, is to be creative and open to the present moment and to take advantage of the dialogical possibilities.

When studying the process of any session, as Orlinsky, Ronnestad, and Willutski (2004) point out, the aspects the researcher as an observer finds helpful for the clients do not necessarily correspond to the client's opinion of what is helpful. There could also be differences in opinion between family members. A follow-up study of treatment satisfaction of adolescents suffering from anorexia nervosa and their parents showed that parents were more pleased with the therapists than were their children (Paulson-Karlsson, Nevonen, & Engström, 2006).

Talking with children involved

In an early work Stern (1977) describes the way care-givers (referred to as mothers) automatically use an adapted behavior and language in the interplay with young children and infants. Their tempo, rhythm and tone of voice were altered in a way they would never use in contact with an adult (unless perhaps a lover!). As mentioned by Kazdin (2004) the context of child and adolescent psychiatry includes working with both children and adults. It is a challenge, of course, to create appropriate conditions for both adults and children in a meeting. Indeed, it has been found that the voice of the child tends to become secondary in family therapy settings (Cederborg, 1994). In interviews following a series of family therapy sessions, children expressed a desire to be active and to be included (Stith, Rosen, McCollum, Coleman, & Herman, 1996). Strickland-Clark, Campbell and Dallos (2000) interviewed children about their experiences of a family therapy process and found they needed more support. The children appreciated being listened to and not being judged, but it was sometimes difficult for them when the adults reacted to what the children had said, or when the conversation concerned only the parents.

Trevarthen and Aitken (2001) have shown the capacity of intersubjectivity early in the coming of existence; the child is in active communication with the surrounding world already in the uterus. Many studies have shown that the infant is an independent subject who interplays with the parents very early in life (Macfarlane, 1978). As the child grows it learns more about the world and about human relations. Vygotsky (2002) asserts that in this socialisation, the child is an active agent with capacity of community. He argues against Piaget, who saw the child's thinking as ego-centric, gradually withering away by the adults' rational thinking. Instead,

Vygotsky means that the child learns and relates in an inter-subjective process, where the child's own thinking plays a constructive role, instead of being replaced by an adult mode of reasoning (ibid.).

The situation where the interaction takes place is important as learning and development as well as conversation is facilitated by a sense of security and meaningfulness (Säljö, 2010), and so it will be important for a child that the therapist creates such an atmosphere. Övreeide (2010) describes how to create a safe context which will reassure that the child's views and contributions will lead to positive consequences for her or him. He has found, that triangulated conversations are helpful; which means to have a third party present – preferably one or more real persons, or objects of some kind. The interaction then could be related to phenomena outside the one-to-one conversation, and be something they both could perceive and relate to (ibid.). The act of sharing has also been discussed by Bråten (2009), where he describes moments in therapy when changes happen. In these moments, the parties have a mutual experience which open up for new possibilities to explore. Bråten argues that what he calls common altercentric participation happens in "now moments" described by Stern (ibid.) and found in studies of infants, is also applicable in therapy with adults. Again, we find that already very young children have a capacity for interaction, and some of that playful interaction one automatically starts with a small child (Stern, 1977) may be cherished and taken advantage of in an adjusted way in conversations where children and parents are present.

Cederborg (2000) describes strategies in interviews with children, mand proposes listening, an adjusted way to use the language and the importance of being neutral and also flexible in relation to the child. A later work by Cederborg (2009) focuses on children with mental disabilities, and the guidelines for interviews are similar but more specified. Certainly, some elements are applicable also with "normal" children since every child has specific and varying needs. It could be necessary to explain the purpose of the interview several times, for example. Building a safe-enough relation could take longer with a child with big difficulties The child's capacity to interaction and dialogue is involved in its efforts to handle the world and the child's own intentions. Into this exploring comes the social confirmation from others. Adults have great power to affect the new experiences with their reactions and emotional signals. The created meaning has in it the relations in which it was created. To change the meaning of a phenomenon is not easily done, as there is a risk of tension in relation to the person or persons who the meaning was created together with. It could take a lot of safety and also courage for a child to risk such loyalty (Övreeide, 2010).

Tuttle et al. (2007) found that the beginning of a contact is of certain importance, because that is when a mutual meaning is created. In a therapeutic meeting, which the first meeting at CAP has a capacity to be, the child needs to be not only secured, but met with empathy and respect. To put

oneself imaginary into the child's position is important. I could be helpful to make use of Andersen's (2003) suggestion to let every person decide whether he or she wants to talk or not. Also, the polyphonic dialogue (Seikkula, 2003) shows a way for all voices, including the children's, to be heard.

Lack of studies

As mentioned, many authors have pronounced and asserted the importance of the first encounter for the continuation in psychotherapy. Still, to my knowledge, no research exists on first encounters in psychotherapeutic or psychiatric settings. There were no studies on first meetings to be found in international data-bases. Most studies, both quantitative and qualitative, were made after a shorter or longer contact, not in the beginning of it. There are studies which describe how the client's perspective is taken into close consideration and is used in the on-going psychotherapy process (e.g. Sprenkle, Blow and Dickey, 2002). The lack of knowledge about what happens in a first meeting and what clients feel about first meetings with professionals awoke an interest to study this field more closely. To make it possible to catch the participants' own descriptions and words a qualitative approach would therefore be valuable.

Aims of the study

The overall aim of this study was to attain a deeper understanding of the first face-to-face meeting with CAP as expressed by the children, their parents and the therapists.

Paper I: The purpose was to attain a deeper understanding of the first face-to-face meeting with CAP as expressed by the children.

Paper II: The purpose was to achieve a deeper understanding of what parents would focus on when they recalled the first face-to-face meeting with professionals at CAP together with their daughter or son.

Paper III: The aim was to learn more about the first meeting at CAP as seen from the therapists' perspective.

Paper IV: The aim was to illuminate discourses and their influence on the first face-to-face meeting at CAP as described by children, parents, and therapists who had attended such a meeting.

Methods and material

The project was conducted in Uppsala, a university city, and the fourth biggest city in Sweden, with about 200 000 inhabitants. CAP is a part of Uppsala University Hospital. The place for the research project was chosen due to its availability for the author, who was an employee, rather than because it was a typical Swedish CAP-organisation.

Staff and settings

The first part of the project was located at the emergency unit, and had the character of a pilot period, later embraced into the rest of the project. A group of therapists at the emergency unit was a reference group, with which I could try my ideas of how to carry on with detailed planning. We also had workshops including role-playing interviews and opportunities to challenge the coming experience of being filmed. I also had workshops with the group.

   As the project was moved to an out-patient unit a few changes were made. The emergency unit handles all kinds of child psychiatric problems. The out-patient unit deals with a range of problems including depressive symptoms, anxiety, consequences of child abuse and trauma-related problems. Generally, probable ADHD or autism related problems are referred to another unit. At the emergency unit, the families generally meet a nurse and a doctor when they come for the first time. The out-patient unit offers other combinations of staff, and sometimes families meet only one professional. At the emergency unit half of the staff actively took part of the project, although the whole staff was supportive. Almost everybody in the staff at the out-patient unit was engaged in the project. At the emergency unit 3 out of 6 nurses and 4 out of more than 10 doctors were directly engaged. Doctors often stayed for shorter periods, and new ones were introduced to the project. All of the ordinary doctors wanted to participate, and about half of the rest of the staff, mainly nurses with different competences. At the out-patient unit, most of the staff, consisting of doctors, nurses, psychologists, and psychiatric social workers, 8-12 persons, agreed to participate. The extent of family therapy training varied greatly; some had had several years of training and supervision, while others had only attended short courses or workshops. Most of the therapists had little experience of family psychotherapy (table 1).

Table 1. *Therapists' experience and training when they joined the project*

Case	Therapists	CAP-experience, five years or more	Experience of family meetings	Experience of family psychotherapy	Formal family psychotherapy training	Formal psychotherapy training, other approach
S	Doctor	No	Moderate	Minor	No	No
	Nurse	Yes	Great	Minor	No	No
B	Doctor	No	Minor	Minor	No	No
	Nurse	Yes	Great	Moderate	No	No
C	Doctor	Yes	Great	Moderate	No	Yes, basic
	Psychologist (MH)	Yes	Great	Great	Yes, basic	Yes, basic
L	Doctor	No	Minor	Minor	No	No
	Nurse	Yes	Great	Moderate	No	No
A	Psychologist	Yes	Great	Moderate	No	Yes, basic
	Psychiatric social worker	No	Moderate	Minor	No	No
R	Psychologist Psychologist (MH)	Yes	GreatSee case C	Great	No	Yes, advanced
W	Psychologist		See Case C			
D	Psychologist	Yes	Great	Great	In training	No
E	Psychologist Psychologist (MH)		See Case A See case C			
F	Psychologist (MH), Psychiatric social worker	Yes	See Case C Great	Moderate	No	Yes, basic
G	Psychiatric social worker	Yes**	See Case A			
H	Doctor	No	Moderate	Minor	No	In training
N	Doctor	Yes	Great	Moderate	No	Yes, basic
J	Doctor Nurse*	No	See Case N Moderate	Minor	No	In training
	*Did not attend research interview	**Got extended experience during the project time				

Design

The families at the emergency unit got information in the waiting-room about the project both verbally and in written form. The information was presented in simple words (appendix 2) so it would be easier to involve the children in the families' decisions of whether to participate in the research project. At the out-patient unit information letters to the families were sent to them by mail and as they came they were given verbal information in the waiting-room. One difference compared to the emergency unit was that the therapists at the out-patient unit had the freedom of choosing whether to inform families about the project or not. There was an on-going discussion who not to invite throughout the rest of the project time. Some therapists, especially in the beginning of the project, did not want to expose clients for the extended distress they expected even asking about participation the research interview would be. Eventually, a few therapists modified their opinion.

Interviews were expected to be good also from a clinical point of view (not just a scientific one). For example, it could be an opportunity for parents to get to know more about their child's perspective or find out in what way their child appreciated their support and their presence. Secondly, therapists could get feed-back from their clients without delay. If the process would continue with the same therapists, they could use the information in the joint, continuing work with the family.

The design was consistently qualitative, based on the grounded theory process in the first three papers (Charmaz, 2006; Glaser & Strauss, 1967; Thulesius, 2003) and in paper IV a qualitative content analysis was conducted. The study was approved by the ethics committee of Uppsala University (dnr 01-356, 01-359). Compared to an earlier study of CAP in Sweden, the cases matched the distribution of sex, age, and contact reason as described by von Knorring, Andersson, and Magnusson (1985).

About 2 % of the families who visited the unit for the first time were interviewed. There were several reasons why they were so few. Only parts of the staff had agreed to be in the project. Many families declined participation. Also, as mentioned, in many cases they were not asked to participate as certain therapists included in the project feared that it would be too stressful for some families.

Within two weeks after the initial meeting the author conducted an interview with the family and the therapists. A second interview, intended to provide extended information about the first meeting, was organised six months later and was arranged in the same way as the first interview.

The venues were nicely decorated with paintings and plants. Both rooms had two big windows on one of the walls. There were comfortable chairs and a table in the middle. Smaller lamps were placed in the rooms, and the ceiling had strip lightning if necessary. At the out-patient unit the room there

was a small table with a chair, crayons, paper and jig-saw puzzles, and there were toys in a big basket. Two small stationary cameras were placed in opposite corners and two tiny microphones hang in the lamps in the ceiling. In short, they were ordinary rooms for meeting a family in CAP.

Fourteen cases were analysed, of which four were from the emergency unit, and ten were from the out-patient unit. In case S (see table 2) the family members did not attend the research interviews, but left the city the day after the first meeting. Only the therapists were interviewed, and there was no co-creation of the data. The findings from case S in paper I come from the therapists who commented on the boy's non-verbal behaviour. Case W was omitted from the analysis in paper III, since MH was alone as a therapist. In the study, 14 first research interviews and 11 second research interviews were conducted; 25 interviews including 47 interviewees were conducted altogether. The second interviews also were video-recorded. Table 2 displays an overview of all participants including age and sex of the children, contact reason, and persons present at the interviews.

Table 2. *Overview of the participants in the research interviews*

Participants in first meeting	Age of child	Contact reason	Therapists	Attended first research interview	Attended second research interview
S: son, father	10	Anxiety, lack of parent responsibility	Doctor, nurse	No	No*
B: son, mother, social worker	11	Neglect, behaviour problems	Doctor, nurse	Yes	No
C: daughter, mother	15	Depressed	Doctor, psychologist	Yes*	Yes*
L: daughter, father, sister	16	Avoids school, adjustment disability	Doctor, nurse	Yes*	No
A: son, mother	12	Domestic violence	Psychologist, psychiatric social worker	Yes*	Yes*
R: daughter, mother	13	Sexual abuse. Avoids school	Two psychologists	Yes*	Yes*
W: son, father, mother	7	Sexual harassment	Psychologist	Yes*	Yes*
D: son, father, mother	14	Depressed	Psychologist	Yes	Yes
E: son, father, mother	6	Sexual harassment	Two psychologists	Yes*	Yes*
F: daughter, mother	12	Refuses school, depressed	Psychologist, psychiatric social worker	Yes*	Yes**
G: daughter, mother	13	Aggressive behaviour	Psychiatric social worker	Yes*	Yes*
H: son, mother	12	Depressed, not motivated for school	Doctor	Yes**	Yes*
N: daughter, mother	11	Eating problems	Doctor	Yes*	Yes*
J: daughter, mother	15	Depressed, suicidal thoughts, self harm	Doctor, nurse	Yes*	No

*one reflector present
**two reflectors present

Ordinary clinical routines were followed whether or not the family chose to participate in the project. In the cases the family agreed to participate, the therapists video-recorded the first meeting, and the film was archived, so as not to bias the interviewer. It was presumed to be useful in a later study.

There were variations among the parents in living status and educational level, presented in table 3. No specific trend could be found. There were single parents, parents living together as well as parents living with a new partner. The education level of the parents was high, middle or low. However, there was a dominance of high level educated parents, which reflects the distribution in Uppsala, being a university city.

Table 3. *Attending parents: living staus and education level/profession*

Child's initial and age	Participants in the first meeting	Parent living with the other parent	Single parent	Parents' theoretical educational level (high, middle, low)
S: 10	son, father*	No	Yes	?
B: 11	son, mother, social worker	No	Yes	Low
C: 15	daughter, mother	Yes	No	Middle
L: 16	daughter, father, sister	No	No	Middle
A: 12	son, mother	No	Yes	High
R: 13	daughter, mother	No	Yes	Low
W: 7	son, father, mother			
	Father	Yes	No	High
	Mother	Yes	No	High
D: 14	son, father, mother			
	father*	No	Yes	Low
	Mother	No	No	Middle
E: 6	son, father, mother			
	Father	Yes	No	High
	Mother	Yes	No	High
F: 12	daughter, mother	No	Yes	High
G: 13	daughter, mother	No	Yes	High
H:12	son, mother	Yes	No	Low
N: 11	daughter, mother	No	Yes	High
J: 15	daughter, mother	Yes	No	High

* not interviewed

Data collection

Qualitative research approaches claim the interviewer must have good knowledge of the field at hand in order to put forward relevant (Patton, 1990). In this case, the interviewer can be regarded as well informed after working in the organisation for 15 years as the project started. Also, it is important that the researcher is aware of her or his limits in perceiving the present phenomena of study, and to what extent she can reach the subjective world of the interviewees (Ruth, 1991). Without doubt, the interviewer

brings into the interview situation thoughts and ideas about what is important. These pre-understandings might govern which questions or issues will be addressed (Andersen, 1992). The author's background and preferences in psychotherapy and research are presented in appendix 1.

In order to collect as rich data as possible (Charmaz, 2006) about the first meeting at CAP, the best conditions possible had to be created. My ambition was that the attendants would give me a picture of the first meeting and their perception of it in their own words, unattached by questions formulated in advance. Every participant should be given space, especially the children. The source of inspiration in this context was the unprejudiced stand in grounded theory, where no hypotheses rule, but emerge in the analysis process. Secondly, many ideas came from Andersen's (2003) descriptions of reflective processes including the interplay between the ones who listen and the ones who talk; the ones who are in or have been in a process of change and the ones who in the moment see it from the outside. It became important to let every voice be heard and to contribute to hold on to or give space for themes that ran the risk of being hidden. Andersen (2003) introduced and developed reflecting processes in psychotherapy. It has been world-spread and is used in many fields (Anderson & Jensen, 2007; Eliassen & Seikkula, 2006; Friedman, 1995). In a reflecting conversation the reflector facilitates the process and contributes to open up for more perspectives and thoughts. The family members and other possible attendants are in the focus of attention. In a reflecting research interview like the ones in this study, the focus is on the purpose of the research. The target is to receive as much data as possible. This will in turn enhance the trustworthiness of the analysis.

The reflector's role in the research interview as an assistant to the interviewer is quite similar to what is the case in a therapeutic conversation, namely

- base on what he or she has heard or seen
- convey few reflections rather than many
- try to turn comments hopeful
- if appropriate, start a conversation with the other reflector or reflectors, or the interviewer
- notice if every attendant is heard and mark if that is not the case
- strive for to even out the balance between the attendants

During the reflection coming from the reflector, the research interviewer gets an opportunity for breathing space and own reflections. Giving the attendants the opportunity to listen to others' descriptions hopefully would inspire them to compare and develop their associations, keeping the first meeting in mind as "the main character of the play."

I gave the assignment to be reflector to six trained persons, interested in the family therapy field. Before the project started, I had two days of training with them. During the project we met regularly and discussed and developed the task of the reflector. The six reflectors had the professions psychiatric nurse, psychologist and social worker, and all of them came from other organisations.

The interview plan

The interview plan was roughly outlined in advance, and was modified (Lincoln & Guba, 1985) especially in the beginning of the project. The plan was as follows:

1. The initial interview question can be phrased: "What is the first thing that comes to mind when you think about the first meeting?"
2. Begin by turning to the family/network, first the parents, but very soon to the child, and ask each person about the first consultation. Encourage them to help each other to describe their encounter. If somebody from the family's professional network is included, he or she is asked after the family members.
3. Ask about what was important to each person, words that made an impression, what they remembered afterwards, expectations, etc.
4. Talk about what the staff did in connection to the memorable or crucial situations.
5. Stop the questioning and listen to what the reflector has to say. Common themes can be what the interviewer did not follow up on, and going back to what the staff did or said, as well as wanting to hear the family relate more about certain themes. This can be done early in the interview and usually 2-4 times altogether. The reflectors can for example comment on whose voice had not yet been heard much in the research interview, or say they would like to hear the family say more about what the therapist did in a certain sequence of the first meeting.
6. Turn to the staff and ask if they agree or have a different view of what the first meeting was like. How does it feel to think about what the family says? Do they have questions?
7. Members of the family can give feed-back to the staff, and are also free to say more if they wish.
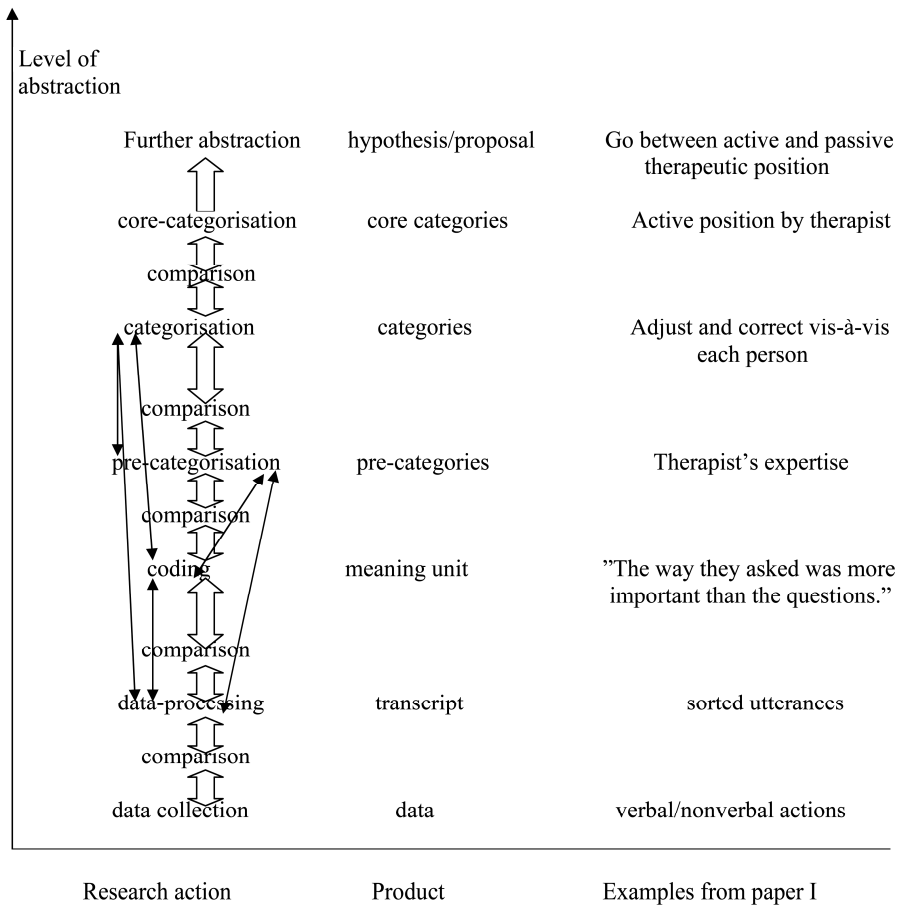8. The interview ends with the last words coming from the family.

Data analysis

In the thesis, two approaches were used; grounded theory in papers 1, II, and III, and qualitative content analysis in paper IV.

Grounded theory

The fundaments of grounded theory were laid by Glaser and Strauss (1967), who later developed the approach into separate directions. Charmaz (2006) puts constructivist grounded theory against objectivist grounded theory, and means that researchers with the latter stance "assume that data represent objective facts about a knowable world." (p. 131). Constructivist grounded theory researchers, on the other hand, are alert to conditions under which differences and distinctions between people arise and are maintained, and this view permeates data-collection, analysis and construction of theory (ibid.)

Grounded theory offers a way of evaluating the data without pre-knowledge of or prejudices toward the material (Charmaz, 2006). In addition to interview data, some grounded theorists make use of every thinkable piece of information that can be of interest, like short notes, comments from people outside the research project, early efforts of writing the report etc. (ibid.) Conclusions are formed without constraint of an a priori hypothesis (Levitt, Butler, & Hill, 2006). Thulesius (2003) describes how concepts and categories emerge in the analysis process by constantly comparing data with the found categories in this inductive work. Each level of categorisation is more abstract than the previous one (see fig 1).What can come out of a grounded theory study depends on how far the abstraction can possibly go. The analysis process needs to be scrutinised by others to reassure that the researcher does not go too far in her or his interpretations. Grounded theory may lead to core categories or hypotheses about a phenomenon, or even to a theory, consisting of related hypotheses and grounded in data. Thus, a theory is not the ground for the study; the data are the ground for a new theory (Creswell, 1998).

Figure 1. The analysis process in papers I, II, and III

Level of
abstraction

Further abstraction	hypothesis/proposal	Go between active and passive therapeutic position
core-categorisation	core categories	Active position by therapist
comparison		
categorisation	categories	Adjust and correct vis-à-vis each person
comparison		
pre-categorisation	pre-categories	Therapist's expertise
comparison		
coding	meaning unit	"The way they asked was more important than the questions."
comparison		
data-processing	transcript	sorted utterances
comparison		
data collection	data	verbal/nonverbal actions

| Research action | Product | Examples from paper I |

Each arrow stands for a comparison activity

Papers I, II, and III

The first author transcribed the data from the video-recorded interviews into 760 pages of text with one column for each person present. This gave a graphic and time-related overview of the interviews.

Spoken words and certain visual expressions were noted. The interviews lasted between 23 and 58 minutes. Apart from the reflectors, a total of 47 persons, children, parents and therapists, were included and interviewed, most of them twice, both in the first and in the second research interview. A social worker came together with the family in case B, and was included in a research interview. The data were analysed as follows:

1. The first author read and re-read the transcripts with as little pre-plan or anticipation as possible.

2. Utterances from the participants, with exception of the reflectors, concerning the first meeting, were marked as meaning units (Rennie, 2000).
3. The meaning units, in paper I 951, in paper II 1883, and in paper III 1184, were sorted and put into preliminary categories.
4. The preliminary categories were repeatedly compared to each other and to the text as a whole. Categories were then created.
5. In papers I, II, and III the categories were split into two groups because of their differing nature. In paper III the analysis ended at this level of abstraction.
6. After a further comparison phase in papers I and II, two core categories emerged out of one of the categories.

It was not included in the families' nor in the therapists' engagement when participating in the study to be contacted later to help with the analysis process. In paper I, a senior researcher examined the material and helped the author to scrutinise the analysis.

In paper II, a senior researcher followed and scrutinised the analysis process. To test trustworthiness from the parent perspective, I examined the results together with a parent who had not been in the project. She and her daughter had visited the policlinic for the first time about one year after the project was ended. I asked if she was willing to help me since we were acquainted but not close, and I knew her as a verbal and considerate person with integrity.

In the work with the analysis process in paper III three therapists, one from the project, one therapist who had worked for more than a year at the out-patient unit, and one experienced therapist from another city who had worked in adult psychiatry studied the material. Secondly, a group of researchers not involved in the project examined the material and gave comments on the results and their trustworthiness. Thirdly a senior researcher helped the first author to scrutinize the analysis process and check that the thought-chain which led to the results was possible to follow.

Qualitative content analysis

In the fourth paper the purpose was to bring together the whole data volume in the analysis and study if there would be traces of which discourses influenced the participants in their interaction Qualitative content analysis was chosen to analyse the data with the intention to direct the attention towards underlying meanings and discourses. Content analysis is a method that has developed since the 50s. Some of its approaches were questioned as

they were built on quantitative data but still claiming to be of a qualitative kind (Baxter, 1991). Qualitative content analysis is the term used and described in recent papers (Clausson, Pettersson and Berg, 2003; Graneheim & Lundman, 2004; Hertting, Nilsson, Theorell, and Sätterlund Larsson, 2003) and it allows the content in the social voices to show, not just the amount of similar statements. Talk and conversation is regarded as co-created and adjusted to the context. Also transcribed into text it can have several meanings, and an analysis includes the researcher doing some degree of interpretation (Granehim & Lundman, 2004).

Paper IV

Following Graneheim and Lundman (2004) the data were analysed as follows:

1. The first author read and re-read the transcripts with apprehension to utterances connected to discourses.
2. A total of 492 utterances were found and marked as meaning-units.
3. The meaning-units were condensed and still close to the text.
4. The condensed meaning-units were abstracted into central notions and labelled with a code.
5. The codes were divided into two groups, representing two themes.
6. The themes were labelled Structuring and Collaboration.

An experienced therapist with a sociological back-ground and a senior researcher scrutinized the analysis process at several stages and were active discussion partners to the author throughout the analysis period.

FINDINGS

The findings in the thesis emanate from the same study. Each paper had its own aim and focus, although the overall aim was to get a deeper understanding of the first meeting at CAP on several levels and from different perspectives.

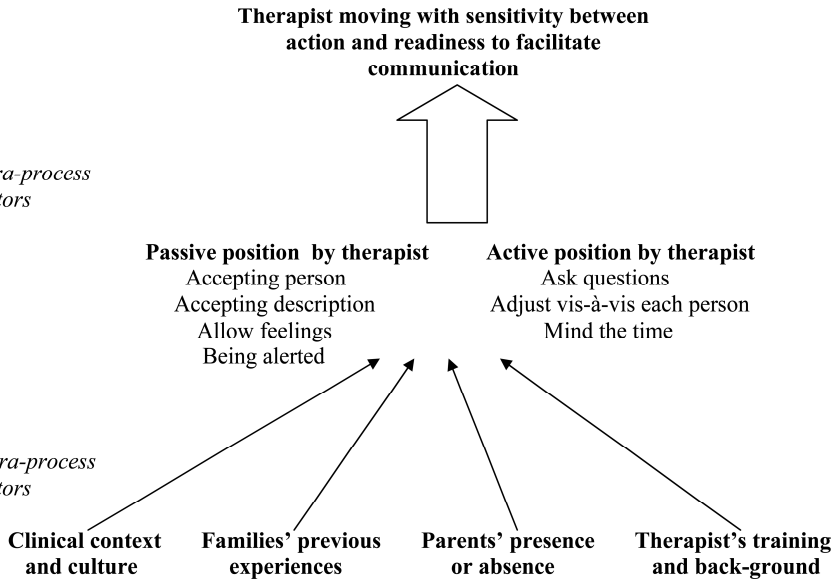## Paper I: What children feel about their first encounter with CAP.

Opinions and descriptions about the first meeting expressed by the children during the interviews were collected and analysed. In the findings, factors outside the process as well as inside it were lifted (fig 2).

Figure 2. *What the children appreciate from the therapist during the first meeting, and what limits its possibilities.*

*Desired
achievment*

**Therapist moving with sensitivity between
action and readiness to facilitate
communication**

*Intra-process
factors*

Passive position by therapist
Accepting person
Accepting description
Allow feelings
Being alerted

Active position by therapist
Ask questions
Adjust vis-à-vis each person
Mind the time

*Extra-process
factors*

**Clinical context
and culture**

**Families' previous
experiences**

**Parents' presence
or absence**

**Therapist's training
and back-ground**

Extra-process factors

The extra-process factors were *Previous experiences* and *Parents' presence or absence*, and represent phenomena that certainly influence the ongoing process, but were set in advance.

Previous experiences

This category pertains to the families' earlier experiences of similar meetings. The children and other members of the family make comparisons between the present meeting and others they have attended. Previous experiences are likely to affect how the first meeting with CAP is perceived.

Parents' presence or absence

The second extra-process factor is about whether parents should be in the room or not and its impact on the meeting. In this study, most of the children wanted them to be there. Some children seemed ambiguous.

Intra-process factors

The intra-process factors were connected to the therapists' attitude and actions during the first meeting. They were divided into <u>passive</u> position of the therapist and <u>active</u> position of the therapist as described by the children.

Passive position of the therapist

Accept person
The children felt they were accepted for who they were by the therapists.

Accept description
This is an aspect concerning being allowed to tell your story on your own.

Allow feelings
Some of the children felt there was room for feelings

Stay alert
This category catches the therapists' ability to be present, attentive and ready to act.

   To sum up, the passive position of the therapist includes neutrality, acceptance of each person and what he or she describes, and allowing feelings to occur. It also involves being ready to deal with serious matters, being mentally present and alert. The passive position does not imply doing nothing. Rather, it means being in a state of readiness and acceptance of each person present. It also implies reflecting and keeping the inner dialogue going (Andersen, 2003).

Active position of the therapist

Ask questions
Comments connected to the therapist's questioning occurred frequently.

Adjust vis-à-vis each person
The way the therapist related to the client and to the other persons in the room was noted by the children.

Mind the time
This category is about the therapist taking responsibility for the length of the session. Some of the interviewed children found the first consultation to be too long.

   In summary, much of the active position is about helping the children communicate. Some children say that the therapists corrected themselves if they found they had made it difficult for the child to express herself or himself, and that it then became easier. Many of the children found the therapists to be good listeners. Some conveyed the importance of letting all

parties be heard. Some children described how the therapists facilitated for them by asking clarifying questions, by simplifying and by suggesting answers. These are all examples of the therapist acting and being in an outer dialogue (Andersen, 2003), asking questions, adjusting and correcting vis-à-vis each person.

Paper II: Parents' perception of their first encounter with CAP

The parents focused on two areas (fig. 3). One of them was *Contribution* (I) which concerned the meeting between the persons present and what it gave the families. This included I a) relation and dialogue (what happened between their child and the therapists) and I b) insights and conclusions (what in the meeting might be useful for the family, looking ahead). The second area was *Structure and Prerequisites* (II) which was about the context surrounding the first meeting. This was connected to II a) parents' role (the parents' own role in the meeting) and II b) planning, results, and transparency (reflections on the meeting, how to proceed, and the circumstances at the venue).

I: Contribution

a) Relations and dialogue:
- the therapists listened to the child's own words without any hurry
- the therapists were able to hold on to a difficult matter as well as to let go and perhaps come back to it later
- questions were well adjusted to the child and to the situation
- the therapists appeared free from pre-judgement and prejudices and did not make rapid decisions

b) Insights and conclusions:
- It became obvious for one parent that the problem they came for was not just her daughter's
- The meeting gave additional perspectives
- It gave insights about considering alternative ways of talking with their child
- Some parents had the opportunity to see new sides of their child
- Both children and parents were able to bring ways of talking and certain topics with them and to talk at home
- Therapists conveyed calm, acceptance and comfort, which could be brought from the meeting
- A few important words from the therapist could be enough

## II: Structure and Prerequisites

a) Parent's role:

- Parents were uncertain as to their own position in the meeting in relation to the child and to the therapist
- Some were uncertain whether their presence was beneficial for their child or not
- Some parents appreciated the way the therapists balanced between family members
- For some parents it felt good that they could leave control to the therapist

b) Planning, results, and transparency:

- Parents would have wanted an understandable plan or alternatives of what would happen the next time. It created uncertainty and insecurity not to know
- Some parents wished for more information on the therapist's opinion and way of working
- Not keeping the same therapist was a disappointment
- The routines at the reception desk and in the waiting-room were dissatisfying for one parent
- One parent mentioned it was good to have two therapists in the room as they complemented each other
- In another case the second therapist's silence was disturbing

Figure 3. What parents focused on in the first meeting.
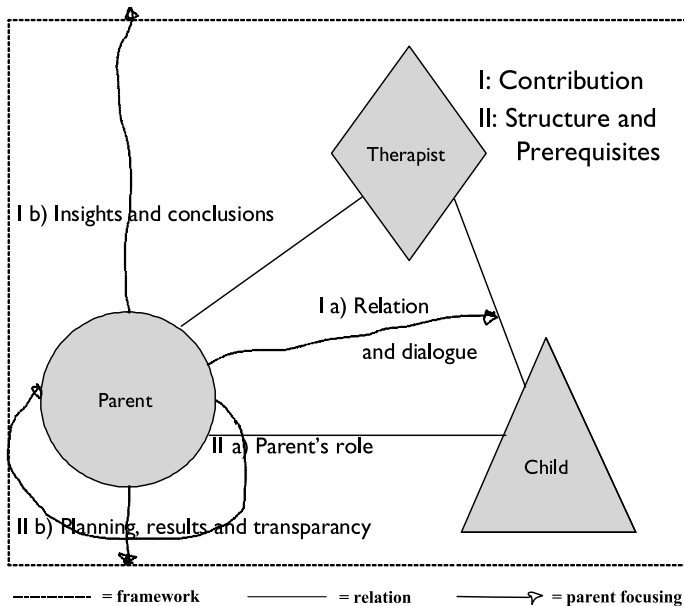
What seems to have made an impression and had been useful for the parents was related to relational and contextual matters rather than traditionally psychiatric issues. We detected confusion from some parents concerning how therapists are supposed to handle or conduct the meeting and which role the parents should take. Some parents could state with satisfaction that their child was actively involved in the conversation, something that does not always occur in family therapy sessions (Cederborg, 1994, Strickland-Clark et al., 2000). This gave rise to the question if CAP personnel are more skilled in involving children in a family conversation than are family therapists.

Paper III: Therapists' views of the first meeting in CAP

The therapists focus in the interviews about the first meeting came to be on two major areas connected to their work in the first meeting. One area consisted of aspects that could be described as psychiatric. It included a) collecting data, b) making assessments and make the family members want to come back, and c) making decisions - how and when. The other area concerned family psychotherapeutic aspects and was about a) therapists' contribution in the meeting, b) family members' contribution to the meeting, and c) the character of the meeting.

Psychiatric aspects

Collecting data
The therapists were generally occupied with the assignment of collecting data. Questions of background seemed necessary and important. One therapist said that she felt compelled to ask difficult questions.

Making assessments and making people want to come back
One therapist talked about the two-headed purpose of the first meeting: make an assessment and make the family wanting to come back

When and how decisions are made
It was a returning view that decisions are not made until the inquiry is completed, or enough questions have been answered. Sometimes a second meeting could be necessary to get more information.

Family psychotherapeutic aspects

Therapists' contribution
Therapists had the ambition of creating a good atmosphere.

Family members' contribution
Some therapists talked about the children's and the parents' role in the meeting. The family members' contribution to the conversation, like openness and motivation, was helpful for several of the therapists.
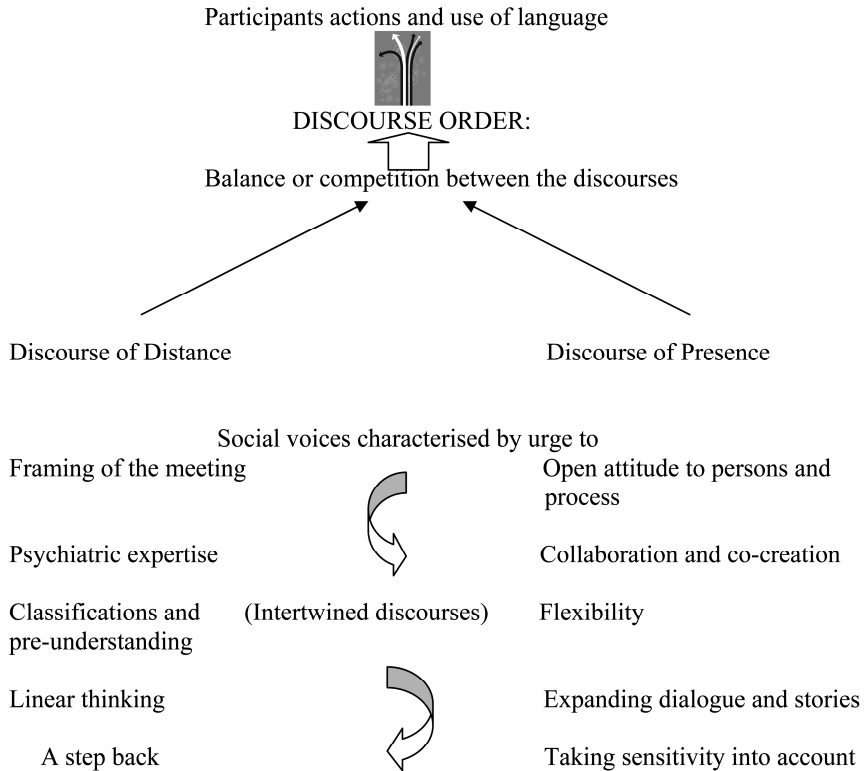
Character of the meeting
Therapists noted if there was a balance between the family member's perspectives, and mentioned the beneficial aspect of talking with several persons in the room.

The therapists handled the first meeting aware of what assignments they were supposed to conduct. The linear pathway of the medical model to begin by finding out what has happened earlier in the patient's life before deciding treatment or remission seemed clear to them. Since the contextual model stresses relational aspects, a central focus is on what happens between therapist and client or patient. Therapists in the study modestly lifted that their own achievement was limited, and stressed the family members' contribution. When the therapists valued the meeting, they often talked about it in terms of good atmosphere, presence of several perspectives and possibility for the family members, especially the child, to tell their story – all of which are family psychotherapeutic aspects. Still, none of the therapists was a trained family therapist. At times, there seemed to appear a dilemma; should the therapist adhere to the rules in the organisation, or adjust to the family's needs and wishes the way they were perceived by the therapists in the first meeting.

Paper IV Structuring and Collaboration

The aim of this paper was to join together all participants' views and detect underlying meanings, discourses in the material. Discourses are defined as certain ways of talking about and understanding the surrounding world and activities in it (Cameron, 2002). They are changeable and in interaction with social voices in and between people. The discourses that were found in the material were intertwined which means that social voices housed by a specific participant could be contradictory and depending on other social voices in the inner dialogue. Alternatively they were found in the dialogues with others. It was possible to sift out two separate discourses in the participants' descriptions of the first meeting (figure 4).

Figure 4. *Discourses in the first meeting, concepts connected to them, and balance between them*

Participants actions and use of language

DISCOURSE ORDER:

Balance or competition between the discourses

Discourse of Distance   Discourse of Presence

Social voices characterised by urge to

Framing of the meeting		Open attitude to persons and process
Psychiatric expertise		Collaboration and co-creation
Classifications and pre-understanding	(Intertwined discourses)	Flexibility
Linear thinking		Expanding dialogue and stories
A step back		Taking sensitivity into account

Structuring

The social voices within the discourse of *Structuring* were about

a) **Framing of the meeting**, with key-words structure, planning, agenda, time limit and confidentiality.

b) **Psychiatric expertise**, with key-words experts help you, symbolic power, hierarchy, directing, expertise, assignment given, step-by-step decision, decision with colleagues.

c) **Classification and pre-understanding**, with key-words judgements and pre-judgements, categorise, exclude, pre-understanding, marginalise.

d) **Linear thinking**, with key-words data-collection, questions for facts, manual, make assessment, linear, causality.

e) **A step back**, with key-words impersonal, meta-perspective, reflection, objectivity.

Collaboration

The social voices within the discourse of *Collaboration* were about
  a) Open attitude to persons and process, with key-words empathy, trust the process, tolerance of uncertainty, accept person, accept narrative, listening.
  b) Collaboration and co-creation, with key-words assignment negotiated, collaboration, explore, empowerment, transparency, deciding together, co-create.
  c) Flexibility with the key-words adjusting, flexible, individualise, taylor-made, follow.
  d) Expanding dialogue and story, with key-words include, generate dialogue, expanded thinking, conversation in itself, questions for dialogue.
  e) Taking sensitivity into account, with key-words safety, sensitivity, emotions, caring, satisfy.
  f)

Thus, *Structuring* was characterised by structure, expertise and the therapist as a director of what would happen. It could be characterised as an instrumental position. *Collaboration* was about the emotional and caring side of the encounter, actively including everyone to collaborate in the meeting and let all voices be heard. There seems to be constant movements between them (structure - tolerance of uncertainty, directing - co-creation, exclude - include, be flexible - having an agenda, ask questions to get facts - ask questions to generate dialogue, make the plans in the room - decide afterwards somewhere else etc). The discourses varied among and between the participants, and accordantly none of the discourses seemed to be more common in any of the participant groups children, parents, or therapists. One conclusion was that combinations of certain elements in both discourses could be beneficial in the first meeting.

GENERAL DISCUSSION

> "Truth is not to be found inside of the head of an individual person, it is born between people collectively searching for truth, in the process of their dialogic interaction." (Bakhtin, 1984, p.110)

The family members' main concern when they come to the first meeting at CAP is that they want help. The therapists they meet want to help and are set by the organisation to do it. The ways to achieve this help and the underlying rationales for it differ, and discourses (Cameron, 2001) and discourse orders regulates the dominant social voices which should and will be accentuated in practice. As Shotter (1993) points out, we can't say or respond as we please. We adjust our interactions and our speech to the context at hand. Looking closely at what the participants describe about the first meeting we can find that the contracting parties try to understand the situation and adjust to what they believe is expected by them from others and from themselves; they try to give air to and adjust to the social voices in the situation.

Children in the study focused on the therapists' doings and liked them to be in an active and an alert position whether talking or listening. It was evident, that the children wanted to communicate when they felt bad about things, and they needed help to be able to find the words. The findings suggest that it is beneficial and appreciated by the children when the therapist moves between being active and being passive but prepared to act. The children described the importance of the therapist being neutral, accepting each person and his or her story and allowing emotional communication, including being mentally present, alert and ready to deal with all types of serious matters. On the whole, the children felt they were included, which seem opposite to findings by Cederborg (1994), Stith *et al.* (1996), and Strickland-Clark *et al*. (2000). In the light of this we can ask ourselves whether CAP personnel is more skilled in involving children in a family conversation than are family therapists.

A lot of the parent's attention was on the dialogue between their child and the therapist. They seemed to have watched and weighted this relationship closely. Some parents could with satisfaction state that their children were actively involved in the conversation. What seemed to have made an impression and had been useful for the parents were related to relational and contextual matters, rather than traditionally psychiatric ones like data-collection.

Some parents wished to have had more transparency according to the therapists' views and how they worked, which is connected to being clear about what the first meeting could be filled with and used for. Also, there was critique from the parents about the lack of planning for the coming process. In a context like psychiatry the personnel are regarded as experts on peoples' problems, which might lead to the unfortunate assumption that it is unnecessary to take patients' and families' different opinions into account. For that reason, many decisions in CAP are probably made elsewhere, without the families or patients present, and are seldom negotiated or mutual. A negotiation about this would probably be the most respectful way of planning first meetings, as Andersen (2003) describes. The same idea could direct the planning of the following process of treatment and service and be part of what Tuttle et al. (2007) remarks is the important creation of a mutual meaning in the beginning of a contact. Reflective processes (Andersen, 2003) implicates openness from the professionals, and Seikkula et al. (2003) has described the use of open dialogue, where planning or conversation about a patient always occurs in the presence of that person and in a polyphonic dialogue with her or his network. In the present study the children's description of the importance of therapists' listening both to them and to the parents fits well with both Anderson's (1997) and Seikkula, Aaltonen & Alakare's (2001a,b) statements of the importance of giving everyone involved the opportunity to contribute with their views.

Apart from the psychiatric aspects of their work, therapists described family therapeutic matters. The first meeting at CAP according to hand-books is neither intended to be therapeutic nor dialogical, but in fact many such passages were described by the participants. The first meeting can be seen as a junction between psychiatry and family therapy where family therapy is not pronounced as an active ingredient. Instead family therapy is regarded as one of several forms of treatment, like medication, CBT, or psychodynamic forms of therapy, which could be considered later in the process, after an assessment or diagnosis has been established. The medical model is prevalent, and we detected some confusion from some parents concerning how therapists were supposed to handle or conduct the meeting and which role the parents should take in this. The families' limited degrees of freedom of choice in terms of therapy or treatment in a psychiatric context may create uncertainty of what is allowed and to what extent negotiations about for example parents presence or absence can be made. Also, as Andersen (2003) remarks, the act of listening is important in family therapy, which means it is crucial that children and parents get the opportunity and support to talk as well as listen to each other. If we see it as an encroachment to separate child and parent, doing it is worth a great deal of consideration, and perhaps the most respectful is to carefully negotiate this act as well.

In line with the medical model, before making a decision of any kind of treatment or therapy, you need requisite data. There is a risk that focusing on

collecting data takes over, so that what is meant to be a thorough investigation which aims to offer the best treatment possible results in feelings in the families of being excluded and without personal agency. It could be important to deal with the issue of how to convey hope and empowerment to families seeking help at CAP. Being an active part of the planning of both the first meeting and the following process could contribute to parents and children feeling included and having influence.

New perspectives which unfolded in the first meeting helped some parents to see new sides of their child. Some parents had already tried to use a "new way" of interacting with their child when they came for the second research interview six months later. The parents had "taken impression" as to how the therapists related to their child. It was as though they have been presented to alternative ways of having a conversation, which is close to Gehart's (2007) description of how ways of talking in the therapy room generates to other contexts. As Seikkula (2008) noted, being present in the moment seems to become more important compared to collecting information for the future therapeutic process. If one purpose of the first consultation in CAP is to gain information for the treatment, as a surprise the dialogue in the interview by itself can be more productive for change.

The therapists handled the first meeting aware of what assignment they were supposed to conduct. The linear pathway to begin by finding out what has happened earlier in the patient's life before deciding treatment or remission seemed clear to them. Therapists in the study modestly lifted that their own achievement was limited, and stressed the family members' contribution, which fits with the findings of Bachelor and Horvath (2002). When the therapists valued the meeting, they often talked about it in terms of good atmosphere, presence of several perspectives and possibility for the family members, especially the child, to tell their story – all of which are family psychotherapeutic aspects. However, most of the therapists had little experience of family psychotherapy. At times, there seemed to appear a dilemma, for example when the therapists found that the family members were eager to tell their own story, and at the same time the therapists felt they should ask more about specific data; they had to balance between the demands of the organisation in which they were employed and the needs and benefits of the children and their families. The therapists are the ones who come in direct contact with the clients and have to execute plans and guide-lines, often made by administrators who, as Johansson (2007) found, do not come in contact with clients.

When therapists talked about the character of the meeting, they seemed satisfied as family therapeutic aspects were described. Psychiatric aspects, if they were fulfilled, did not seem to give the therapists the same gratification in their work. The psychiatric assignments that the therapists are supposed to conduct sometimes appeared to serve as restrictions rather than facilitators. If it is important as a therapist in the first meeting, as Seikkula (2008) found,

to be creative and open to the present moment and to take advantage of the dialogical possibilities, then following certain assignments could be a cause of interference. Maybe some of the outlined assignments deriving from the medical model following a linear thinking hinder the development of a beneficial process.

Clients often know themselves what is good for them and what feels helpful (Anderson & Goolishian 1992). They are experts on their own lives. Most of the therapists in the study seemed to have been adjusting to the families' needs, and some of them might have been in a state of "tolerance of uncertainty" (Seikkula & Olson 2003), which means they could remain open-minded, and refrain from following an agenda or be presumptuous. Trained experts, like therapists, can find themselves to know better, and so therapists, as described in the study, ask other colleagues after meeting the clients, what is best for a certain patient or family instead of asking those who it concerns. As mentioned, this differs the psychiatric thinking from the family psychotherapeutic one, and prolongs the decision process to unwanted lengths.

The emotional side of the therapists' capacity could be expected to be of great value in building a bearing contact, important in a following process. Not only could it help to encourage people to come back again, but also convey hopes and expectances of a promising mutual work ahead of them. Although the therapists were in a psychiatric context, they described experiences common to those of psychotherapists, like generating dialogue, building trust etc. For some of them it was a meeting on several levels, for data collection and assessment, a meeting in words, and a meeting on an emotional level as well.

The participants in the first meeting demonstrated that two discourses were at hand, woven into each other, and that different, sometimes contradictory social voices were activated in and between children, parents and therapists. They described how they, during the first meeting tried to find her or his position and a proper attitude; thereby being in a dialogue with social voices in any of the discourses *Structuring* and *Collaboration* or both of them. Parents and children, as well as therapists, indicated the importance of finding a balance between the two, which is of course unique to each family or family - therapist constellation. Confronted with wishes from families to take a more active part of the meeting and to be in a dialogue, the discourse of *Structuring* comes in sway and vice versa the discourse of *Collaboration* is shaken by the need of predictability and framing.

The therapist, although regarded as an expert when it comes to mental suffering, is not always formally trusted to make own decisions of further planning (an exception would be the situation at the emergency unit, where decisions are made more rapidly). Following this procedure strictly, he or she is not sanctioned to make decisions together with the child and parent,

and it is not sanctioned to promise that he or she will be the one who will meet them later. This way of acting appears to be in conflict with the *Collaboration* discourse, where many things are connected to negotiation and collaboration. Family members in the study had certain expectations on the therapists and on themselves to live up to according to an anticipated image of the first meeting. Both discourses, though, appeared to contain elements necessary for a successful first meeting. The national legislation of health care in Sweden (Hälso- och sjukvårdslagen) declares that all actions should be grounded in respect for the patient's autonomy and integrity, including making own decisions. A predictable structure accompanied by tolerance and openness to adjustments is probably a requisite for any successful first meeting. In some of the cases the attending parties in a meeting had different views of what should rule, and the competing of discourses was obvious. Individual plans for treatment should be formulated. The discourse that wins dominance at certain points of time can to a great extent be supposed to depend on the therapists, their training and experience, how they interpret their professional assignments in the organisation, and the way they choose to encounter each family. However, also the therapists are restricted by the organisation and its rules and conventions and cannot form practice freely. The medical model (see e. g. Wampold, 2001) has a great impact since CAP is a branch of medicine. In psychiatry this risk is connected to the dominance of the medical doxa (Carlhed, 2007), in which for example aspects of collaboration and generating dialogue are not obviously included. As a consequence, parents' and especially children's wishes could easily be suppressed. There is a latent risk to execute symbolic power in the practice of any bureaucratic welfare organisation (Johansson, 1997).

CAP is more or less unknown for families and children when it comes to context and practice. The children and also the parents are at a disadvantage compared to the therapists; some of their social voices are lower or do not find expression since the situation is new and the family members can be expected to be in a stressful period. . What is sometimes seen as resistance in individuals or families, could be a matter of how safe it feels in the meeting and whether it feels meaningful or not. It is up to the therapists whether the first meeting will be meaningful and hopefully a fruitful communication will emerge, as Säljö (2010) proposes

Families with a poor socio-economic status or minority groups might find CAP incomprehensible and strange and even terrifying, created and conducted as it is by Western academics. The therapists they meet, however educated, might regard some people as strange or frightening, and put them into cultural or other categories, which makes it more difficult to be unbiased and open-minded. Rober and Setzer (2010) warn for the therapist ending up in a "colonizer position." Certainly, this could happen in relation to any constellation of clients or patients. As a consequence it might be difficult for

the counter-parts to make a connection. Misunderstandings and conflicts might appear, with the result of iatrogenous injuries (Salamon, 1993) and increased suspicion towards both staff and organisation. Another consequence was reported by Luk et al. (2001). In two studies on children who showed conduct problems they found high drop-out rates (36% and 48 %) from CAP after assessment or early in the treatment process.

One element in the *Structuring* discourse was A step back. This category would represent aspects like meta-position, objectivity, reflection and an impersonal attitude. Aspects of this position could be regarded as important to help therapists to neither become overly involved in the process nor be too distant and formal. At times, the therapist would need to take a step back, reflect and consider ethical aspects, both in the moment and in the long run. From the family members' perspective, such a position could help parents and children to keep their personal integrity and add a critical perspective to the meeting. In fact, research interviews, like in this study, bring an opportunity to take a step back and see the situation i. e. the first meeting from above or from the outside. Doing research concerning the therapeutic situation has been made later in a therapeutic process or after it has ended together with clients to enhance therapists' sensitivity (e.g. Andersen, 1997). Certainly, this approach could be helpful in early stages of a contact and also in on-going processes.

Psychiatry and its fundaments were seriously questioned by the anti-psychiatry movement in the 1960s and 1970s (Svensson, 2005). During the last ten years or so, critical psychiatry has emerged (Thomas & Bracken, 2004) and another movement with a more low-voiced character has started to grow, called post-psychiatry (e.g. Bracken & Thomas, 2006) which seeks to develop a debate about contexts and values connected to current mental health services and question the dominant medical view of Western psychiatry. Instead, the influence of the users is welcomed. The post-psychiatry movement does not dismiss psychiatry the way anti-psychiatry did, but hope for exciting challenges in rethinking roles and responsibilities (ibid.).

When families come to CAP they can be expected to be in a difficult situation in life. What is said and done to them is probably of great importance. A considerate way of partnering with them is respectful and takes into account their own resources in a better way than if decisions and planning on all levels are left to the so called experts. Actively involving the parents and children is satisfying from an ethical perspective as well as a democratic one in that the risk of misuse of power and of repression could be reduced. Dialogism, of which this is an implication, can be understood as a counter-theory to monologism with its individualistic perspective, which has influenced for example philosophy and psychology for several hundred years (Linell, 2007). By dialogism also follows that being in a dialogue is the human way of being, in which we connect, learn and develop. Hermans

(2001), proposes that cultures as well as selves are "moving and mixing" in a dialogue with others. His notion of "the dialogical self" refers to Bakhtin's polyphonic tradition (ibid.) and the many social voices each one of us can house and alter. Referring to Linell, Hermans states that "the microcontext of concrete dialogical relationships cannot be understood without some concept of macroframes (organizational and ethnographic context)" (ibid. p. 264). He thereby helps to connect the first meeting at CAP with its organisational and socio-cultural context.

Earlier we have stated that there are social voices connected to discourses, and as Cameron (2001) asserts, discourses, too, are changeable. To give room for the social voices within and between the discourses *Structuring* and *Collaboration* might open overt discussions about continuous reconstructions of CAP and its first encounters with family members suffering from mental difficulties.

Data collection and analysis

When choosing a method of analysis for papers I-III, the grounded theory analysis process appeared suitable in that it could satisfy the need both to present the data in a form as close as possible to the participants' own descriptions and to delve deeper into understanding the process of the first consultation and the topics connected with it. Consequently, the interviewees were not confronted with questions made in advance and deriving from hypotheses. Instead the family members were free to choose whatever they wanted to express concerning the first meeting without direction from constructed questions. Hopefully, this contributed to more of idiosyncratic data. Qualitative content analysis was used in paper IV to detect signs of discourses in the collected material.

The ethics of interviewing families in an especially vulnerable situation was discussed together with the therapists continually throughout the project. It was only possible to interview a few of the families who visited the CAP centre for the first time, and the cases represent a convenience sample (Patton, 2002). As a consequence, the collected data were valuable in that there were no similar studies found; especially the children's utterances were precious and rare.

The interviewer must have knowledge in the field of study to be able to ask relevant questions (ibid.) which was assured as I was a clinical psychologist with more than 15 years in the field as the project started, and was familiar with the organisation as an employee. By this, many advantages were won, that had not been possible to achieve elsewhere. I was known, available, and I could repeatedly visit the venues. Since I had very little paid time for the planning and also for the project, I had no time-limit or dead-

line. Therefore I was never in a hurry, and I could let therapists listen to my proposals, think them over, and decide whether to participate or not.

The competence and experience of having met many children and families was useful, not least since now and then the children needed guiding questions in order to be able to express themselves. The advantages of seeing everybody together and giving them the opportunity to fill in and comment on each other's stories made it more likely to recreate a multifaceted image of the first meeting. Contrary to what is usually recommended, I did not start by turning to the children. My clinical experience told me, that it would create safety for the children to make a brief connection to the parents in front of the children and thereby giving the daughter or son an opportunity to watch some interaction between me and the parents on a distance.

The use of reflectors in the research interviews gave transparency to the research process and helped to secure a greater amount of data. The reflectors' comments were helpful for the interviewer to hold on to themes and to broaden answers. Also, their presence was important to prevent interviewer bias, since the interviewer could be a member of the staff.

A senior researcher not involved in the project examined the material and helped the author to scrutinize the analysis process. In addition to this, in paper II a selected parent evaluated the results, in paper III a group of therapists and a group of researchers were involved in the scrutinizing, and in paper IV there were numerous discussions with an experienced therapist at all stages of the development of the article.

Qualitative methodology

Qualitative methods were used in the thesis. Hill (2006) describes what is common in these approaches:

"The defining features of qualitative approaches are the use of open-ended, data-gathering methods; the use of words and visual images rather than statistical data to describe psychological events or experiences; the idea that findings are socially constructed rather than "truth" being discovered; and the search for the participants' meaning using a recursive (i.e. going back and forth between inductive and deductive methods) approach."(p. 74).

Kazdin (1998) discusses generality and specificity of qualitative research and means that the expressed experiences, "although unique, special, and nonreplicable, may resonate with the experiences of others." (p. 256). The data-collection is made via interviews and sometimes written material, and the analysis is made in steps which should be described and possible to follow. According to Lincoln and Guba (1985) four criteria should be fulfilled in a qualitative study to give trustworthiness to the results. The first criterion is credibility, in which is included to describe the phenomenon in such a way that the people involved in it can easily recognise it and be familiar with the presentation. Also a varied and transparent data collection

and interplay with impartial colleagues or people concerned by the phenomenon is requested, and so is a thorough presentation of the researcher's back-ground and pre-understanding. Second, transferability is the criterion to show that the results fit where it is meant to be useful, which is a situation different from the research situation. It should be possible to answer the question whether the results are of importance. This means that irrespective of the results looking good in the context they were retrieved, they have to fit and be applicable and useful *in vivo*. The third criterion, dependability, concerns whether one can trust the data procedures and if independent coders and fellow researchers would be able to follow the analysis process and understand how the researcher has arrived in the results. The fourth criterion is conformability; it should be possible for an independent reader to reach the same conclusions by access to raw-data and earlier manuscripts.

Malterud (2001) discusses the researcher's influence, and means that the question is neither whether the researcher affects the process nor whether such an effect can be prevented. Instead, she argues, reflexivity and transparency should be made use of. There should be given an account of what is the researcher's preconception and motivation. In case the researcher is personally involved one way or another, there should be a presentation of which strategies he or she has made use of to create adequate distance from the study setting (ibid.)

There are expected risks in qualitative research of which "elite bias" is one, which alludes to that informants might be extra well articulated and of a high status or by some reason the ones easiest to get in touch with. "Holistic fallacy" is another bias and appears when data are presented as more coherent than they are, or when the results are presented as if all data were included, but in fact they are not. The third threat against trustworthiness in qualitative methodology is "going native", which means that the researcher is overly involved in the research process (Lincoln & Guba, 1985). Patton (2002) writes that the researcher in qualitative research needs to have good knowledge of the field of study to understand what is relevant and to be able to ask initiated questions. At the same time, he or she must look out for becoming too familiar with the material and lacking nuances in the presentation.

An advantage of qualitative research is that it can come close to the individual's perspective. The descriptions could thereby give space for understanding and empathy in the reader. In addition, with the researcher's openness to the unexpected, new discoveries can happen when participants share their experiences (Hill, 2006). Results in qualitative research can also give rise to hypotheses which can be used in quantitative research. Goering, Boydell, & Pignatiello (2008) highlight the relevance of qualitative research in psychiatry to add knowledge and expand the definition of evidence-based decisions in clinical practice. Similar ideas have been presented also by

Malterud (2001), who sees quantitative and qualitative methods as complementary.

Content analysis versus discourse analysis

In the planning of the forth paper, discourse analysis, its underlying theory and method (Potter & Wetherell, 2007) gave inspiration to detect signs of the participants' discourses concerning CAP and the first meeting. Discourses can be defined as societal currents which influence us and become parts of our inner dialogue, where different social voices occur. In discourse analysis, content of utterances are scrutinised with importance attached to finding regular patterns and then "proposing an interpretation of the pattern, an account of its meaning and ideological significance" (Cameron 2001). Contradictions in people's utterances are recorded as well, since the social voices are adjusted depending on who a person talks to. Discourse analysis is a matter of analysing discourse, Burman (2003) argues, criticising Antaki, Billig, Edwards, & Potter (2003) for simplifying their description of the analysis process, and warns for under-analysing.

Instead of discourse analysis, Van Dijk (2007) prefers to use the term discourse study, and emphasizes it is not a method. Rather it is a way of looking at a phenomenon from a discourse perspective and searching for signs of discourses. Van Dijk means discourse studies could comprise many fields and levels in society and contribute to social changes. Social interaction in macro and micro contexts are of interest, and institutional talking is one example of a study object (ibid.). Therefore, the talking and description of the first meeting at CAP by the attendants would be a suitable phenomenon for a discourse study. Van Dijk proposes the same rigorousness and systematization as in any qualitative study when conducting a discourse study (ibid.). The method of discourse analysis is built not only on a theoretical basis, but also uses certain concepts on communicative micro-level, like intonation and interruption in the search of discourses, which makes the coding comprehensive (see examples in studies by Bolden, 2010; Hutchby & O'Reilly, 2010).

Before deciding which analysis procedure should be used in paper IV discourse analysis was considered along with content analysis. One purpose in this fourth paper in the study was to bring together the whole data volume in the analysis instead of splitting it up in groups of participants, as was the case in papers I-III. However, it was found, that discourse analysis with its rigorous analysis of details would have fitted better on more limited material.

Qualitative content analysis was finally chosen to analyse the data, although the intention to direct the attention towards underlying meanings and discourses was kept. Content analysis is a method that has developed since the 1950s. Some of its approaches were questioned as they were built

on quantitative data but still claiming to be of a qualitative kind (Baxter, 1991). Qualitative content analysis is the term used and described in recent papers (Clausson, Pettersson and Berg, 2003; Graneheim & Lundman, 2004; Hertting, Nilsson, Theorell, and Sätterlund Larsson, 2003) and it allows the content in the social voices to show, not just the amount of similar statements. Talk and conversation is regarded as co-created and adjusted to the context. Also transcribed into text it can have several meanings, and an analysis includes the researcher doing some degree of interpretation (Granehim & Lundman, 2004).

Clinical benefits following the study design

It is unusual in research studies that therapists get feed-back from their clients without delay. Most studies of family members' views are made after a contact has ended (see e. g. Cederborg, 1994; Hubble *et al*., 2002; Levitt *et al.*, 2006; Lobatto, 2002; Stith *et al.*; Strickland-Clark *et al.*, 2000). Therapists in the present study commented on the interviews and regarded them as valuable also from a clinical point of view (not just a scientific one). If the process would continue with the same therapists, they could use the information in the joint, continuing work with the family.

One therapist lifted that it was a good thing to for once have the opportunity to ponder what happens in meetings. This kind of evolution of knowledge does not have much space in a work-situation with lots of daily pressure.

Another therapist said quite happily about recalling and reflecting on the first meeting: "It's pure philosophy!"

Limitations and future research

The lack of relevant research findings to compare to the present results makes the conclusions somewhat tentative.

The data were collected from a small convenience sample, and the results may therefore not be representative of families or children visiting CAP for the first time. The included families were probably unusual compared to the ones who declined when it comes to e.g. verbal skills, seriousness of condition, or relations to authorities.

The interviews were surrounded by a number of reservations and uncertainties, each of which limited the amount of families in the study:

- all personnel were not included, since they could decide for themselves whether to participate or not.

- at the emergency unit, acute actions were dealt with prior to first meetings and to research interviews as well.
- at the out-patient unit it was up to each therapist to avoid informing families about the project.
- the appointments for research interviews had to fit family and staff as well as researcher and reflectors.
- technical devices must work.
- therapists occasionally forgot asking families about participation.

The CAP cases are a convenience sample, and the therapists represent a sample built on the convenience sample (Patton, 2002) of CAP cases. Reasons for joining or not joining the project could be connected to the therapists' attitude towards family therapy and to the first author's reputation as a family therapist when the project started. As a consequence, the number of included therapists was limited, and results may therefore not be representative for therapists in first consultations in CAP. The results might have been different with another constellation of staff.

The participants' utterances were made in a context where others were present, after having listened to what they have said. This means that everyone probably took this into consideration, and what was said during the interviews was co-created. If the attendants had been interviewed separately there would have been fewer options for reflecting on others' utterances. Consequently alternative data would have been collected. Alternative data could have appeared also if utterances had been collected from the video-recordings of the first meetings instead of being co-created in the research interview situation, as they were.

The author (MH) served as interviewer, researcher, and therapist in the study, which could be both a weakness and strength and which posed great demands on how the analysis process was conducted, especially as therapists were informants in the study, and could be colleagues to the first author. There was a risk of being overly involved and lacking nuances while on the other hand involvement at several levels gave access to the entire research process (Patton, 2002). Being responsible for the project, I participated in each step of the process; I planned, prepared, worked therapeutically in some cases, conducted the interviews and finally analysed the data. Also, I was an employee in the organisation. Thus, I was to the highest degree part of the ecology of the research itself (Kelly, 1986, Raush, 1986), meaning I might have had difficulties of being in a meta-position and seeing the course of events and the collected data from there. On the other hand, I have had a good insight and control of the data collection coupled with a genuine competence of the culture at hand. Therefore, it was possible to deepen the information via initiated questions. Qualitative research requires understanding and co-operation between the researcher and the participants, and the data therefore are mutual, contextual and value bound and involves

multiple meanings, and so a certain amount of interpretation is needed (Graneheim & Lundman, 2004). Transparency and a varied scrutiny are essential. My back-ground and preferences in therapy and research are presented in appendix 1, and give a requested clue (Malterud, 2001) to choices I have made during the research process.

Contact reasons were not taken into account by the study design. The results may have been different if we had interviewed children who were seen for the same contact reason together with their parents. Our interest, however, was to look at how the first consultation would be described, rather than to search for differences in perspectives among parents and their children connected to the specific contact reasons. The families included represent common child and adolescent psychiatric clientele at the emergency unit and at the out-patient unit children whose contact reason was perceived to be ADHD or autism related generally went to another out-patient unit. If all these children had been included, the results of the study might have been different.

The second research interview after six months was conducted to gather more data about the first consultation. There were no comparisons made between the first and the second research interview, since changes in opinion over time were not the focus of the study. The use of reflectors in the research interviews gave transparency to the research process.

Paper IV consists of a qualitative content analysis which led to the finding of discourses in the utterances. In the findings I try to describe how they like underlying themes have influenced the first meeting and the relations between the participants. A regular discourse analysis would have claimed more focus on language use and would have fitted better on a more limited material (Winther Jörgensen & Philips, 2000).

In qualitative research the degree of fitness is decided by the reader; how useful are the results in other contexts? The study sheds light on the first encounter with CAP from children's, their parent's, and the therapists' perspective, respectively and in interaction with each other. Some of the findings could be applicable later in a contact process in CAP, not just in the first meeting.

I suggest that the results can be expected to be useful in other settings where professionals meet children and parents like mental health services, school and social services.

The findings of this study may be useful also in continued research in the field, both qualitative and quantitative.

Conclusions

Children in first meetings at CAP wanted to communicate when they felt bad about things, and they expressed that they need help from the therapists to be able to do so. They wanted the therapist to move with sensitivity between being a) active by asking adjusted questions and involving the parents and being b) passive but alert by listening and accepting, and minding the time of the meeting.

Parents were focused on the relation between child and therapist and could be inspired by the way the therapist talked with their child. They were uncertain of the importance of their presence. They had wanted to know more about the future planning.

The therapists had a humble attitude concerning their contribution and pronounced how much the family members contributed to facilitate for them. They described the meeting as including psychiatric aspects as well as family psychotherapeutic aspects, and it seemed to be a dilemma for them which needs should be prioritised; the ones they apprehended from the organisation such as to get information for an assessment, and the way they wanted to support the family members by creating a good atmosphere and to generate the dialogue.

The two discourses *Structuring* and *Collaboration* found in the meeting were present and intertwined in all three parties children, parents, and therapists. There seemed to be a balancing or a competition between the social voices included in the discourses; on the one hand framing, expertise, and categorisation; on the other hand openness, co-creation and expanding of dialogue. The former seemed to dominate. The proportions between the discourses could make the meeting strict and suppressive or unstructured and overly flexible.

Summary in Swedish – Sammanfattning på svenska

Det första möte som sker mellan familjemedlemmar och personal antas ha stor betydelse för hur den fortsatta kontakten artar sig. Det är ett tillfälle när var och en kan vara öppen för intryck och nyfiken på hur kommunikationen utvecklas och vilken hjälp som ska till. Förutsättningarna för mötet är etablerade på många plan. Föräldrarna och barnen har tidigare erfarenheter av både personliga och professionella kontakter, och de har förväntningar på vad som ska eller bör ske under det första samtalet. Personalen befinner sig i ett sammanhang där de har förväntningar på sig från organisationen. De har utbildning och erfarenhet och har anammat organisationens kultur och vanor i större eller mindre utsträckning.

Både inom det psykiatriska eller det psykoterapeutiska området har det varit brist på studier som rör det första samtalet mellan professionell och patient/klient. Detta väckte ett intresse att studera området närmare. Syftet med studien var därför att försöka ta reda på mer om det första mötet ansikte mot ansikte mellan personal och familjemedlemmar. Vad händer där och hur upplevs det här mötet av dem som deltar? Ytterligare ett syfte var att försöka ta reda på vilka diskurser som påverkar det som sker mellan deltagarna. Vilka underliggande meningar har deltagarnas tankar och sätt att bete sig, och som har förankring i allmänna föreställningar om hur ett möte av det här slaget går till? Hur framträder det i deltagarnas kommunikation med varandra?

För att finna svar på dessa frågor gjordes forskningsintervjuer inom två veckor respektive sex månader efter det första mötet på BUP (barn- och ungdomspsykiatrin). Vid intervjuerna deltog de som varit närvarande vid det första samtalet, d v s personal, föräldrar och barn. Intervjuaren hade till sin hjälp forskningsassistenter, reflektörer, vars uppgift var att bidra till att alla fick komma till tals och att man höll fokus på hur det var under det första samtalet.

Fyra delstudier genomfördes. I de tre första användes analysmetoden grundad teori, och i den fjärde kvalitativ innehållsanalys.

Den första delstudien lyfte fram barnens perspektiv. Barnen uppskattade om behandlarna befann sig ömsom i en aktiv ömsom i en passiv position, där de samtidigt var alerta i förhållande till barnen. De gillade att behandlarna å ena sidan anpassade sig och sina frågor till barnen och å andra sidan tog med

föräldrarna i samtalet. Behandlarnas förmåga att lyssna och att hjälpa barnen att uttrycka sig var viktig för barnen. De tog också upp vikten av att behandlarna höll reda på tiden, så att samtalet inte blev för långt för dem.

För föräldrarna, i delstudie II, visade det sig vara avgörande vad som skedde mellan deras barn och behandlarna. De ifrågasatte sin egen roll i mötet, och var tveksamma till om de borde vara närvarande eller inte. Dessutom var de inriktade på hur upplägget av samtalet såg ut och hur den fortsatta planeringen skulle bli. Vissa teman och yttranden i dialogen kunde vara till nytta för samspelet därhemma. Fynden i delstudien antyder att det som var till hjälp snarare låg på ett familjeterapeutiskt plan än ett psykiatriskt.

I delstudie III framkom att behandlarna nedtonade sin egen insats och lyfte fram det viktiga i familjemedlemmarnas bidrag till hur mötet blev. Behandlarna balanserade mellan ett psykiatriskt och ett familjeterapeutiskt förhållningssätt. De mest tillfredsställande arbetsuppgifterna rörde att lyssna på barns och föräldrars berättelser och att hitta sätt att uppmuntra och stödja deras vägar till att må och fungera bättre. De önskade möta familjemedlemmarna på deras villkor, men hade också att samla information för bedömning och fortsatt planering. Det innebar ett dilemma för dem hur de bäst skulle kunna uppfylla de uppgifter som de uppfattade att BUP-organisationen gett dem.

Två konkurrerande diskurser framträdde i delstudie IV. De var inflätade i varandra och stod att finna hos var och en av parterna barn, föräldrar och behandlare. Det syntes pågå balanserande eller konkurrens mellan de sociala röster som ingick i diskurserna. Diskursen *Strukturering* innehöll sociala röster som rörde exempelvis inramning av mötet, expertis och kategoriseringar medan diskursen *Samarbete* inriktades mot aspekter som öppenhet, sam-skapande och en utvidgad dialog. Om diskursen *Strukturering* skulle överväga blev följden antingen ett undertryckande och okänsligt förhållningssätt och diskursen *Samarbete* skulle om den övervägde kunna skapa ett otydligt eller alltför flexibelt förhållningssätt. Den förra diskursen tycktes dominera, men båda diskurserna syntes innehålla delar som behövdes för att det första mötet skulle uppfattas som givande.

Fynden i studien är preliminära av två skäl. Dels finns få eller inga studier att jämföra med; dels var antalet intervjuer begränsat.

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Appendixes

Appendix 1

About the author

By the time I started to make the plans for the research project and this thesis, I had worked in the CAP organisation in Uppsala county, Sweden, for about 14 years as a clinical psychologist. I came from a context of psychiatry (with adults) in Northern Sweden where I had been employed for 4 years. In my training to be a psychologist, CBT was the main approach; something I could not quite embrace. I was more interested in Carl Rogers and his client-centered therapy. Some called me woolly. I might have been. In the back of my head there was a secret interest growing. Family therapy. Sounds good. Sounds interesting. I put out a feeler or two, took a short evening course, no more.

As a green psychologist in psychiatry I did my best to adjust to and adapt to the context and the dominating influence of psycho-analytic thinking in the individual therapeutic contacts which I conducted. Psychological testing with projective methods, intelligence testing and brain injury testing was part of my assignments as well. Things changed when I came to CAP. It became more and more obvious that an individual perspective was insufficient and did not take advantage of the capacity and potential resources in relations between family members and their helpers. I had to change my way of thinking, and it was not easy. The price was cold sweat and less sleep for some time. After that shift, I started to struggle with the enormous assignment to get to know the field of family therapy; authors, approaches, books, journals, congresses, persons and associations. I started to apply what I learned on children, parents, networks, and absorbed every bit of my supervision. A couple of years later, I had the opportunity to hear Tom Andersen talk. I am not sure that I understood much, but I was fascinated by what he said. I liked it, and I was moved. I listened to him many times after that, and I also had the privilege of having conversations with him now and then. Tom became my main source of inspiration in the field. Thanks to this source so many other ideas and such a lot of inspiration have reached me.

My work with this thesis has given me many opportunities and necessities to read, think and discuss. It can be detected that my sphere of interest lies in dialogism, co-creating, and a mutual exploring in the search for new

meanings and actions when life is hard. As a researcher I have an aim to give voice to colleagues who put so much effort into helping people who suffer, and to let the children and the parents be heard and taken seriously in their strive to find other ways to be together. Also, I hope for never-ending dialogues in and about the different socio-cultural context we are involved in, dialogues which might lead to alternative meanings and actions.

Appendix 2

1(4)

Till dem som kommer till oss för första gången - föräldrar, barn/ungdomar och andra

Vi frågar här om du och ditt barn vill delta i ett forskningsprojekt. Projektet kallas **"Det första samtalet vid en BUP-mottagning".** Deltagandet i projektet är frivilligt. Säg till när ni kommer om ni vill delta eller ej. Om ni tackar nej, kommer det inte att ändra hur vi tar emot er. Om ni är med i projektets första del, kan ni ändå senare ångra er eller tacka nej till fortsatt deltagande.

Meningen med projektet är att öka kunskapen om **hur det kan gå till** och **vad man tycker** om det första besöket. Det ska utveckla våra möjligheter att göra ett ännu **bättre arbete** än idag.

Forskningen kommer att gå till så här:

1. Det första samtalet, videofilmas (ljud och bild)
2(4)

2. Gruppintervju inom två veckor, videofilmas (ljud och bild)
Alla som var med vid det första samtalet samlas igen inom två veckor till en gruppintervju. Projektledaren, psykolog Monica Hartzell, ställer frågor till var och en om **hur samtalet gick till, om något saknades** o s v. Tar högst 1½ timme.
Ytterligare 2-3 personer, som är utbildade, finns med för att hjälpa till. Varken de eller projektledaren har sett videofilmen från det första samtalet i förväg.

3. Gruppintervju efter 6 månader, videofilmas (ljud och bild)

Ännu en likadan intervju som under punkt 2.

Videoinspelningarna kommer att **förvaras i låst skåp** som inga andra än projektledaren och hennes handledare har nycklar till. Banden kommer endast att ses av dessa två och av dem som hjälpte till vid intervjuerna. En eller två erfarna forskare kommer framöver att se banden för att göra oberoende bedömningar. Alla har **tystnadsplikt**. När forskningen är avslutad och rapporten har blivit tryckt, kommer banden att **förstöras**.

Om du vill läsa det färdigskrivna materialet, eller om du vill veta mer om projektet, prata med dem du kommer att träffa på mottagningen, eller kontakta Monica Hartzell.

3(3)

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