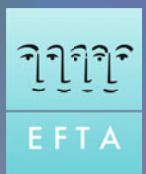
European Family Therapy Association Series

Terje Tilden
Bruce E. Wampold *Editors*

Routine Outcome Monitoring in Couple and Family Therapy

The Empirically Informed Therapist



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Editors

Routine Outcome Monitoring in Couple and Family Therapy

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Foreword

This book is a fabulous undertaking in zooming in and zooming out. In the main focus stands the empirically informed (family) therapist as a new figure in the therapeutic landscape. Who is (s)he? What is (s)he doing? With what means? What attitudes does (s)he have? What is her/his professional background? In what power relations is (s)he embedded?

From a closer perspective, it is a Norwegian landscape where Ibsen's ghosts point at the potentiality of family structures being oppressive. In our day, maybe in learned consequence, family as a social institution follows here an egalitarian ethos, which is also the "regulative idea" for society as a whole. And the basis for other institutions—like mental health organizations. We might say that one materialized conclusion of this ethos is the implementation of service user involvement on a legal level. From a wider perspective, it is an enquiry of international discourse and relevance: What does user involvement mean in the area of psychotherapy? How to bridge the gap between nomothetic research and ideographical practice in systemic and family therapy as well as in psychotherapy in general?

Psychotherapy is one effective and ethically approved service offered in the portfolio of possible mental health treatments. Mostly, it follows a voluntary principle with a risk of negative side effects (Linden 2013) and possible dropouts, accompanied by national economic costs if the services are provided by the state. Both levels have to be taken care of: the pain of the patients and the resources of the polity.

Routine outcome monitoring (ROM) is one way to meet these demands. Patients are asked to fill in questionnaires for providing information about their personal situation and to give direct feedback about the effects of therapy. Of course, this creates a difference in the traditional way of seeing the psychotherapeutic relationship. It seems that one query with regard to ROM comes up as: How to become an empirically informed therapist without becoming a technocrat?

This book gives a lot of answers to these and related questions. One response is providing guidelines on *how* ROM should be used. The silver bullet seems to be that ROM data become part of the conversation between therapists and their patients or clients. Through a feedback procedure, which is to bring the patient

information back into the therapeutic system and make joint sense of it is enriching for the process and can bring up topics, like risk factors, which might otherwise be not addressed adequately. The conversation about the data can be also looked at—from a social anthropological point of view—as opening up the private to a community. The ethnographic observation of the family inpatient clinic Modum Bad shows how a "therapeutic agora" can be cultivated where ROM becomes one integral part of creating "public spaces." These processes categorically leave behind structural features of the "total institution" (Goffmann 1961) and of oppressive mental health establishments. But to serve the well-being of the so-called service user and to guarantee the autonomy of the professional, the implementation of ROM into an everyday professional setting has to be well prepared, continuously monitored, and critically reflected, as several contributions show.

One theme, a revenant in diverse chapters, is the alleged (in)compatibility of epistemological standpoints. Social constructionism was and is the leading paradigm for many family therapists in the last decades, and it is pointed out several times how systemic practitioners struggle with the application of a tool like ROM which seems to be grounded in a positivist epistemology. Interestingly, research on the implementation of ROM shows that not the use of the feedback system per se has an influence on the outcome of therapy, but a combination of variables where the attitude of the therapist as well as that of the client toward ROM plays a crucial role. This seems to be very much in accordance with the notion that the way we are looking at the world is and becomes our world. In any case, this book challenges what is often perceived as incompatible dichotomies. For instance, is it possible to work in agreement with a "not-knowing position" within a new public management structure? Is this an irreconcilable contradiction or a dilemma that can be lived—and not necessarily solved? In what way may ROM play a role in such a situation?

By connecting the systemic arena with sociopolitical and legal foundations as well as with psychotherapy research, this book points to the varieties and responsibilities of systemic practices. It broadens the horizon of family and systemic therapists, and the work of trainees should be grounded in it.

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Part I
Introduction

Chapter 1
How Do I Know Whether My Efforts Are Helpful for the Client? Implementing Feedback in Norway

Terje Tilden

Introduction

The use of feedback tools in psychotherapy has during the last decade expanded in Norway, and in this development, couple and family therapy (CFT) field has had a central role. This book will address several aspects of why and how this focus has been given such a great attention in our country. Chapter 1 will shed the light on the professional premises, within the CFT field as well as the Norwegian governmental priorities that have paved the road for feedback to become such a central topic within our field.

Our Mission and Challenge

As therapists, we want to help our clients. And research confirms that psychotherapy is helpful for about 50% of those who seek our help (Lambert 2007). This proportion is also relevant for CFT, which produces effect sizes in the moderate to high range (Sexton et al. 2013). Even though this implies that CFT works, there is still a challenge how to increase the proportion of successful therapies. Applying these general findings into the therapy room raises the following questions: How do I as a therapist know whether the client sitting in front of me will eventually improve? Will he or she end up experiencing little change, like approximately 40% of other clients? Or even worse, is he or she at risk for treatment failure, by deterioration or dropping out of therapy prematurely?

The majority of clinicians will probably respond to these questions by arguing that based on one's professional assessment and clinical dialogue with the client,

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the therapist will have a sufficient impression about the treatment status so that concerns of no-change or deterioration will be addressed as part of the ongoing treatment process. Research however suggests that this may be an illusion: Clients do not voluntarily tell their therapists when they are not improving, and therapists are overly optimistic in assuming that they are helping every patient, even when, in fact, this is not the case (Harmon et al. 2007; Walfish et al. 2012). For instance, Walfish et al. (2012) found that therapists only identified 2.5% of those patients who actually deteriorated. This "self-assessment bias" among therapists represents a challenge when it comes to the assessment of therapy progress and outcome with regard to identifying clients with risk of not benefitting from treatment. Even though having self-confidence as a therapist is a desirable characteristic, it should be based as much as possible on facts, and not simply beliefs. The best information about the progress of therapy is derived from the client (Duncan et al. 2004); is the client, in his or her own view, improving? And this perspective is in fact a crucial component within a systemic perspective on psychotherapy.

The Professional Development of Systemic Practices

The growth of the CFT field was to a great extent motivated by a reaction against the dominating use of the medical model within mental health practices, exemplified by a therapist prescribing a treatment that will best help the client based on the therapist's exclusive knowledge (Anderson 2016; Johnsen and Torsteinsson 2012, see also Chap. 2). Influenced by postmodernism, this uneven distribution of power and authority was challenged, followed by growth of a more collaborative psychotherapeutic approach. Mainstream CFT has been a central part of this movement, adopting a systemic approach that is characterized by an ethical imperative of humility and respect for the client's own goals and means, emphasizing the individual's autonomy and empowerment. Embedded in this concept is the therapists' strong belief and trust in the client's wisdom and resources that have relevance for treatment decisions. This includes relying on the client as the expert on himself or herself, respecting the client's own knowledge about truth and reality, and emphasizing the client's own theory of change. As a consequence, the systemic therapist actively invites such knowledge from the client that is used to plan the direction of treatment, a process which is often referred to as "client-directed therapy" (Duncan et al. 2004). Further, the systemic approach typically includes emphasis on circularity, context, and pattern interruption, implying that "systemic theories are more concerned with how problems are maintained interpersonally, i.e., circular causality, rather than how and why they originated" (Heatherington et al. 2015, p. 349). The systemic focus on between-person relationships and context more than the individuals' intra-psychic processes encourages the therapist to take a collaborative role by relating to the client with curiosity, wanting to learn from the client's own world view, and communicating that the client should hold the steering wheel in therapy (Rohrbaugh 2014). As a consequence of this role, the therapist

needs to acknowledge that he or she influences the clients, as well as is reciprocally influenced by the clients, creating, or better said, co-creating the therapy. Hence, the therapist needs to be self-observing as well as observing the clients. For this reason, the therapist cannot claim to be objective, but rather acknowledges contributions of the client that may open new perspectives and solutions not thought of in advance nor described in any theoretical model, manual, or guideline. Hence, one common characteristic of systemic therapists is that they are trained to be very aware of the voice of the client—for instance by explicitly inviting feedback. In such a framework, feedback is an implicitly critical element of therapy.

Evidence-Based Practice and Levels of Evidence

Of relevance for the use of feedback in psychotherapy was the American Psychological Association's Policy Statement on Evidence-based practice in psychology (APA 2006), which states that clinical practice should be an integration of (1) the best available research with (2) clinical expertise in the (3) context of client characteristics, culture, and preferences. In particular, this declaration emphasizes that client preferences need to be taken into account, reflecting the increased attention toward empowerment and user involvement in mental health treatments. This evidence-based practice policy statement has also been acknowledged by the Norwegian Psychological Association (Norsk Psykologforening 2007) and is the basis of governmental principles and guidelines for social and health practitioners in Norway. In transforming this statement into clinical practice, Gullestad's (2001) levels of evidence are helpful. The "efficacy" level informs the clinician about knowledge derived from randomized clinical trials (RCTs) and summarized in meta-analyses. According to this evidence, the therapist should inform the client that a treatment or set of treatments are generally more effective than others for his or her specific distress or disorder. The next level is called "effectiveness" by Gullestad (2001) and relates to whether the recommended treatment at the efficacy level also is found effective in naturalistic settings. Hence, the therapist should then let the client know: "Studies from regular therapy settings show that the recommended treatment is also experienced as useful by clients with the same problems as you have." Thirdly, even though the therapist through the two previous levels has searched thoroughly for the recommended treatment of choice, if one exists, the therapist cannot be assured that this treatment will help *this* particular client. Hence, the therapist needs to ask the client: "Based on the research recommendations, this specific treatment approach is what I would suggest we go for. However, we will not know in advance whether this will fit *you*. So if you agree to try this approach, it is important that you let me know—based on your experiences—whether this treatment is helpful and meaningful for you. If not, we will figure out something else to try." Gullestad (2001) calls this level of evidence "efficiency" and is by definition an idiosyncratic level of knowledge as opposed to the first two levels, which could be characterized as nomothetic. Thus, nomothetic evidence needs to be

weighed against the client's own experience, theory of change, and so forth (idiosyncratic knowledge). In other words, Gullestad's levels of evidence exemplify how idiosyncratic knowledge and nomothetic knowledge function as integrated parts of evidence-based practice.

The Governmental Guidelines

During the 1990s, the attention on quality assurance in mental health services was strengthened in Norwegian governmental reports, legislation, and guidelines (Sosial- og helsedirektoratet 2006), emphasizing patient safety and rights (Tuseth 2007, see also Chap. 6). A shared objective in this endeavor among all parties involved—the client, the client's family, the therapist, as well as the service owner and stakeholders—was that treatment efforts should result in the desired goals with as little costs (personal and public) as possible. Further, the concepts of empowerment and user involvement were highlighted, emerging from a blend of political values and professional influence. At the same time, expert knowledge about treatment efficacy through clinical trials became influential and resulted in the empirically supported treatment movement (Tuseth 2007). This development raised a debate on what is valid knowledge: Should the assessments of treatment outcome be left to the professional experts, or should the clients be asked about their experiences? Research evidence that the client's own assessment of the therapy alliance and early change in therapy is important (Bohart and Greenberg 1997) supported the governmental guidelines on consumer involvement. Hence, the challenge was to find a systematic way of recognizing the clients' view of their treatment, and the most concrete means to realize these governmental guidelines was by adopting feedback systems (Tuseth 2007).

The Characteristics of Feedback

Feedback includes a systematic way of monitoring the course of treatment, and it will from now on be labeled "routine outcome monitoring" (ROM; Boswell et al. 2015). ROM is carried out by the client completing standardized questionnaires as a systematic and regular procedure during psychotherapy followed by feedback of this information to the therapist during the course of therapy. ROM may include completing frequent reports of therapy process (alliance) and progress (achieved targets/"small outcomes"), something that will enhance the therapist's understanding, contributing to the basis for intervention planning. In particular, ROM gives the therapist and client information that can imply a warning if there is no-change or signs of deterioration or dropout risk. And for the sake of client safety, some ROM systems also report risk items (suicide or homicide threat, abuse, violence, etc.). Because this information is available for the therapist in real time,

the therapist is informed whether the treatment is progressing adequately, or whether action needs to be taken because there is no progress or deterioration. It is recommended that this information should be shared with the client, so that the client and therapist collaborate and reflect about how to interpret the ROM information, and to consider appropriate action (Pinsof and Chambers 2009).

Studies with the use of ROM in psychotherapy have so far found that the treatment length decreased by more than 40%, cancellation and no-show rates dropped by 40 and 25%, respectively, and the percentage of patients in long-term treatment that experienced little to no improvement fell by 80% (Lambert and Shimokawa 2011; Miller et al. 2005). Research has in particular found feedback to be valuable as an aid in discovering treatment failure in real-time therapy followed by needed adjustments to optimize outcome (Lambert and Shimokawa 2011). And clients' as well as therapists' positive attitude in the use of ROM also seem to be associated to better outcomes (Lutz et al. 2015, see also Chap. 13). In CFT, ROM has been found to be associated with better outcomes and more rapid improvement (Anker et al. 2009; Reese et al. 2010). Hence, based on the research results so far, the use of ROM has been suggested as the most promising means for improving the quality of mental health services (Boswell et al. 2015; Lambert 2007).

The Implementation and Dissemination of ROM in Norway

An important ROM initiative was taken in 2002 by a Norwegian network of professionals at The Center for Child and Adolescent Mental Health, Eastern and Southern Norway (RBUP), who established contact with the Institute for the Study of Therapeutic Change, USA (Ulvestad and Henriksen 2007). This network implemented a Norwegian version of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) (Duncan et al. 2004), called KOR (Klient- og resultatstyrt praksis) in Norway, a ROM system for use in therapy sessions with adults, adolescents, and children (see Chaps. 6 and 7 for more detailed information on the KOR system). The primary aim of the KOR project was to assess client-directed, outcome-informed therapy as a means to enhance user involvement in clinical work, and to increase attention to therapy outcomes (Tuseth 2007). Further, research on the use of KOR was encouraged, and subsequently, two PhD theses within CFT contexts have so far been completed. Anker et al. (2009) found that couples in therapy using KOR improved significantly more than those receiving treatment as usual (i.e., did not use KOR), a result that was also maintained at six-month follow-up. Sundet (2011, see also Chap. 7) concluded that KOR helped the clients and therapist to focus on essential aspects of therapy in their collaboration, in particular making the therapist aware about his own limitations of his or her understanding.

Among the existing ROM systems implemented in Norway, KOR is the most widely used due to the implementation within the two largest public CFT service agencies (RBUP and The Family Counselling Services). However, there are other

ROM systems that also have been implemented within CFT in Norway. One of them is the STIC system (Systemic Therapy Inventory of Change; Pinsof and Chambers 2009), which currently is being tested in a multi-center RCT study (Tilden et al. 2010, 2015, see also Chaps. 5, 9 and 11 for more detailed information of the STIC system). A third ROM system is the SCORE (Systemic Clinical Outcomes in Routine Evaluation; Stratton et al. 2010), consisting of 15 items completed by the client that assesses primarily the family climate.

Other ROM systems primarily used with adult psychiatric services have also been implemented in Norway but will not be given attention in this book. Hence, we experience that different ROM systems have been developed and implemented that are tailored to serve different systems and client groups, as well as serving different purposes. One example that is not within the scope of this book is how municipal managers may use ROM as a way to assure the quality by developing public helping services in collaboration with the clients according to their needs (Valla 2014). Summarized, we find that ROM seems to constitute a shared objective from several perspectives: as a systemic practice, as an evidence-based practice, and as a realization of political values emphasizing consumer involvement. ROM information can also be used for research purpose, which is now discussed.

Practice-oriented Research

Lambert et al. (2004) recommended:

> A necessary and productive direction for psychotherapy researchers involves methods of monitoring patient treatment response in real time and modifying ongoing treatment when its intended positive impact fails to materialize. We call for more such research and encourage those in the field to give special consideration to engaging in this "patient-focused" or "outcome-focused research." (p. 818).

It seems like this recommendation has been put into action by the term "practice-oriented research" (POR; Castonguay and Muran 2015) that makes use of ROM procedures and frequently collected data. POR is conducted within a naturalistic setting something that creates high external validity; the generalizability of the research findings is applicable to regular clinical practice. This is promising with respect to reducing the gap between clinical practice and research (Pinsof and Wynne 2000). Further, POR involves clients and clinicians into research to a greater extent than regular quantitative research does. By using ROM information as part of therapy, the boundaries between clinical practice and research are reduced; both the client and therapist partly enter roles as researchers on their own joint therapy project. Such a change in role distribution has particular relevance to the discussion of expertise in our field, c.f. "the not-knowing position" (Anderson 2016, see Chaps. 7 and 8).

POR implies that the researcher actively involves practitioners (and perhaps clients) in every step of the research process, something that should ensure that clinical relevant topics are addressed as research questions. And because ROM information consists of frequently collected research data, this yields unique research possibilities that traditional psychotherapy research has not extensively utilized: Because frequent ROM data during the course of therapy creates change trajectories, the analyses of these data can address mechanisms of change, which will increase our knowledge of what makes psychotherapy work.

The Pros and Cons of ROM

There are good reasons why ROM has been implemented to such a great extent in Norway. In this last part of the chapter, and as an introduction to the coming chapters, I will sum up some of the advantages in the use of ROM, but also address some concerns that should be noted.

The Pros

(1) ROM is a good means to identify clients who are not improving in treatment or have a risk for dropout so that the lack of progress can be discussed. If ROM implies that the course of treatment is not achieving desired outcomes nor good enough therapeutic alliance, therapist and client will still have time and possibility in the subsequent sessions to take action to see whether the treatment can be put back "on track." In particular, this procedure increases the possibility of discovering clients at risk of no-change, deterioration, or dropout from therapy (Shimokawa et al. 2010).
(2) The ROM approach in therapy is compatible with all treatment approaches, contexts, and client groups.
(3) Ethically, ROM procedures seem to be a very concrete way to strengthen client involvement in therapy.
(4) Because some ROM systems include monitoring of risk items (suicide or homicide threats, domestic violence, abuse), the issue of client safety is addressed.
(5) The client's frequent completion of ROM questionnaires implies a process of becoming more aware and conscious of the abstract material in therapy (emotions, thoughts, relationships) as this is made more concrete via text, numbers, and graphs. Monitoring these changes may motivate the client for change efforts.
(6) For research purposes, ROM enables the collection of data in naturalistic settings, which produces evidence about outcomes in practice and allows for the investigation of the process of psychotherapy.

(7) ROM enables accountability by assessing how services are working, at a unit, agency, or regional level.
(8) The use of ROM communicates to the client that the primary goal of therapy is to improve—and that therapy will be focused on that goal. ROM information promotes the content for a discussion of therapeutic progress between client and therapist.
(9) ROM data can be used to identify underperforming therapists, as a basis for focused skill-building, supervision, and training.
(10) Using ROM includes the possibility for introducing and integrating research into CFT (Boswell et al. 2015). Hence, the concept of "practice-based evidence" could be an important complementary paradigm to the established "evidence-based practice" (Holmqvist et al. 2015). The POR approach yields a promising new direction for how to integrate research into clinical practice by partly creating empirically informed therapies, partly by facilitating research to become a natural part of daily clinical practice. This approach implies a promising step toward reducing the gap between research and clinical practice (Pinsof and Wynne 2000).

The Cons

As will be presented by several of the subsequent chapter authors (see Chaps. 6 and 12 in particular), the implementation of ROM in clinical practice has been challenging. Implementation questions have been the subject of two issues in prominent psychotherapy journals (in *Psychotherapy Research, vol. 25, no. 1*; see Castonguay and Muran 2015; in *Psychotherapy, vol. 52, no. 4*; see Wampold 2015). The obstacles to using ROM effectively were addressed by Boswell et al. (2015) and include the following issues:

(a) There is a significant financial cost of implementation, including training and supervision, buying equipment such as hardware and software for the collection, storage, and processing of data, paying the charge to copyright owner for the use of a system, and opportunity costs due to the time taken to train therapists to use a system.
(b) There is a time commitment that is associated with learning a new approach. This includes overcoming difficulties with acceptance and utilization of a new instrument and procedures, in particular when this competes with other, important tasks, and the professional's working day is already overloaded.
(c) A concern has been raised that using standardized ROM tools would interfere with the genuineness in the interpersonal meeting between client and therapist that could jeopardize the therapeutic alliance.
(d) A concern has been raised whether the use of ROM information can be misused by the external service management ("big brother") for control purposes, giving grades on how successful each therapist is with the risk to reveal some

therapists to be incompetent, or resulting in sanctions, something that is perceived as a threat to the therapist's autonomy (Boswell et al. 2015; Ekeland et al. 2014).

(e) A concern of the privacy and ethical risks about confidentiality involved in collecting such data.

Concluding Section

This introduction chapter has addressed several aspects of how the implementation and use of ROM systems have come about and been developed and experienced within the Norwegian CFT community. The following chapters will present a wide approach, addressing these questions and more, based on experiences from the implementation of ROM in CFT contexts in Norway. As a back curtain, Vigdis Wie Torsteinsson and Astri Johnsen present in Chap. 2 the establishment and growth of couple and family therapy in Norway in relation to the international currents in the field. Another important reference is written by Liv Johanne Syltevik who in Chap. 3 sees this development from a sociological perspective, and in particular addressing the change of family life in Norway the last 50 years. Because the theoretical background of systemic family therapy to a great deal has been influenced from philosophy, Harald Holm Nilssen sees in Chap. 4 this development through the lens of a philosopher. Chapter 5 is written by William M. Pinsof, one of the pioneers of introducing ROM to the CFT field, and who also collaborates with Norwegian CFT contexts on a feedback research project. The most comprehensive implementation of a ROM system to date in Norway is presented by Marianne Bie in Chap. 6. This is followed by Rolf Sundet who in Chap. 7 discusses the results from a study of the use of this feedback system. One central objective in the use of feedback as part of clinical practice is whether this enhances the user involvement in therapy, something that is discussed in Chap. 8 by Camilla Jensen Oanes. The use of feedback as part of residential family therapy is presented by Bente Barstad, Hilde Opstvedt, and Terje Tilden in Chap. 9. From the same context, the Family Unit at Modum Bad, two anthropologists, Halvard Vike and Heidi Haukelien, share their observations and reflections from their field work in Chap. 10. How some clients experience the use of ROM as part of therapy is presented by Rune Zahl-Olsen and Camilla Jensen Oanes in Chap. 11. Åshild Tellefsen Håland and Terje Tilden present in Chap. 12 a study of how the implementation of a feedback system was evaluated. ROM is introduced to several treatment contexts in several countries. In Chap. 13, Julian A. Rubel and Wolfgang Lutz from Germany present experiences and updated research in the use of feedback worldwide. Bruce Wampold (USA/Norway) refers in Chap. 14 on how feedback research can contribute to become better therapists. In Chap. 15, Jenna Jacob, Elisa Napoleone, Victoria Zamperoni, Lily Levy, Matt Barnard, and Miranda Wolpert present their experiences and research from use of feedback within the context of child mental health in Great Britain. The three latter contributors as well as

Pinsof in Chap. 5 put the Norwegian experiences in the use of ROM into an international perspective. The editors of this volume sum up and point at some trends and future challenges in Chap. 16. In total, the scope of this book is to present the use of feedback in the CFT field, mainly illustrated by Norwegian experiences, however aiming to address central topics relevant for other contexts and countries as well.

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Part II
Couple and Family Therapy in Norway

Chapter 2
The History of Family Therapy in Norway

Vigdis Wie Torsteinsson and Astri Johnsen

It is not easy to pinpoint the start of a new idea in a practice field. When we talk about the archeology of a discourse, you can easily get the feeling that you are looking for something substantial, a physical thing. Looking for the roots of a tradition in a practical, professional context is something completely different (Foucault 1972). As new ideas lead to organizational changes or new institutions, the task gets easier. There is a conspicuous lack of written material describing these developments. Therefore, the story could have been told in many different ways. This is one way of telling it.

What Paved the Ground for the Development of Family Therapy in Norway?

In Norway, the first Health Center for Mothers (Mødrehygienekontor) was opened in Oslo in 1924. By 1934, eight health centers of the same kind had opened. Between 1900 and 1930, there was population decline in Norway, creating a need for improving health services for mothers and children (Kummen 2016). The mandate of these services was to spread information about sexuality and to give professional advice about contraceptives and pregnancy. Added to these tasks were the responsibility to give advice about child health and nutrition and to give medical assistance to pregnant women and newborn children. In the 1930s, the first center with the responsibility to give advice about mental health problems was established. The focus on sexuality and child health was most probably connected to great

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poverty and epidemics that prevailed in the same period (Eriksen 1967). These centers became the cornerstones of the family counseling offices (Kummen 2016).

The Norwegian society in the 1950s and 1960s was still strongly affected by the consequences of the Second World War. Large parts of the country were in a reconstruction phase, with a lack of housing after massive bombing during the war. Many ordinary commodities still were rationed. The nuclear family was the norm, as reflected by the fact that only 36% of the female population worked outside the home (the lowest number in history). Divorce rates were low.

In the 1960s and 1970s, the traditional family was under attack from left-wing ideology. This criticism has a tradition in Norwegian culture—the classical plays by Henrik Ibsen (e.g., "A doll's house") may serve as an example. Like Ibsen, left-wing ideologues underscored the repressive function of family structures—for women, for social development, and for social responsibilities (Holter 1962). At the same time, worrying about the family was also present. Divorce rates were increasing, as was juvenile delinquency. Could the family in one way or another be responsible for these developments? At the same time, there was a marked idealization of the family, in popular magazines and in films.

Social scientists also studied the family from a class perspective. Family functioning was described as formed by the capitalist economic system and with socializing practices determined by which class you belonged to. Researchers identified differences in values, with upper-class families socializing their children to independence, while working-class families valued obedience. Fathers' involvement in family life also varied, with working-class fathers spending more time with their families than upper-class fathers. Studies also showed that material circumstances influenced how parents related to children's needs (Stefansen 2007). Families were emptied of functions, except for satisfying emotional needs; hence, socializing children was the only task left for the family (Grønseth 1966).

In the same period, family life changed. The relations between family, labor force, and welfare state found new forms. Since the 1970s, women have steadily increased their level of education, are to a greater degree working outside the family, and earn more than in the earlier decades. Today, the Norwegians of age of 20–66, 76.8% of Norwegian women are in paid employment compared to 82.9% of men (SSB 2014a). Over 90% of Norwegian children under school age go to kindergarten (SSB 2014b).

The start of offering professional guidance to families in Norway can be traced back to the 1920s, where questions about family functioning arose because of changes in society: e.g., industrialization, poverty, breakdown of traditional social networks, and social isolation. Among other themes, people sought advice about sexual and marital problems. The first indication of a need for advice in relational and sexual matters was expressed by Karl Evang, a young physician who later became the Director of Health at the Norwegian Governmental Office. He started answering questions about health matters in a popular journal *Arbeidermagasinet.* Among the questions he received were ones about sexuality, which he responded to in the same way as other health issues. And these responses led to a stream of questions that he had not foreseen. As a result, a group of physicians established the

journal *Populært tidsskrift for seksuell opplysning* in 1932 (Evang 1964), which presented information about sexuality. As the Director of Health, he contributed to the establishment of the first family counseling office in the town of Steinkjer, as both a continuation and expansion of the work done in the existing health centers. From the start, the family counseling offices were social medical institutions, with physicians as administrative and professional heads (Wathne and Sundland 2008). These offices represented a wide definition of health and sickness, based on modern social medical principles (Gaasø 2003). In 1939, the founder of Modum Bad, Gordon Johnsen, started to give advice to youth who had sexual difficulties through the magazine *Christian Youth*. At the same time, he initiated a service called "Christian help with sexual questions," which was staffed with volunteers, who were mostly priests and physicians.

Overarching Themes—Trends and Headlines Seen as Historical Processes

From the start of family therapy work, the Norwegian scene has been characterized by comprehensive international relations. Norway is a small country with a very long coastline, and Norwegians at all times have been travelers and merchants of the seas. From the Viking period on, Norwegians were used to traveling long distances to provide for the needs of the population at home. Maybe, this can account for some of the eagerness to go abroad to learn new things and to invite international trainers to Norway.

In Norway, most of the health and social services are state agencies or organizations. One consequence of this is that most family therapists work in public agencies, funded by the state or by local communities. Traditionally, professional organizations have had a great deal of professional freedom, being able to organize their activities from the best available knowledge. The first official organization working with families in Norway was the Church Family Counseling Office established in 1958. The roots can be dated back to the services advising about sexuality in the 1920s, but the concrete initiatives were inspired by Norwegian professionals who studied abroad, mostly in USA and Great Britain. One example is social worker Till Eriksen, who, after studying in USA, was one of the pioneers in introducing family therapy techniques and thinking in the Norwegian context. She gave a comprehensive speech about family therapy at the 9th psychotherapy congress in Norway in 1967 (Eriksen 1967). Eriksen highlights among others Theodore Lidz's family therapy as a way of working with families that easily could be integrated with the psychodynamic therapies that already were in use in most therapeutic settings. In the same period, the search for ways of working with families was also present in the child and adolescent psychiatric services, which started in the 1950s, inspired by Child Guidance Clinics in USA. Among others, Nic Waal, who was one of the pioneers in developing psychiatric services for

children and adolescents, visited several clinics in USA and wanted to establish similar clinics in Norway. One interesting development was that therapists started to explore ways of involving the family when they shared results from individual testing and examination of children's difficulties. The experience of having better dialogues with the parents when the whole family was present was one of many arguments for introducing family therapy methodology in child and adolescent clinics. Family therapy as a way of working also got attention within child protection services. A central person in the child protection services, Ustvedt (1967), wrote an article titled "Family interview as a diagnostic tool in child protection services," where she referred to the use of family therapy in child psychiatry. Here, she argued the results of therapy improved because they could work directly with family themes that maintained a problematic development in the child. We will return to these themes later.

Family Therapy in Norway Through the Decades

Family Therapy in the 1960s and 1970s

Two strong ideologies characterized the therapeutic milieu in the 1960s: psychoanalysis and behavioral therapy. Between these extremes, family therapy evolved. We will present some headlines of this story. How did family therapy establish itself as an independent way of doing therapy? Which ways of doing family therapy gained ground? What were the main discussions?

In these first decades, family therapy got its inspiration from many different approaches: Communication-oriented family therapy, represented by Paul Watzlawick and the Mental Research Institute in the USA, was the inspiration behind Forum for Aktiv Psykoterapi (FAP), which was later called Institutt for aktiv psykoterapi (IAP) in Oslo. The systemic thinking/theory and method were introduced first by the psychiatrist Phillipe Caille's presentation of the Milan School. The psychodynamically oriented family therapy, with special emphasis on the multigenerational perspective (Ivan Boszormenyi Nagy and Murray Bowen), was an inspiration to treatment programs in several places, including Modum Bad, Statens Senter for Barne- og Ungdomspsykiatri, and Nic Waals Institutt. The family dynamic model of Helm Stierlin was introduced both in adult psychiatry (e.g., Ullevål Hospital, in the psychiatric departments at Dikemark and Gaustad hospitals) and in child psychiatry. At Nic Waal's Institute (NWI), Stierlin's model was used as the base for a project in short-term family therapy. The structural model of Salvador Minuchin was an inspiration for the family counseling offices (and in child and adolescent psychiatry). Jay Haley's strategic therapy was also practiced, and one who was inspired by this approach was psychoanalyst Marie Nævestad who worked with couple therapy. Gestalt therapy, which was discussed in an entire issue of the Norwegian (later Scandinavian) journal of family therapy (*Fokus på familien* nr. 4,

1976), was also offered. For instance, Walter Kempler established his own Gestalt Institute in Norway. Network therapy was already a therapeutic method in the early 1970s within adult psychiatry (Vaglum 1973). At the psychiatric ward in Ullevål hospital, multifamily groups were practiced (Albretsen 1979).

This overview demonstrates that family therapy was a new approach in Norway in the 1960s and 1970s. The question of what effect it had was naturally raised followed by some research and evaluation studies. Examples include a short-term family therapy project at NWI and evaluation studies at Statens Senter for Barne- og Ungdomspsykiatri. Within adult psychiatry and family counseling offices, there are also many examples of testing and evaluation of family therapy methods (Fokus på familien 1973–1980). An overview of some trends in research on family therapy in Norway will be presented later in this chapter.

The systemic approach challenged our understanding of the relation between the individual and the system (Engelstad 1979; Johnsen 1997). This is a question we will discuss later in this chapter. The medical model's disease concept and diagnostic understanding were challenged. Was it possible to diagnose family problems? Discussions about prevention and prophylaxis were also a theme. Which problems should be treated with family therapy? The question about indication and contraindication for family therapy was an important issue.

In addition to *Fokus på familien*—the Scandinavian journal on family therapy—two central books edited by psychiatrist Svein Haugsgjerd and sociologist Fredrik Engelstad (Engelstad and Haugsgjerd 1979a, b) should be mentioned. They gave a thorough introduction to family therapy and were widely read.

Creativity was the characteristic of the family therapy in Norway in the 1970s. Transparency, courage, and curiosity were the typical attitudes toward family therapy. There was no right or wrong, but rather an openness toward new possibilities. We might call this decade the pioneer's phase.

The 1980s

From mid-1980s, postmodern epistemology and constructivist thinking were included as part of the theoretical foundations of most family therapy practices in Norway. Family therapy in Norway before the 1980s was mainly dominated by three forms of therapy: strategic, structural, and systemic therapies. But gradually, the idea that the therapist was the expert on how families should live their lives was questioned. From being the experts on family life, therapists wanted to be midwives for the families' own possibilities for change. The ideas that therapists could have objective knowledge about the families they were working with were challenged in the same way.

What made his change possible and necessary? The field was blooming with conferences, seminars, and lively discussions in different arenas. The international trendsetters were invited to Norway, and Norwegian therapists went abroad to see and learn. The influence was strongest from USA, Britain, Italy, and Germany. The

German psychotherapist Helm Stierlin built a bridge between the psychodynamically oriented and systemic therapy. Luigi Boscolo and Gianfranco Cecchin from the Milan team visited regularly for training purposes from 1983 onward. The Institute of Family Therapy (IFT) started a collaboration with the Norwegian Psychiatric Association on training in family therapy. IFT has continued to be significantly involved in educating Norwegian family therapists (will be presented later). The Norwegian professor Tom Andersen was a central part in making this international exchange available to Norwegians, especially through a yearly seminar in Northern Norway where everyone who counted for something on the international scene participated. These seminars had titles like "A Greek kitchen in the Arctic" and represented a melting pot for everyone who was engaged in the family therapy field. Tom Andersen was the professor of social psychiatry at the Institute of Community Medicine, University of Tromsø, and was the initiator of the approach called "Reflective Processes in Therapeutic Practices." These seminars ("Nordkalottseminarene") served as an established arena for professional debates and "the place you had to be" if you wanted to keep track of what was happening in the family therapy field. Luminaries such as Harry Goolishian, Ken and Mary Gergen, Humberto Maturana, Harlene Anderson, and other well know figures from the international science were frequent visitors. In this context, the ideas and practice of social constructionism were held high.

Tom Andersen also contributed to the development through his and his team's work with the reflecting team (Andersen 1987). This represented an epistemological break with the idea of the therapist as the expert, because the reflecting team presented ideas to the family and presented them in such a way that it was possible for the family to freely choose the ideas that suited them, in their particular situation. The reflecting team also was an important step in the democratization of therapy, a development that continues into the present.

This was a decade where epistemological discussions and reflections came to the center of the scene. How could we really know anything about the people we were working with? Could our constructions of families be anything but our own constructions? The concept of "not knowing" came to the foreground. Constructivism, social constructionism, and postmodernism became household words. And the importance of language in the process of human meaning-making was the grounding theoretical reflection on our practice.

At the same time, family therapy was gradually established as an important praxis, an obvious way of working when confronted with people's struggles. This was especially true in services treating couples or families where children were the "identified patients." Professionals from all groups who wanted to specialize in child and adolescent psychiatry had training in family therapy along with individual therapies. The training was mostly given in interdisciplinary groups.

But these developments did not take place without criticism. And the criticism was concentrated around the import of concepts from fields that had little or nothing to do with relations to other people. In a much cited article with the title "From a naked emperor to just clothes: The rise and fall of cybernetic family therapy," Kirkebøen (1995) criticized the way family therapists introduced metaphors from

disciplines that had little connection to family therapy. He formulated his criticism in ironic terms, as when he commented on the use of the concept "structure-determined," as it was introduced into family therapy inspired by the biologist Humberto Maturana. Kirkebøen's main point was that the language in family therapy was full of new metaphors without meaning—just like the emperor's invisible clothes. He argued that even defining the concepts used was of no help as the definitions are just as confusing as the original formulations. Kirkebøen's article was reprinted in *Fokus på familien*, followed by a big debate in the family therapy community. Were these new concepts really useful for someone who tried to be helpful to real people, in real (and difficult) situations? Among others, Reichelt (1995), one of the central persons in the Norwegian family therapy community, raised questions about whether family therapists needed epistemology at all. Most of all, this controversy probably created a divide between those who believed that epistemological discussions were necessary for the development of any professional area and those who left these discussions to researchers and philosophers of science.

This decade also saw the first textbook in Norwegian on family therapy, *Fra systemteori til familieterapi* written by Schiødt and Egeland (1989). The book, which originated as a master's thesis in psychology, was the only Norwegian textbook until Håkon Hårtveit and Per Jensen published their *Familien – pluss én* in 1999. It took more than 10 years before the next textbook in family therapy was published by the authors of this chapter (Johnsen and Torsteinsson 2012).

The 1990s

The 1990s saw a great diversity in family therapy methods and techniques, while the ideological debates were gradually more or less silenced. The contributions of Tom Andersen and social constructionism to the Norwegian context were still strong, together with the cooperation that was established in the northern parts of Sweden, Finland, and Norway, where the Finish professor Jaakko Seikkula was a prominent contributor. New developments also found their way to Norway. During the 1990s, solution-focused and narrative therapy gained ground in the Norwegian professional milieu. Solution-focused therapy (LØFT) was widespread in the family counseling services (Haaland 2005), but it was also introduced to new environments, among them organizational psychology (Langslet 2008). The practice of narrative therapy also enjoyed increasing importance among family therapists (Lundby 1998). This practice, which was developed in Australia by Michael White and David Epston, found a strong foothold in Norway, following a great engagement in the concept of narrativity in several brands of psychotherapy. Narrative practice also hit a vein in social democratic societies like Norway, with its focus on fighting against oppression and as a protest against solving social problems by diagnosing individual illness. Both in child and adolescent psychiatry and in family counseling this has become a much used approach.

Two new tendencies came to the forefront of the professional discussions during this period. One was the introduction of manualized treatment packages. Multisystemic therapy (MST—Henggeler 1999) is one example of this trend. In the 1990s, there was an increased focus on evidence-based treatments. Among other alternatives, MST was one way of working that claimed to be evidenced-based. Consequently, a political decision was passed to implement MST as the preferred way of working with youth with criminal and behavioral problems. The implementation of MST was firstly established as a project at the Institute of Psychology, University of Oslo. It was organized as a center from 1998 to 2002 as wholly owned by the university. From 2003, the Ministry of Children, Equality and Social Inclusion took full responsibility and established the Norwegian Center for Child Behavior Development (Atferdssenteret). The center was organized as a part of Unirand, owned by the University of Oslo, and financed by the ministry. The research conducted here was partly action-directed and among other factors linked to the implementation and evaluation of methods used to work with behavioral problems.

This center (Atferdssenteret) declares itself as built on three main pillars:

1. implementation, training, and further development of new methods in the work with serious behavioral problems,
2. research linked to the evaluation and development of new methods, and
3. research regarding the prevalence and development of behavioral problems among children.

Through its activities, the center works toward giving children with serious behavioral problems and their families' assistance, based on research, individually adjusted and with effective results according to today's knowledge level. The activities at the center were from the start aimed at being interdisciplinary and integrated. Further to contribute to development of competence and effective family- and community based initiatives to prevent and intervene where serious behavioral problems with children or adolescents was found. The method is today integrated as a central intervention in the child protective services. In this context, it is an example of how governmental institutions intervene in professional developmental processes and give priority to a selected way of working partly outside the traditional institutions.

On the other hand, feedback-informed therapy (FIT—in Norwegian: klient- og resultatstyrt terapi, KOR) was also introduced to the Norwegian scene (see Chaps. 6 and 7 for more detail). Barry Duncan and Scott Miller were frequent visitors to Norway, invited by both the Regional Center for Child and Adolescent Mental Health and Gaustad Sykehus (a psychiatric hospital for adults), both located in Oslo. FIT was first implemented in services for children and adolescents (Ulvestad et al. 2007), but it was also introduced to family counseling services and to adult psychiatry. This coincided with a strong political process regarding the role of patients' involvement in the delivery of health services and a strong commitment to expanding psychiatric services. The government underscored the importance of

allowing patient's voices to be instrumental in planning and execution of health services. A white paper called "Openness and wholeness" was presented in 1997, which redefined the relationship between therapists (of all kinds) and patients, giving the patient's voice an important role in his or her own medical or therapeutic processes. Later on, the Directorate for Children, Youth and Family Affairs (Bufdir) decided that FIT should be used in all family counseling offices as part of the project called "User-oriented quality improvement". In this context, one could believe that the focus on co-constructed realities as seen in the collaborative practice of social constructionist therapy would have an advantage, compared to other ways of doing therapy. But this is only half of the story. The social constructionist foundations also come with a fundamental skepticism toward generalized knowledge as a source of information to guide therapy.

The critique raised against systemic therapy in the 1980s continued in the 1990s, but took a different direction. The relationship between systemic therapy, theory, and psychological knowledge was addressed more directly by a group of psychologists and family therapists within child and adolescent psychiatry. They questioned the role of social constructionism as the only way of approaching epistemological questions and pointed out that family therapists lacked relevant theories about human relations in developmental psychology (Johnsen 1997; Johnsen et al. 2000). The understanding of the individual, the privileged role of language, and the place of nonverbal communication and emotional exchanges were central in developmental psychology and had the possibility of making important contributions to the work done by family therapists. Among others, the work of Daniel Stern was offered as a way to approach these topics (Stern 1995). This debate was also inspired by a parallel debate in Great Britain, even though the British discussions were based on attachment theory (Sundet and Torsteinsson 2009). The discussion about family therapy and developmental psychology and other bodies of knowledge continued in the 2000s (Johnsen 2007; Mæhle 2000, 2001, 2005; Sundet and Torsteinsson 2009; Torsteinsson and Sundet 2010).

After 2000

The development toward democratization of the health services continued into the 2000s. We have seen a growing interest in collaborative practices, defined as a focus on collaboration between therapists and clients about goals and methods as main elements in what defines good clinical work (Ulvestad et al. 2007). This included the increased use of client feedback and a focus on the therapeutic alliance as important aspects of working for change (Sundet 2011).

On the other hand, the introduction of new public management as the dominant organizational ideology in the public sector combined with the growth of the evidence-based movement has introduced another dilemma. The research world of course also wants to represent the phenomena it strives to understand as adequately as possible. But the gold standard in evidence-based medicine, the randomized

controlled trials (RCTs), has the form of a competition where the people who contribute to the studies (i.e., the patients in the trials) have no say in the choice of therapy they get. In this context, the collaborative principles of FIT are overruled by the need for randomization. So as the social constructionism-inspired part of the family therapy professionals holds a fundamental skeptical attitude toward quantitative empirical research, others accept nothing but this context (the RCTs) for determining what is good family therapy practice. To the clinician, the main objective is to make treatment tailor-made to the needs of the individual family. Hopefully, this controversy can be remedied by a greater focus on how to transform knowledge from quantitative group data to clinically useful knowledge.

This controversy has led to a divide in the professional milieu. On the one hand, we had the proponents of dialogical, unique processes, created in cooperation with the clients we meet. On the other hand, we saw a number of new therapy manuals introduced, built on different theoretical premises and relevant for different problems or diagnoses, some with empirical support for being useful. Treatments proliferated, with abbreviations such as FFT (functional family therapy), ABFT (attachment-based family therapy), EFT (emotion-focused therapy), MBF (mentalization-based family therapy), and MDT (multidimensional therapy). They are introduced in different contexts, with the hope of increasing the impact of therapies offered to clients. This might have generated a split among family therapists of different convictions, but we did not see a revival of the epistemological debates. And it is even possible to note a passivity in debates about "what works for whom." Family therapists do not highlight good results for family therapy when these questions are raised, even if there is evidence for the usefulness of family therapy in many circumstances (Carr 2014, see pp. 28–29). But the challenge to the family therapy field probably goes beyond this distinction: Clinicians tend not to use research to inform their clinical practice, even when they themselves do research as part of their professional life (Safran et al. 2011). This has led to debates about how clinicians and researchers can work together to create a space for a common development of our practice field.

Family therapy also lost its importance in some areas. In child and adolescent psychiatry, family therapy was seen as a necessary part of a specialist education for all groups of professionals. Today, the family therapy course is voluntary and mostly sought by social workers and child welfare workers.

The Important Working Contexts for Family Therapists

Family Counseling Services

The two first family counseling offices in Norway that started in Stavanger and Oslo in 1950 and 1952, respectively, paved the way for a new national family counseling service. These two offices stayed open two afternoons a week, and their assignment

was to advise in sexual, religious, and marital questions. Later, the first Church Family Guidance Office was established in 1957 in Oslo and received their first clients in 1958. Their mandate was to treat clients suffering from relational problems, as well as to prevent the formation of familial or marital problems. It was also expected that they should work to establish new offices in other cities around the country. At one point, there were 31 offices with a religious foundation in Norway. The organization Kirkens Familievern (KF) was established 1967 to strengthen and coordinate cooperation between these church-affiliated offices and to coordinate the cooperation with local and central authorities.

In the same period, the state also established a public family counseling service. In 1959, the Department of Social Affairs decided to establish pilot projects at offices in two small cities in Northern and Midpart of Norway (Bodø and Steinkjer). These two offices were run as a pilot project for three years and gained a very positive evaluation. The ministry funding the service concluded that the project had "very encouraging results" and underscored the need for expanding this service (St. mld. 27 1964/65). This was the start of the public family counseling service that has grown over the last 50 years. Similar to the church offices, these were also organized in an overarching organization in 1983 to create a professionally coherent service and to make family counseling visible in the public sphere. The question about how two different organizations, offering the public the same kinds of services, could live side by side arises naturally. Both services are free of charge, and no referral is necessary. The religious foundation of the church-based offices was implicit and not visible or obvious to the clients. The church offices were inspired by British and American initiatives whose purpose was to protect the family as a social institution and prevent divorces. The public offices were to a greater degree inspired by German ideas and concerned with health issues, but gradually also attended to marriage and family problems (Kummen 2016). Gradually, the state has taken over most of these offices. In 2005, the State Ministries reorganized, and a new ministry, the Ministry of Children and Families, now called the Ministry of Children, Equality and Social Inclusion, was established. As part of their responsibility, they established the agency Norwegian Directorate for Children, Youth and Family Affairs (Bufdir). Their main task is to provide children, young people, and families in need of help and support with appropriate, high-quality assistance on a nationwide basis. In addition to being a competence center for child welfare and family counseling, Bufdir is also responsible for the management and operation of state-funded child welfare and family counseling service (Bufdir 2016a). Today, there are 50 family counseling offices in the country, 12 of these church-affiliated (Bufdir 2016b). Their main tasks are traditional family or marriage work and mediation. Mediation is mandatory when parents separate or break up, married or not, when they have shared responsibility for children under 16 years. This is established as a help to parents to secure good access to agreements between them and to take care of the children's best interests. The main task for the family offices has been couple therapy. At the same time, all along it has been a wish and a struggle to include children in the work they do. In the last years, many methods for

involving children have been developed (Ask and Kjeldsen 2015), including participation in family therapy and in mediation processes.

Child and Adolescent Psychiatry

The development of child and adolescent psychiatry in Norway started in the 1950s. Inspired by the Mental Hygiene Movement in USA, the first Mental Hygiene Association was founded in 1930. Their main aim was to prevent psychological and social problems through counseling and through creating facilitating environments. During the 1960s, the child and adolescent psychiatry expanded. The first outpatient clinics were established in the main cities, with the first institutions located in Oslo. This represented a challenge in many ways. There were some discussions about how to organize the services, with questions about how to facilitate cooperation between services working with children and adolescents as the main issue. There was a great lack of professionals and no real strategies for compensating for the shortage. For some districts, this was addressed by a close connection with adult psychiatry, which provided psychiatrists necessary for setting up outpatient services. In other areas, close collaboration was established with the child protective services and with local physicians and health nurses.

This variety of collaborative practices in many ways was determined by local conditions. Norway is a sparsely populated country, with difficulties traveling from the districts to the cities where the hospitals were located. There also has been political agreement on a regional policy that wants development in all parts of the country. When a child and adolescent clinic was established in Tromsø, Northern Norway, they wanted to establish a service that was available to all, no matter where they lived. This meant that the employees had to travel to meet the children with their families and the local professionals. Focus was on consultation techniques and family-based interventions. Working with families was not family therapy in the form we know it today, but rather it was done in the casework tradition, inspired by Virginia Satir, and with social workers as the main contributors to the professional development (Sommerschild and Moe 2005). The principles of this therapy were to contribute to the understanding of the difficulties and needs of the child in their local context. Further to mobilize support and resources in the family for a continued development (ibid). But this meant that the principle of involving the family in the treatment of children and adolescents already was well established when family therapy was introduced in the professional field.

Today, individual child therapy still is the main form of treatment in child and adolescent psychiatry (Mæhle 2005). But family therapy has played an important role in the development of service delivery in working with children and adolescents. From the 1970s, every institution within child and adolescent psychiatry had one or more family teams making use of one-way screens and teams (Sommerschild and Moe 2005). These teams had the double function of doing therapeutic work, but

also being a way of teaching family therapy to new generations of therapists. To underscore the importance of this form of treatment, training in family therapy was mandatory in teaching programs educating all professional groups for working in child and adolescent services.

In the 1970s and 1980s, new outpatient clinics were established all over Norway. The policy of establishing treatment services as close as possible to the citizen's natural context was a guiding principle in structuring the services. Following this principle, it was considered desirable to have as few inpatient units as possible. Further, one tried to avoid moving children and adolescents away from their families and domestic context for treatment purposes. Family units that offered four weeks of intensive family therapy were seen as a better approach. Almost every new child and adolescent psychiatric clinic that was established had a family therapy unit as a way of offering more intensive treatment to children without taking them out of their family context. In some places, original plans for a psychiatric ward for children or adolescents were replaced with a family therapy unit. The first family units that were established were located at the Norwegian Center for Child and Adolescence Psychiatry (Statens Senter for Barne- og Ungdomspsykiatri—SSBU) in Oslo in 1971. In the late 1980s, this institution alone had four family inpatient units that in total could treat eight families simultaneously, in addition to a day care department that also saw families. In the later years, many of the family units have been changed into outpatient services, still working with children in their families, but primarily in their natural environment. One way to characterize the development is to say that the concept of context has become more important than the concept of family.

In line with the same ideology, the few institutions that were established were small units called "treatment homes" (behandlingshjem). They were for a great part inspired by "Barnbyn Skå," a Swedish institution located outside Stockholm, founded by Gustav Jonsson. Skå was built like a small village, with several houses with small groups of children living together with grown-ups in much the same way as in a family. This way of organizing proved to be too demanding for the employees, but showed a willingness to give children who could not be treated within their family a context as similar as possible to a family to develop in.

Adult Psychiatry

Family therapy has not had the same position in psychiatric services for adults as within child and adolescent psychiatry, although family problems were treated within several psychiatric hospitals in the 1970s (Johnsen 1968). At Lovisenberg Hospital, psychiatrist Arne Kanter (1961) conducted a survey on the frequency of marital conflicts among psychiatric patients as early as the 1950s. In his study, marital problems were present in one quarter of the male and in one half of the female population. At Ullevål Hospital, department 6B, psychiatrist Carl Severin Albretsen was an avid proponent for family therapy. In the 1970s, the 6B department initiated

multifamily groups as part of their treatment program. This way of doing treatment has seen a revival in this century, in a Norwegian context especially in the treatment of eating disorders. Another inpatient unit, Lien at Dikemark Hospital, was both ideologically and practically committed to treating people as close to their families and communities as possible. In the 1970s, the adult psychiatrists were active proponents of family therapy, with active engagement in introducing theories and practice on family therapy in the medical curriculum, in their workplaces, and on the public scene. Mainstream adult psychiatry continued, however, to be individually oriented.

Modum Bad

An exception to this trend is Modum Bad (MB), the first Norwegian institution to establish a family therapy unit. Until "Viken Center for Psychiatry and Pastoral Care" in Northern Norway was established in 2006, MB was the only family unit in adult psychiatry. Because of this, we will here pay special attention to this institution.

History

Modum Bad (originally Modum Bads Nervesanatorium) was established in 1957 on the grounds belonging to a previous curative bath sanatorium established a century before. The clinic specialized in the treatment of patients suffering from nervous disorders, mainly anxiety and depression. MB is organized as an independent foundation, based on a Christian and humanitarian ideology and originally funded through private contributions. Today, it receives a majority of its funds from the government. The foundation had a clear psychotherapeutic objective and clearly differed from other psychiatric institutions of that period. From the very start, MB established connections to the international cutting-edge psychotherapy milieus. MB is located on rural grounds about 80 km outside of Oslo. Included in the property are ten villas situated in the woods and several other Swiss-style buildings originating from the time of the curative baths. The villas in the forest that were part of the original site offer a unique possibility of treating families in a next to normal family atmosphere, which is preferable to commitment to a ward.

MB is divided into two units: a clinic offering individual psychotherapy for depression, anxiety, trauma, and eating disorders, and a family unit providing couple and family therapy to couples and to the entire family, which was established in 1968. The families were and still are staying in family houses inside the hospital compound during treatment.

From the very start, interest in family therapy was present at MB. At the beginning, special attention was paid to relational problems in couples, and spouses were included from an early stage within the frame of individual treatment. The founder of MB Gordon Johnsen had invited spouses to participate in therapy

already when he was the head psychiatrist at Lovisenberg psychiatric department at the beginning of the 1950s. On a study trip to the USA in the early 1960s, he learned that psychoanalytically oriented therapists of non-improving individual patients experienced that when including the spouse in the treatment, the dynamics of the treatment changed and there was a significant improvement. Five years prior to the opening of the family unit in 1968, MB had used their summer villas for family treatment, without remuneration, but in order to gain experience with this type of treatment. It could well be called a pilot project. Should they then proceed by admitting the families into the hospital, or should they rebuild the summerhouses to a standard, which made them habitable all year round? They chose the latter. The advantages seemed obvious; here, the families could live by themselves, cook their own meals, and live in a household together as they would in their own home.

The Treatment

Milieu therapists were of great importance within the staff in addition to head psychiatrist, child psychiatrists, assistant residents, social workers, and psychologists. Following the families in their daily lives, the milieu therapists could share their experiences in the family sessions. The setup is approximately the same today (see Chap. 9 by Barstad et al.). In connection with the family wards, there is a school as well as a kindergarten, a family house offering various activities, and a family center with treatment facilities and offices. At a very early stage, rooms with one-way screen and video equipment were set up with the aim of doing research, learning, and developing methods of treatment. The onsite teaching facilities also were (and still are) aimed at the assessment and evaluation of the therapeutic practice and to develop parallel working teams of various professions.

The treatment model applied is characterized by holistic thinking and built on a systemic frame of understanding, while at the same time examining the place of the individual within the family. This model of treatment is also called “integrative practice” (Tilden 2008). The treatment was focused on family resources with psychoeducation playing a significant part of the therapy.

The family unit offers residential treatment to couples and families struggling with relational problems in addition to psychiatric problems among the adults. The family therapy, as before, contains various therapeutic approaches with the common denominator of emphasizing how interhuman relations and context influence individuals and systems. Psychological issues are treated within this relational and contextual perspective. All patients at the family unit get courses in the Prevention and Relationship Enhancement Program (PREP, relationship workshops; Markman et al. 2010) and Circle of Security (a relationship-based parenting program; Powell et al. 2013) as part of the psychoeducative treatment program. In addition, several of the unit’s staff members contribute to preventive work with educational courses and counseling organized via the Modum Bad prevention and conference center Kildehuset.

Evaluation and Research

Evaluation and research were, and still are, part of the profile of the family unit (Ravnsborg 1982; Tilden 2010). From the start, they have written about their experiences and included both indications and contraindications for treating families in an institutional context. Publications also included reflections on treatment ideology—the main premise was that treatment should include strong pedagogical and resource-oriented elements (Johnsen 1968). The journal *Fokus på familien* encouraged therapists to publish and discuss their experiences. In a doctoral thesis, an evaluation of 220 adult patients during the period from 2001 until 2003, an improvement was registered with regard to individual symptoms as well as in relationship with the partner (Tilden 2010).

Currently, the ward uses an electronic report system called Systemic Therapy Inventory of Change (STIC; Pinsof and Chambers 2009, see Chap. 5). This adds to the basis for the understanding of each couple and family and how to adjust the treatment to their particular situation. In addition, this system collects research data.

Diagnostic Challenges

The diagnosing of families with children was a challenge much discussed from the start. Family conflicts and family treatment were used as parallel diagnosis in addition to the fact that family members were diagnosed individually in accordance with public diagnostic criteria.

International Contacts and Inspirations

The family unit at MB and Kirkens familiekontor collaborated in arranging yearly family therapy seminars held at MB. To these seminars, internationally renowned family therapists and researchers have been invited, including Helm Stierlin, David Reiss, Ivan Boszormenyi Nagy, and Harry Goolishian. This was of course a great input and inspiration to the people working at the MB family unit.

The Research Institute

The close cooperation between clinical work and research that has characterized MB, including the family unit, was made possible by the creation of a local research institute in 1985 based on a combination of donations and gifts from private sponsors. The primary goal of the research institute is treatment research aiming at developing the clinical services within the institution. At the family unit, the current research is based on the use of a feedback system, STIC, systematically collecting feedback from patients/families (see Chap. 9). A close cooperation between clinical work and research contributes to strengthening of treatment legitimacy and quality.

And the possibility of having scholarships or visiting other institutions for study purposes also contributes to professional inspiration and further development of the clinical practices. In addition, Modum Bad has recruited well-known directors of research from the international scene, which has been a great inspiration to a wide circle of professionals.

Publishing About Family Therapy

The journal *Fokus på familien – Tidsskrift for familiebehandling* (Focus on the Family—journal for family treatment) was founded by Kirkens Familievernkontor in cooperation with Modum Bad in 1971, and the first edition was produced in 1973. The journal developed from the newsletter produced by the Church Family Counseling Office and represented a wish and a determination to professionalize the family therapy field. The founders recognized a growing interest in family therapy, to such an extent that they could not supply enough copies of the first issues to satisfy the demand. The journal has since the start been the leading journal in family therapy in Norway, later on also in the Scandinavian and Nordic countries. In 1983, it was established as a Scandinavian journal, owned by the Norwegian publishing company The University Press. The recruitment of editors also expanded, the editorial board now consisting of editors from Norway, Sweden, Denmark, and Finland. The publisher has established a council of representatives from the professional organizations, with the founding organizations still represented, including the national family therapy organization in Norway. From the beginning, one main goal for the journal has been the wish to contribute to a professional discourse in the Scandinavian languages. We represent small language communities, and in a professional world dominated by English and American influences, it has been an important policy to represent a possibility to publish in the readers' mother tongues. The journal has also had a policy of representing several genres of writing, from personal essays to peer-reviewed scientific articles. In the later years, due to the increase in master-level students, many publish the results of their master thesis in this journal. In a survey conducted by the journal of the Norwegian Psychological Association in the 1990s, *Fokus på familien* was the journal most frequently read by Norwegian professionals.

Norsk Forening for Familieterapi (NFFT)

The Norwegian Association for Family Therapy (NFFT—www.nfft.no) was established in 1983. It is a membership organization, open to anyone who wants an affiliation to family therapy as a way of working and thinking about relational or psychiatric problems. A yearly conference is the main meeting place for family therapists. In addition, NFFT has been the host of several Nordic conferences, as

well as the world congress in family therapy in 2000. They publish a magazine (Metaforum) available to all members, which keeps the organization oriented about national and international happenings and professional developments.

Family and Family Therapy Research in Norway

Family therapists have always been concerned with feedback from the families they have been working with. Early on, small projects were initiated in the child and adolescent services. In recent years, several Norwegian-practicing family therapists have initiated and completed research projects on a Ph.D.-level on families and family therapy. Common to these projects is that the researchers all have been active, practicing family therapists. This contributes to making the research relevant to the clinical field. The studies mentioned also represent themes that in some ways characterize some main interests of therapists working with family therapy models.

In this context, we want to start with presenting a study of trends in Norwegian psychotherapy in the period 1970–2000. Hjort (2003) based her study on the central therapeutic literature from this period, with a comprehensive questionnaire to practicing therapists and interviews with central professionals. The most important contribution of family therapy according to this study was the strong focus on epistemological questions. How do we establish valid knowledge about the world around us, included the people who we relate to, and the relations we are part of? This humility about what we can know has affected the debate about knowledge in the whole psychotherapeutic milieu in Norway. In this way, family therapy has had a large influence on questions about self-reflexivity in the total therapeutic context. Another important contribution to the field of psychotherapy is that family therapy has developed new forms of practice that are based on contextual aspects of the problems presented. This is seen as a consequence of the societal and political currents in the 1960s and 1970s.

The narrative that connects personal and private experiences and professional, therapeutic practice is the theme of Per Jensen's research (2008). How does the therapist's own life history and personal and private experiences influence the way he or she understands and practices family therapy? Jensen's research suggests that both the practice of family therapy and the therapist's personal life may be influenced, something that should impact family therapy education as well as research.

Anne Øfsti's study "Some call it love" (2008) shows how therapists' discourses about love are a mixture of professional and cultural discourses and that the advice therapists give is based on a combination of these, without making this explicit. Her findings led to a new concept, "discursive couple therapy," which acknowledges that therapy is in part a cultural negotiation about what love is supposed to be.

Two studies have been important in the implementation of feedback systems in family therapy contexts. Morten Anker examined whether feedback-informed therapy (FIT, in Norwegian KOR) in couples' therapy improved outcomes vis-à-vis treatment-as-usual (Anker et al. 2009, 2010). In the feedback condition, therapists

received systematic feedback on how the couples evaluated the progress as well as the therapeutic alliance. The results showed that feedback improved outcomes, regarding both the number of breakups among the couples and satisfaction with the relationship after ending the therapeutic process. The study also added to the knowledge about the value of the alliance, in underscoring the connection between alliance and good outcome of therapy. Further it represents an important background for FIT now being mandatory practice in family counseling offices.

In another study done at the family and network unit in Drammen, Rolf Sundet and his colleagues implemented FIT, followed by interviewing therapists as well as the families (Sundet 2009, see Chap. 7). The study concluded that the families see the dialogue, cooperation, and therapeutic relationship as important factors in helpful therapeutic processes. These studies have been crucial in the process of establishing a context for making systematic feedback a way of improving family therapy processes.

As previously mentioned, Terje Tilden found that patients at the family unit at Modum Bad improved significantly on individual as well as relational variables during treatment that was maintained at follow-up (Tilden 2010). Currently, an RCT is being conducted there by the use of the STIC feedback system.

Research Concerning Family Therapy with Children and Adolescents

The first systematic study of family therapy in Norway was initiated in 1977 at Nic Waals Institute, a large child and adolescent outpatient psychiatric clinic in Oslo. Clinical psychologist Borger Haavardsholm and colleagues initiated a project about the effects of short-term family therapy based on 57 families and 20 therapists (Johnsen 1988). Seen as a group, there was a marked improvement both in symptoms and in relational function at three months as well as at one-year follow-ups. The families also evaluated the process as beneficial. This study was an important contribution to the central standing of family therapy in child and adolescent psychiatry in the following decades.

Family therapy with eating disorders has been in the focus of several studies in the Norwegian context. Wenche Seltzer's doctoral thesis examined family therapy for children with anorexia nervosa, psychosomatic disorders, and conversion disorders treated at a somatic hospital (Seltzer 1995). In this context, she developed a cultural narrative approach to family therapy. This approach represented an integration of anthropology, psychology, and medicine in which the family was seen as a cultural unit, representing learned and shared patterns of action. The result of this study has had a great influence on the work with patients suffering from eating disorders in a somatic/psychiatric context in Norway, with family therapy as the basis for interventions. Even in a somatic hospital, the whole family was admitted and with good results (Seltzer 1995).

One example of the continued focus on family therapy as the preferred treatment for eating disorders is another study of the effect of family treatment for anorexia nervosa. Inger Halvorsen completed a retrospective study of 51 out of 55 children and adolescents treated with family therapy in one county (Buskerud) between 1986 and 1998 (Halvorsen et al. 2004; Halvorsen 2007). This study confirmed the effectiveness of family therapy as the main treatment strategy for eating disorders in children and adolescents. In the study, 82% of the subjects had no eating disorder at the follow-up. The study also concluded that there is a need to continue developing our treatment models and that a tight cooperation between the different service providers is necessary to create a safe treatment environment for the families involved. The results from this study have guided the way we organize eating disorder treatment in clinical work.

One project that emanated from the discussion about developmental psychology's relevance for family therapy was a theoretical thesis done by Magne Mæhle, where he argued for the necessity of involving developmental psychology, both as theory and as an empirical field of knowledge, in the practice of family therapy with children and adolescents (Mæhle 2005). Through epistemological, ethical, and practical reasoning, he shows how knowledge about developmental processes is both necessary and useful for doing family therapy where children and adolescents are involved.

An important issue in working with families in different contexts has been the concern about children living in extreme situations. One line of research on family therapy has been named the FOBIK project (Tjersland et al. 2006). This is an acronym for "Foreldre og Barn i Krise"—Parents and Children in Crisis—and builds on earlier research on children and adolescents suspected of being exposed to sexual abuse. This research underlined difficulties and dilemmas in handling both a legal and a therapeutic approach to these extremely complicated cases. The results showed that the therapeutic strategies chosen (family members sharing information about concerns and taking part in decisions of how to protect children) reduced the levels of conflict in the families, and the children to a large degree became symptom-free. Another project addressed violence in the family (Middelborg and Samoilow 2014). Traditionally, the violent parent has been referred to individual therapy. Here, they instead offered couple therapy and sometimes included children. Included in the treatment manual was a plan for securing safety for everyone involved. The results show the possibilities of effective therapeutic strategies for handling violence as a family issue.

In line with a Scandinavian focus on seeing the living conditions as an integral part of understanding family functioning, May-Britt Solem's project (Solem 2012) studied parental stress and mastery based on Antonovsky's term "salutogenesis," which emphasizes resilience and sense of coherence. This project challenged existing theories on the connection between parental stress and coping processes. Parental stress is related not only to internal family processes, but also to risks and opportunities in the social systems surrounding the family. A child with problems raises stress in every family, but this represents an extra challenge to parents who

have difficulties in other areas of life. The study points to social–cultural factors that have to be addressed to deliver useful therapeutic assistance to families.

Educating Family Therapists

The first family therapy education in Norway was initiated by the Church Family Counseling Office in 1971. The educational program was interdisciplinary and specified clear claims as to what was necessary for becoming a family therapist (Bastøe 1973).

The psychotherapy committee in the Norwegian Psychiatric Association created a two years' program in family therapy in 1981, in cooperation with the Institute of Family Therapy in London. This educational program continued until 1985 and was interdisciplinary, as are most of the family therapy programs.

Family therapy training and education was part of the mandatory advanced training at Nic Waals Institutt (NWI) from the early 1970s. Family work was seen as a natural part of working with children and adolescents. At the Norwegian Center for Child and Adolescent Psychiatry (Statens Senter for Barne- og Ungdomspsykiatri—SSBU), a formal education in family therapy was established in the 1980s. This came about as a result of the internal training program primarily aimed at the milieu therapists working at this institution's family units at the end of 1960s. Later on, this program expanded and was offered to several groups of professionals working in different family therapy contexts. Through this program, SSBU established cooperation with the Institute of Family Therapy in London in a similar way that the Norwegian Psychiatric Union had done a few years earlier. This program has later been offered with academic credits, in cooperation with two university colleges in Oslo. The Regional Center for Child and Adolescent Mental Health (RBUP Ø/S) later took over the responsibility for the specialist training courses, including the family therapy programs. The Institute of Family Therapy is still a valued collaborator in this venue. During the first years, these programs had a primary clinical focus, with a main interest in giving practicing therapists understanding of and training in working with families. In the later years, the education programs steadily have become more academic, in the sense that academic credits were part of the goal of education, and the curriculum was adjusted to academic demands. The University College of Oslo and Akershus have established a master's degree education as a continuation of the postgraduate training.

This also has an influence on what becomes a focus in the training courses. One main goal is to find the balance between theoretical, empirical, and practical aspects of acquiring new skills as a therapist. Epistemological questions and research methodology are included in the curriculum, but the research is mainly concentrated on qualitative studies, focusing on subjective experiences of therapeutic processes. Empirical studies are to some extent looked upon as difficult to reconcile with family therapy epistemology. The mandatory family therapy education in all specialist courses has also disappeared—today, family therapy is one of many different

methodological specializations the students can choose as part of their training courses.

The other major family therapy training in Norway is run by Diakonhjemmet University College (VID University College). It includes both a postgraduate course and a master's degree education. Both programs are interdisciplinary and aim to achieve a balance between clinical, theoretical, and research skills. It is a part-time education, which enables students to work part-time when studying.

Other milieus have also been active in establishing programs. The most profiled one has been the context around Tom Andresen in Tromsø and what was called "Nordkalottprogrammet." Tom Andersen invited internationally recognized family therapists and created an important meeting place for family therapists from all the Nordic countries. This program has developed into a networking program in cooperation with the Finnish psychologist Jaakko Seikkula.

The 1970s and 1980s were also a period that saw private initiatives in establishing educational programs. The Institute of Family Therapy in Oslo (IFFT, established in 1987) offered a four-year program in the years 1987–1999 in cooperation with the Milan team, represented by Luigi Boscolo and Gianfranco Cecchin, who themselves took part in the education program on a regular basis. The Institute for Active Psychotherapy (IAP) presented a two-year educational program primarily aiming at educating psychologists in family therapy.

What about the established educational system? At the Institute of Psychology, University of Oslo, the dominating form of therapeutic practice was based on psychoanalytic and psychodynamic principles up to the 1970s. During the 1970s, the psychodynamic education program was modified to include a course in family therapy (Schibbye 1988). This course had a solid grounding in psychodynamic thinking and concepts, but merged into communicational and relational theories. Besides psychodynamic therapy, behavior theory and communication theories were gradually established as ways of thinking about therapy that to a greater degree saw therapy in terms of active interventions, including seeing actions and individuals as part of a context. This opened the way for introducing systemic and communication theories as a basis for doing therapy that lead to a parallel, alternative way of becoming a clinical psychologist (Reichelt 2009).

Family Therapy in Norway—Is There a Future?

During the later years, there has been a reduction in family therapy work within the specialist health services for children and adolescents and for adults. The work here has been characterized by the evidence-based trend on the international scene, which has given priority to manualized forms of individual therapy, especially cognitive behavioral therapy and trauma-focused cognitive therapy. At the same time, contextual understanding is highly sought after, but family therapists have only partially taken this chance to promote their competencies.

On the other hand, there has been an increase in the number of professionals getting master degrees and Ph.D.'s in family therapy. Most of the new professionals with a master's degree work in the primary services and in family counseling offices. Many Norwegian municipalities have established what is called "Familiens hus" (The Family House), which gather many different public services under the same roof. The main goal of this way to organize public professional help to families is to create a coherent service and to make it easier to coordinate and adjust the different helping services to the needs of those who are seeking assistance from professionals. "Familiens hus" has special responsibilities regarding pregnancy or issues concerning children and adolescents. In this context, many family therapists make good use of their professional competence. And the family counseling services are an important part of the total helping context, giving assistance to anyone struggling to cope with family or relationship issues. They also conduct statutory mediation for couples with joint children under the age of 16, whether married or cohabiting.

In child and adolescent psychiatry, the working conditions of family therapists have deteriorated in the last years. As many family therapists adhere to a social constructionist epistemology with the associated skeptical attitude toward quantitative research, they have been marginalized in many work contexts, especially in the health system. In the healthcare system, the emphasis on evidence-based practice has been substantial and has led to a sharper focus on what therapists do when they are asked to intervene. Problems arise when some research results are marginalized because they do not meet the RCT criteria. Further, a great deal of high-quality family therapy research documenting effect on different problems tends for unknown reasons to go unmentioned when effect or efficacy of therapy is discussed (Carr 2014; Jones 2003). One may speculate that this can be explained by the relatively short history of family therapy research and the skepticism against quantitative research among several family therapists. Hopefully, through conveying research results that are applicable to clinical practice, family therapists will make better use of the research at hand in the future. The growing interest in feedback systems (e.g., FIT, SCORE 15, and STIC) should also make a valuable contribution in this area as these data also are suitable for research purposes. More research establishing the efficacy of family therapy will be an important contribution to promoting its use.

On the other hand, the last decade has also seen the introduction of several new therapeutic interventions, many specifying their use in relation to specific diagnostic groups. One example of this is "attachment-based family therapy" (Diamond et al. 2002), which has been introduced as a way of working with depressed youths and their families. This method is introduced combined with a research project initiated by Ahus, a university hospital. Hopefully, one positive result of the expanding use of manuals will be more and better research on the impact of family therapy interventions when people seek services for a particular disorder.

In spite of the development toward greater specialization, as in specific treatments for separate diagnostic categories, we also see tendencies toward greater integration. An example of this development is the introduction of multifamily group therapy in the treatment of psychosis and eating disorders. These treatments

are structured by a manual and have psychoeducative content based on knowledge about the specific dynamics of the illnesses, but still require a broad family therapeutic approach. Elements of many existing family therapy methods are prerequisites for the therapists. The first Norwegian study on the effects of multifamily group therapy with eating disorders is under way. The interest in including knowledge from other sources to family therapy can also be seen in a greater trend that has been characterizing the Norwegian debate since the turn of the century. As previously mentioned, several family therapists, mostly with a background in psychology, have in different ways advocated for a stronger focus on the connections between developmental psychology and family therapy. The argument has been presented with different foci, but with the same conclusion: Family therapy has a lot to learn from both theoretical and empirical studies conducted in developmental psychology. The most important argument is that both areas underscore the importance of close relationships and possible ways of understanding relationship work (Johnsen et al. 2000, Johnsen and Torsteinsson 2012; Mæhle 2005; Øvreeide 2001). The same development, but with a different focus, can be seen in Great Britain, where the family therapy field has been extended with a combination of attachment theory and family therapy. In Norway, the inspiration from developmental psychology has been broader, including a wider range of developmental theories (Sundet and Torsteinsson 2009). This is a promising trend in that it also underscores the responsibility to develop new theories, new understandings of what a relational perspective on human development and well-being will and can imply. The greatest challenge represented by the evidence paradigm might be its possibility to preclude the further development of the theoretical basis for doing family therapy by narrowing down the possible contenders for best practice.

In the later years, the authorities have exerted a gradually greater control over professional activities. The implementation of new public management in state-funded services has entailed a greater focus on standardization of services, with active regulation of how much and what therapists should do. The so-called quality indicators consist mostly of quantitative measures of time spent treating patients, not in the results of therapy as the patients evaluate it (Gjertsen 2007). Family therapists, because of the complexities of human relationships and the importance of experiencing families in and from different contexts, often work in teams, which makes them appear in local statistics as less effective than the individual therapist with shorter consultations.

Today, the dilemmas inherent in conflicting trends in the family therapy field in Norway can be paraphrased in the following way: As a family therapist, you have to respect the fundamental equality between therapists and clients, but not in a way that hampers our responsibility to share, to give clients access to our knowledge and our experiences. The process of dissemination has to be done in a respectful way, a way that also includes the client as a "giver-of-knowledge" (Fricker 2007). We also have to find a way to continue debating when our opponents insist on treating their knowledge as absolute, indisputable truths about what we do and the people we cooperate with—the clients. We have to continue developing the implications of our understanding of therapy: talking *with* our clients—not just talking *to* them (Rasmussen 2012).

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Chapter 3
A Sociological Perspective on Changes in the Family in Norway

Liv Johanne Syltevik

Introduction

Family life in Norway has changed considerably since the housewife/male-breadwinner family that was at its peak in the 1950s and 1960s, just at the time when family therapy started to flourish. Since then, the ideal of the nuclear male-breadwinner family has been replaced by an ideal of a two-earner/two-career family where both parents are responsible for both provision and care, thereby creating a more egalitarian relationship. Marriage has gone from being mandatory if a couple wanted to live together and have children to being an optional choice. Cohabitation has become an institutionalized part of couple formation and is widespread in all layers of society. Divorce is available if one of the partners finds it necessary, and divorce rates are high.[1] Same-sex relationships are recognized by law, and same-sex couples are given access to marriage and adoption.

These changes in Norway are similar to family development in many other so-called Western countries (Therborn 2004). However, what singles out the Scandinavian countries is the speed and extent of this development even if many other European countries now seem to be catching up (Grødem 2014). Cohabitation, as an example, has become institutionalized in a sense that stands out with regard to duration and as a child-rearing institution (Syltevik 2012). Scandinavian families are globally well known for a weak marriage institution, widespread cohabitation, strong ideology of gender equality, recognition of same-sex couples, and a generous welfare system taking over obligations of the former traditional family. Compared with Sweden, which has become the ideal type

[1]The divorce rates (divorces per 1000 married or separated couples) were 10.1 for men and 10.6 for women in 2014 (Statistics Norway 2014a).

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of Scandinavian welfare regimes, Norway is often portrayed as a latecomer (Leira 1992). For example, the expansion and development of kindergartens for all children in Norway came in the late 2000s, while in Sweden it occurred in the 1990s.

In this chapter, I discuss what characterizes Norwegian families today and how this has changed in the last 50 years. In particular, I discuss what is special about the developments in Scandinavia as well as the apparent transitions happening globally. A historical perspective is important when we discuss families. As the historian Gillies (1997) so appropriately remarked, the families we live by may be as important as those we live with. When the changes have been so rapid and profound as they have been in the last decades, they are experienced in the lives of people. For contemporary Norwegian families, ideals and practices of former generations as well as their own may be important in everyday life. The changes have made people question whether it makes sense to talk about the family as something distinct anymore. Is there really any shared core when families may be same-sex couples, single parents, or couples with complicated relationships behind them, with her, his, and their children, including all kinds of bonus relationships (bonus children and bonus grandchildren and so on)?

The main sociological debates about the family are related to how fundamental and far-reaching these changes are. Are they part of the development of a totally new relationship between the individual and society? Has intimacy become transformed in ways that make being a couple or a family something entirely different? This is the view of sociologists who emphasize the changes toward individualization (Bauman 2003; Beck and Beck-Gernsheim 1995, 2001, 2011; Giddens 1992). The traditional customs that bind families together (the gendered division of labor, marriage, and patriarchy) have weakened, with a corresponding rise in individual agency and personal choice. For example, Beck and Beck-Gernsheim (2001, p. 204) characterize the family as a "zombie" category. These are social concepts that are dead and yet kept alive in their use by scholars to describe the growing fiction of traditional social institutions. The nature of households and families has to be defined subjectively and individually. Bauman (2003) underlined the "liquid" character of contemporary relationships; Beck and Beck-Gernsheim (2001) emphasized that the increased choices regarding family life are made in the context of a full-time labor market biography. Families make choices but they are based on the opportunities provided in the labor market. Critics have commented on the lack of attention given to the deep structural aspects of contemporary family life and argue that family practices and relationships are embedded in class, ethnicity, and gender relations and/or that individualization is the ideology of our times rather than its practice (Brannen and Nilsen 2005; Edwards and Gillies 2012; Jamiesson 1998; May 2011; Smart 2007; Smart and Neale 1999). Empirical studies support such views, finding a strong sense of commitment both toward partners and among broader family relationships (see Chambers 2012, p. 38f for a presentation of this research). In my discussion of the changes in Norwegian families, I focus on individualization as well as the stability and resilience of family patterns and family practices. Both perspectives are important if we want to understand contemporary Norwegian family lives.

"The family" became a contested concept associated with the function-divided, gender-specific heterosexual ideal family (Cheal 1991, p. 8). In what has been called the "Big Bang" in the sociology of the family in the 1970s, feminism played an important role. Feminists questioned the assumption in standard sociological theory that there is a universal core to family life and made the point that family life looks different from the perspectives of women, men, and children. This made some abandon the concept of family altogether. Intimacy (Jamiesson 1998) and personal life (Smart 2007) are two examples of contributions that attempt to move beyond the assumptions about the family. Others have expanded the concept in different ways. Morgan (1986, 2011) introduced the concept of "family practices" as a way of seeing beyond the nuclear family. Family practices consist of all the "ordinary, everyday actions that people do" and refer to the family as something that is "done" (in different ways) and not something that was presupposed as having a certain character or being more or less "normal." I have chosen to use family as a sensitizing concept (Blumer 1969) in connection with both ideology and practice. Sensitizing concepts give us a direction in which to look, without implying any definition as such. This approach also resonates with the use of the word family in everyday life in Norway, where it is often used for a variety of relationships; for example, family and kin are two concepts that are often used interchangeably. The concept of "family practices" used in this sense makes us aware of what people do in relationships toward partners, other family members, and kin. On the other hand, the concept of "family ideology" moves our attention to the norms, ideals, and values connected with doing family.

To give a context for the discussion of family life in Norway as ideology and practice, this chapter starts with some background information on Norway, the division of labor between men and women, the labor market, and the welfare state. Then, a snapshot of contemporary family lives is presented. The remainder of the chapter explores three topics: how couple relationships have changed, the gendered division of labor and money, and how parenthood has changed in Norwegian society. The societal and family changes are then connected to the growth in activity related to family and couple counseling. The chapter concludes with a broad historical and sociological perspective of the family in Norway.

Background Information on Norway

With approximately 5 million inhabitants, Norway is one of the least populated countries in Europe in relation to its total area of 385,252 km^2. The discovery of oil in the North Sea has had a great impact on Norwegian society. Today, Norway is one of the richest countries in the world based on GDP per capita from its supply of oil, natural gas, fish, timber, and hydropower. The last half century has been a period of unprecedented economic growth and until now, Norway has been relatively unaffected by the worldwide financial crisis of the late 2000s, and unemployment rates have remained low (1–3%). However, in the past year, low oil prices

and dismissals in the oil industry have led to rising unemployment rates, up to the current level of 4.9% of the labor force (Statistics Norway 2016a). The contemporary understanding of the situation is that the country faces a challenging period where readjustment and structural change is needed. Another defining development in Norwegian society in the last decades is the increased immigration to the country, making the traditional homogeneous Norwegian population more heterogeneous. Immigration to Norway (of some significance) started late; 1967 was the first year when immigration streams into Norway exceeded emigration out of the country (Brochmann and Kjeldstadli 2008, p. 13). Currently, 15.6% of the population are either born outside Norway or have two parents born outside Norway (respectively, 666,900 and 136,000 people; Statistics Norway 2015a).

The Nordic family has a number of features with strong historical roots. The family-forming process has traditionally been prolonged and people have married later than in eastern and southern parts of Europe. Young people have also left the family of origin earlier, and neolocality (when a new couple establishes their own household) has been the norm (Therborn 2004). Norwegian women and mothers entered the labor market later than was the case in, for example, Sweden, which also meant that the period of the ideal housewife lasted longer in Norway. In 1960, 53% of all women aged 16–74 considered that their main occupation was housewife (Syltevik and Wærness 2004). In the same year, 95% of all children were born to married couples, the majority of women married, and the divorce rates were very low (Melby et al. 2006). Today, the country has high labor participation rates for both men and women; in 2013, 83% of men and 77% of women aged 20–66 were in the labor force (Statistics Norway 2016b). Gender equality is the dominant ideology, but gender-specific practices are still common with regard to both paid and unpaid work. For example, there are significant differences between men and women with regard to working hours (35% of women aged 20–60 years work part time; the figure for men is 14%) and income (a woman earns on average 86% of a man's income) (Statistics Norway 2016b). Compared with other European countries and North America, the Scandinavian labor markets are more gender-segregated. This is mainly a result of the extensive public provision of care services (and the establishment of the welfare state), which has recruited larger numbers of women to employment. The population in Norway is highly educated: 40% of women and 31% of men aged 25–65 have completed university-level education (Statistics Norway 2016b).

The Scandinavian welfare states are characterized by their comprehensiveness, that is, as having defined their scope of public intervention more broadly than in most other nations. An example is the daddy quota and the efforts to make fathers more involved in childcare by the use of so-called gentle force (Brandth and Kvande 2005). The welfare state is meant to include the whole population, not just targeted groups. Norway has universal child allowance for all children (under the age of 18), paid sick leave up to one year, and unemployment benefits. For working parents, there is a generous scheme for parental leave, some support for single mothers, and a cash benefit for children aged 1–2 if they are not attending kindergarten. From 2009, every child has the right to a kindergarten place from the

age of one until the start of school at the age of six. Because social rights and benefits are granted independent of family relationship, this makes individuals less dependent on their families. The degree of "defamilization" is one of the concepts used to compare different welfare regimes (Esping-Andersen 1990; Sümer 2009). The concept refers to the degree to which a household's welfare and caring responsibilities are relaxed by the welfare system or by market provision. Norway and the other Scandinavian countries have a high degree of independence of family relations. On the other hand, much economic and practical help is given between families and across generations according to moral obligations (Daatland and Herlofsen 2004).

Finally, Norway is one of the countries that have embraced the development of new technological devices: 97% of Norwegians have Internet access and 80% use the Web daily (Engedal et al. 2010; Vaage 2013). Norwegians are also among the most active users of social network sites worldwide, with 67% using Facebook daily (Gallup 2013).

A Snapshot of Contemporary Norwegian Families

An overview of families and households in Norway today draws a varied and differentiated picture. First, 40% of all Norwegian households consist of single persons. An increasing share of the Norwegian population lives alone for a part of their life, because the increase in young adults living alone longer, adults living alone following relationship breakups, and people (mostly women) living alone in old age. Around half of the adult population (48%) lives in households with children aged 0–17 years. Just 6% of all households are those with more than one nuclear family. The average age for having a first child is 28.7 years for women and 31.3 years for fathers (Statistics Norway 2014b). The norm is that children are wanted and planned, and for most parents, entry into parenthood coincides with their entry into or their first years of employment.

Most couples are married, while about 25% are cohabitants. Married couples also include same-sex couples. Norway passed partnership legislation in 1993 making it possible for same-sex couples to register. This was replaced with full rights to marry in 2009. In the 1990s, there were approximately 130 registered partnerships each year, which increased to 260 in the 2000s; in 2014, 269 same-sex couples married. More same-sex couples also have children.[2] Living together is not a necessary condition for committed relationships. Living apart together (LAT) relationships have been introduced as a concept that covers the relationship between people who do not live together, but define themselves as more than lovers (Trost and Levin 1999). Levin estimated that there were roughly 35,000 such

[2]In 1993–2001, 6% had children, which rose to 18% in 2002–2010 (Wiik et al. 2012).

relationships in 2001. However, LAT relationships form a group with very different situations and plans for the future (Levin 2004).

Most children (75%) live with their father and mother. Their parents are either married (55%) or cohabiting (20%). The remainder live with either their mother (21%) or father (4%), and approximately one-third (90,225 children in 2015) also live with stepparents (Statistics Norway 2016d[3]). This situation varies with age: 88% of Norwegian one-year-olds live with both their mother and father; the figure is around 60% for 17-year-olds. Divorce rates were highest between the late 1960s and the 1990s. However, in the 2000s, the divorce rate fell; in 2014, it was at its lowest rate for men since 1989 and for women since 1999. Divorce is most frequent among couples without higher education, even when controlling for income (Noack and Lyngstad 2012). However, the change toward increased cohabitation has meant that divorce rates are not very useful to understand the general level of breakup among couples with children. There are no statistics that report the breakup of cohabitation relationships because they are not formally registered. However, based on figures from Statistics Norway, Goplen (2014) found that in 2005–2013, 20% of all cohabitation relationships with children split up, while the figure was 36% for cohabitation relationships without children. Although the divorce rate and breakups in relationships have made it common to have more than one partner during the course of one's life, it is still rare to have more than two or three long-term relationships (Noack and Lyngstad 2012). To be a single parent (living alone with one's children) is for the majority a phase in the life cycle. In the 1980s and 1990s, the average time spent as a single parent was calculated to be about three years (Terum 1993).

Most families are two-income families. It has been estimated that only 10% of women (who have a partner) of prime working age have fewer than 20 h a week paid work; and only 2% of married and cohabiting women regard themselves as housewives (Kitterød and Rønsen 2013). Part-time and full-time housewives are most common among the less educated and those with health problems, as well as in some immigrant groups. The great majority of children under school age now attend kindergarten (in 2014, 80% of 1–2-year-olds and 97% of 3–5-year-olds) (Statistics Norway 2016c).

If we move beyond the nuclear family, there is significant contact and help between generations in Norway. Among those whose parents are alive, 25% report that they have little contact, although when contact through telephone, email, etc. is included, and this percentage drops to 5% (Statistics Norway 2013). Grandparents (and in particular grandmothers) play a significant role in their grandchildren's lives (Hagestad 2006). However, we have limited knowledge about step-relationships. In a study of younger pensioners (born 1940–1945) Noack et al. (2011) found that 30% had step grandchildren (children they were not related to); yet we know little

[3]A weakness in the statistic is that children who share their time equally between their father and mother are registered at one address. When such an arrangement was generally rare, this did not matter much. However, the situation has now changed; in 2013, 25% of those splitting up chose joint custody (Lyngstad et al. 2014).

about how this influences the relationships. Studies reveal there is a great deal of informal help between adult children and their aging parents, but this support is often provided from a distance (Daatland and Herlofsen 2004).

The Lutheran Church of Norway—until 2012 a state church—has played a significant role in Norwegian society. It started the first family counseling offices to help families with relationship problems and prevent family breakups (Gaasø 2003). In general, the church has been against many of the family practices and new values that have become more commonplace (e.g., cohabitation, abortion, same-sex couples with children). However, this opposition has gradually dissipated together with falling congregations. In 2015, 73% of Norwegians claimed church membership, down from 83% in 2006. More than 10% are members of other faiths (Statistics Norway 2016e).

This snapshot provides a varied picture of how children and adults in Norway do family at given points in time. Compared with 50 years ago, the two main changes are the increase in divorce and breakups of relationships, and the increased role of cohabitation. Both phenomena raise questions about whether couple and family relationships have become more fragile. Other changes concern the altered roles of men and women, and how parenthood (and childhood) is done by Norwegian parents. I now focus on these changes and discuss their implications with regard to how profound the changes in relationships and families in Norway are.

"Liquid" Relationships

Bauman (2003) introduced the concept of liquid love to capture the increased individualization, lifestyles of mobility, and migrant habitus that have emerged. Both cohabitation and divorce have been taken as signs of the increased fragility of relationships and as proof of the individualization thesis representing less committed relationships (see Beck and Beck-Gernsheim 2001, p. xxii).

Norway is one of the European countries where cohabitation has gained most ground in the last decades. The process started in the 1970s, first among young couples before they had a child and then after children were born. Cohabitation has also replaced remarriage as the common step with a new partner after a former marriage. However, the popularity of cohabitation does not necessarily mean that weddings and marriage have lost their importance. Syltevik (2012) sees Norway as a "cohabitation-then-marriage land," since the main pattern is still that couples—if they stay together—marry after a period of time. Cohabitation is also found to be a way of making a commitment, and not the opposite. It is a gradual transition with different meanings for people in different situations involving different levels of commitment. Norwegian cohabitants see cohabitation as the proper thing to do, the guiding idea being not to rush into marriage too soon, while making it possible to act on one's feelings and test out relationships (Syltevik 2012). Cohabitation may be a perfect solution for couples for different reasons. It is a private way of establishing a relationship, as well as a way of accommodating the risky side of

love. The "not as committed as if we were married" aspect of cohabitation might be one of its attractions, as well as being a way of committing oneself gradually.

As noted, the recent development with respect to the divorce rate has been one of stagnation since the 2000s. The breakup rate of cohabitation relationships is probably higher, but we have no statistics on whether it is rising or falling. However, we know that such relationships are most likely less stable (Goplen 2014). What people want from a relationship has also clearly changed. Being a good housewife and being nice was what Norwegian men wanted of a wife in the 1940s; today, both men and women are looking for a soul mate (Barstad 2000). Ideals of gender equality and the changed division of labor mean that today's couples have to manage two-individual work biographies as well as their family life together. Some scholars argue that less stable and more fragile couple relationships are the price to be paid for the democratization of relationships and higher life standards (Beck and Beck-Gernsheim 1995; Giddens 1992). Yet, there are few signs that the couple norm has been weakened. On the contrary, a majority (84%) of young people believe in lifelong love relationships (Brenden 2005). The ideology of how to be a couple today focuses on good communication and talk as well as on relationships as "hard work" (Danielsen and Mühleisen 2009). This aspect of hard work goes hand in hand with ideas about romance and romantic love. The ideology may collide with power differences related to gender, sexuality, class, and ethnicity in ways that are often not problematized.

A recent aspect of couple formation that has been associated with looser relationships is the expansion of Internet dating as a way of finding a partner, which is as internationally big business in Norway. It is no longer an unusual or embarrassing way of finding a partner. For example, the app Tinder was introduced in 2012 and has approximately 50,000 profiles in Norway, mainly in the 25–35 age group (Digital Marketing Ramble 2015). In a study of 15–26-year-olds in Norway's third-largest city, Trondheim, 20% reported that they had met a girlfriend/boyfriend on Tinder (Skog 2015). Some have argued that the Internet is just another arena for meeting people that does not necessarily change relationships. On the other hand, Illouz (2012, pp. 180–182) argues that Internet dating represents a rationalization of partner selection through mechanisms such as intellectualization, rational management of the flow of encounters, visualization, commensuration, competitiveness, and maximization of utilities. The main argument here is that the Internet is organized as a market, where one can make comparisons and opt for the best. Technologies expand the pool of options, and thus enable rapid moves from one partner to another.

The Gendered Division of Labor, Homemaking, and Money

The gendered division of labor has changed considerably. Women spend more time in employment and less on housework. Men have increased their time spent on care for children, and Norwegian fathers now work less when their children are small

(Kitterød and Rønsen 2014). In one of the few studies of how heterosexual couples with children share care and work, Kitterød and Lappegård (2012) found that approximately 40% of couples with children could be characterized as quite gender equal. This implies that couples who have either a generalized or specialized division of labor but who work full time share housework and childcare fairly equally. This may be achieved in different ways; some couples might specialize tasks while others share all of them. The pattern of the majority of couples with children (60%) can be described as either *neotraditional* or *gender-equal light*. *Neotraditional couples* are characterized by family roles that complement each other; women work significantly less and continue to do most of the childcare and housework. Although *gender-equal-light couples* are less traditional, the man is still the main provider. He participates in childcare but she spends more time on family work. *Equal sharing* is most likely if couples are well educated, work regular hours, and when the fathers are employed in the public sector. Hochschild's (1989) concept of stalled revolution, defined as the gap between gender ideology and the actual practices of women and men, captures the situation of many Norwegian families.

Aarseth (2010a) has commented that it is often assumed that we are heading toward a more gender-equal division of paid and unpaid labor; it is just a question of time. However, she points out that this is just one of many possibilities. A second option is that household tasks are outsourced or that domestics are employed so that the gender equality issues of Norwegian couples are solved in this way. To date, servants have not become common in Norwegian households; for example, there are few households that have help with cleaning. In 2010, 8% of couples with children under 20 years of age at home employed such help (Kitterød 2012). Those who employed cleaners were mostly people with high-status jobs who lived in the eastern part of Norway and in the capital Oslo. On the other hand, this practice has increased when compared with earlier studies. In addition, there has been an increase in the employment of migrant care workers as, for example, au pairs (Bikova 2010; Sollund 2010). So far, this is also a practice among high-earners and high-status families, and the numbers are relatively small. One factor hindering such a development is that Norway is a society with a history of low levels of income inequality, which makes it expensive to employ people and buy market solutions. Whether this will change with the new situation of increased immigration has yet to be seen. There is also a strong "do-it-yourself" culture in Norway. Making homemade meals and doing maintenance and building work around the house are things many people do. This is not only a necessity; it gives meaning and pleasure to people's lives (Aarseth 2010a, b). Aarseth has suggested that a third option is the re-creation of the female homemaker and finds this arrangement among the financial elites (Aarseth 2014).

While the division of paid and unpaid work has been thoroughly studied, the economic relationships inside the family have been less so. Although a brief examination of this area shows evidence of many changes and new practices, it also shows how some patterns seem to be deeply embedded in Norwegian society. One of the changes is an emerging individualized understanding of economic

responsibility. Participation in the labor force is no longer only a male responsibility, and increased cohabitation has led to more individualized responsibility and economic risk for individual men and women. However, the responsibility to provide for each other is still part of the marriage agreement, and cohabitation is increasingly recognized in law (Syltevik 2014). However, there is no straightforward connection between laws and people's everyday practices. Lyngstad et al. (2011) found that married couples were more likely to pool their economic resources compared with cohabiting couples without any intention to marry. However, there was no significant difference between married couples and cohabiting couples with marriage intentions. Nevertheless, they found many "gray" areas with regard to the expenses that were defined as collective spending and those that were not. Bøe and Wærness (2005) conducted one of the few qualitative studies on how young middle-class families regarded money and household economics. Their main finding was that beliefs about how money should be divided were associated with different understandings of gender equality. Those who understood equality as income equality contributed equally to expenses and then kept what was left as their individual pocket money, which means that one partner could be better off financially than the other; those who understood equality as having an equal amount left over shared their income. Bøe and Wærness (2005) also found that the norm of providing for each other was no longer necessarily part of being a couple. Their study points to emerging new norms concerning individual economic responsibility (with gendered consequences) and, accordingly, less responsibility toward one's partner. Hence, the norms about couples providing for each other seem to have changed. However, gender equality and sharing equally appear to have emerged as the new formative norms, including an underlying principle of the responsibility to provide for oneself.

Norwegian laws on inheritance are based on transactions between generations along strict family lines, and in terms of the economic relationship between generations, there is a considerable transfer from parents to children. Children inherit from their parents, and if the parents have property, three-quarters of it is shared among the children. According to 2005 data, children received about 60% and grandchildren about 10% of inherited wealth, and 93% of gifts (given during the parent's lifetimes and reported to the state authorities) were given to children or grandchildren (Statistics Norway 2008). On the issue of treating children equally, economists Halvorsen and Thoresen (2007) discussed how Norwegian parents are torn between the ideal of treating their children equally and compensating the disadvantaged child when they have two or more children. They studied gifts and found that the norm of treating children equally was predominant.

Legally, parents are only required to provide for children under 18 years of age (Syltevik and Wærness 2004). With the advent of welfare state benefits in the 1960s, parents were relieved of the responsibility to provide for older children and children were no longer required to provide for their parents (Syltevik and Wærness 2004). However, there are few signs that the economic help that parents give their children has decreased. In one of the few contributions in this area, Hellevik (2007, 2008) compared responses to a 2001 survey that included questions about economic

support with data from surveys conducted in the 1990s. Her main finding was that such support has changed from being seen as a *duty* to being given *voluntarily*. The norm that young people who have moved out of the family home should be economically independent was supported by 68% of the sample in 2001, compared with 54% of the 1993 sample (Hellevik 2008). However, during this same period, the economic support that parents gave their children for education, housing, and in an economic crisis grew. This increase in actual support could be explained by the increasing ability of parents to help their children or by the increasing difficulties faced by the younger generation. Hellevik (2008) concluded that the family had strengthened its position as a contributor to the reproduction of social inequality in society. These data suggest that considerable economic distribution occurs along generational lines.

Similarly, Døving (2007) found many transfers of care, services, and gifts between children, parents, and grandparents in a qualitative sample [middle-class respondents and economically challenged people represented by a sample from the cities of Oslo (Norway), Malmø (Sweden), and Copenhagen (Denmark)]. These transfers are crucial for those facing economic challenges, even if the values given and received are not large. Need drives the exchange for those who are economically challenged, whereas for those who are reasonably well-off, such exchanges represent something extra (such as the chance for a holiday or a more spacious house). Døving (2007) argued that people understate both the actual economic value of such exchanges and the familial duties and rights that go beyond the nuclear family because of the ideological norms of individuality and household autonomy in Scandinavia. Hence, the ideology of autonomy understates the structure of family responsibilities and legal regulations.

"New" Fatherhood and Motherhood: Intensive Parenting

Parenthood has changed considerably in the last decades. For mothers, the main change is that they spend longer time in paid employment. However, this does not mean that mothers generally reduce the time spent on direct care for their children, but rather that they decrease the time spent on housework (Kitterød and Lappegård 2012). For fathers, the main change is the increased involvement in the care for their young children. There is a significant change in fathers' everyday life with more involved fatherhood. Fathers also work less when their children are small and spend more time on childcare than previously (Kitterød and Rønsen 2014).

However, there is also another parallel trend in modern fatherhood. Rates of parental breakup imply that fathers increasingly live apart from their children. Both trends (involved fatherhood and not living with their children) are very strong in Norway (Skevik 2006). For some, divorce may contribute to more involved fatherhood (Smart and Neale 1999). For others, this results in infrequent contact.

For example, Kitterød and Lappegård (2012) reported that 23% of fathers in this situation had not seen their children during the past month. Research highlights a number of factors that increase the odds of fathers having infrequent or no contact (either visitations or by phone) with their children: The parents have never lived together, there is no formal agreement about contact arrangements, and fathers lack the economic resources.

In general, the relationship between parents and children has been marked by more closeness and intimacy as well as parental intervention, for example, in schoolwork and "educational" leisure time. The ideology of intensive parenting—stressing that parents are supposed to stimulate and educate as well as invest greater time, resources, and emotion in their children—has gained ground and expanded the definition of what a parent is (Furedi 2008; Gnaulati 2013, p. 177). However, the context for these ideas about parenting is an institutionalization of childhood as children increasingly spend more time in day care or after-school activities as both parents have paid employment. In 2015, 90% of all 1–5-year-olds in Norway attended kindergarten (Statistics Norway 2016c). In addition, children's leisure time has been marked by more organized activities, and it is common for parents to accompany and drive their children to such activities. Many coach their children's sports activities or contribute with other types of voluntary work related to children. Parental engagement in such activities is one reason why Norwegian parents are foremost among Scandinavian parents when it comes to voluntary work (Wollebæk and Sivesind 2010). For families with children, it is extremely demanding to coordinate the timetables of their own paid employment, voluntary work, and their children's school and leisure activities.

The rapid change in policy and norms about how it is thought best to take care of very young children has in particular created tensions between parents in different circumstances. Stefansen and Farstad (2010) examined the considerations of parents of under three-year-olds and found two patterns: "tidy trajectories of care" versus "sheltered space for care." Tidy trajectories—with a shift from mother to father to kindergarten as the main pattern—accorded with the norms of mostly middle-class parents. Sheltered space for care—where care is not thought about as something you can divide in this way, but as a continuous relationship—accorded with the ideas of mostly working-class parents about how to take care of their children. Stefansen and Farstad emphasized the silencing of alternatives to full-time day care from the time when children turn one-year-old in the public debate. The discussion about how to take care of small children also has an ethnic dimension. Today, there is increasing concern that migrant mothers stay too long at home with their children, with negative consequences for the children's future school achievements and language skills. What was completely normal just a few decades ago—making informal care arrangements for below-school-age children and mothers taking care of them at home—is considered deviant today.

Family Changes and Couple/Family Therapy

Several of the changes in family practices and ideology discussed in this chapter represent challenges that contemporary couples and families are facing, and mirror problems that may be presented in therapy. The emphasis on good communication and intimacy and individual fulfillment in couple relationships may foster better relationships, but may also imply higher standards for what is considered a good relationship. The gap between the ideology of gender equality and gender practices produces tensions in relationships. The two-income family means that there are now usually two workplaces and timetables to consider in addition to the timetables of kindergartens and schools. The rise in the number of stepfamilies may also create challenging complications of different kinds. Intensive parenthood—motherhood and fatherhood—may also lead to more conflicts about where children will live and how to collaborate after a divorce. More-involved fathers mean that the solutions after a breakup are less obvious and more open to challenge. Another trend that may have an impact is the increased emphasis on autonomy and self-determination which in turn may also result in greater awareness among people about their rights concerning, for example, custody of their children after the breakup of a relationship.

In parallel, there has also been a change in the ways of dealing with these issues in our culture in that we are increasingly turning to experts and professionals to get help (Danielsen and Mühleisen 2009; Furedi 2008; Giddens 1992). Ideas about "working" with relationships and communication resonate well with many types of expert counseling and by seeking help people also show that they take relationships seriously. In recent decades, there has been a considerable growth in the number of people seeking help with family- and couple-related issues. Only the activity of the public "family counseling offices" is registered in official statistics. The figures show a steady rise in the number of new cases annually, from approximately 25,000 in 2001 to 33,000 in 2014 (Statistics Norway 2015b). The main activity of family counseling offices is couple and family counseling. Given that around 70% of those initiating contact are women (Allertsen 2009), there is a strongly gendered pattern of those seeking such help. In 2014, problems in couple relationships (42%) were given as the main reason for making contact, followed by problems with parent collaboration (39%), other reasons (14%), and problems related to children and youth (5%). After a breakup, counseling is mandatory for couples who have children together, and such counseling has in particular increased. Of the cases finished by family counseling offices in 2014, 22% were mainly about strengthening a relationship, 14% about how to end a relationship, while 21% involved help with parental collaboration after the end of a relationship. Of course, such figures represent the barest details of the activities of family counseling and therapy in society. In addition, couple and family therapy organized by private actors is regularly advertised in the media, and there are also other actors in the public sector. Voluntary organizations as well as doctors, nurses, health stations, psychologists, social workers, and physiatrists also offer couple and family counseling.

Concluding Remarks

If a spaceship of sociologists left earth 50 years ago and returned to study family life in Norway today, differences would be evident. They would recognize that households are smaller, that more households consist of one person living alone, and probably that there are fewer children in each family. They would also notice that fewer young children and women spend the day at home, but instead commute to kindergartens or workplaces. More families would seem to have a non-Norwegian cultural background. With greater insight, they would conclude that something had changed regarding marriage, with many couples cohabiting and most children born in cohabiting unions. Fathers and mothers would also seem to do more of the same things (even if there were some specialized and gendered patterns in how people behaved). If the returning sociologists could see into people's homes, they would in general be surprised at the higher standard of living and would remark on the presence of technological gadgets. They would also learn that families have more complex relationships, with more half-siblings, stepmothers and stepfathers, and bonus relationships. The historian on the team would remind colleagues of a number of points: that the mid-twentieth century was special, that it was important not to exaggerate the homogeneity of the past, that the housewife family was historically unique, and that step-relationships were more common in earlier times simply because parents were more likely to die younger. Indeed, it might be noted that the variety in family forms that existed in the days before the housewife/male-breadwinner family had been restored (Therborn 2004).

Norwegian families appear complex, heterogeneous, and changed. However, most households still comprise couples and their children. Life as a couple also seems to be the predominant way that people live for large parts of their lives.[4] Most people also say that they want a partner and a stable relationship. There is no evidence for a decentering of couple relationships in people's lives. Both the couple ideal and norms of monogamy appear strong. As we have seen, many of the changes that could be interpreted as looser relationships and more fragile families can also be interpreted in other ways. Divorce or breakup can, for example, be seen as a search for better relationships. If the connections between households are explored, there are also signs of strong family bonds and relationships. Economic flows seem to follow family lines; the elder generations help the younger generations by giving them much practical help and support with the grandchildren and by leaving them their property and belongings. That people seek help for problems in their intimate relationships is also a sign of their importance.

[4]Sequential analysis of Norwegian couple histories has been collected from the birth cohorts 1927 and 1967 and shows a process of destandardization of the life course in the Norwegian population (Kaldager and Lyngstad 2012 cited in Noack and Lyngstad 2012). The type of "complicated" couple history that increased the most was a sequence with a short-term first relationship, followed by a longer second one.

In addition to the differentiating of family forms, which is very striking compared with the 1950 and 1960s, there is also a new standardization of family life. For example, what we see in contemporary Norway could be analyzed as the development of a new type of standard family ideology (dual-earner/dual-career model), that is, just as widespread and predominant as the housewife/male-breadwinner family was in the 1950s and 1960s. The contemporary normative ideal of a nuclear household is two adults (either same-sex or different-sex partners) who are both assumed to work full time and be economically independent of each other. If they have children, they will be taken care of in kindergartens after they reach the age of one. Policies, as well as powerful norms, support this way of doing family. Contemporary personal life is not just a road toward less rigid moral conventions; it is also an embrace of different moral rigidities.

Similar to the other Scandinavian countries, the Norwegian family stands out as characterized by having a more equal division of labor between women and men, prolonged family formation, high levels of divorce and cohabitation, as well as independence of family relationships because of the welfare state. Family life is lived and formed by strong welfare states that also intervene in family life, with an ideology of gender equality and high labor participation rates among mothers and women. In Scandinavia, the relationship between the welfare state, labor market, and family is a particular mix that represents opportunities of choice but also standards. This standard family model represents different challenges and opportunities for couples with different material and cultural resources.

The changes in the family are many and profound. In *The War over the Family: Capturing the Middle Ground*, Berger and Berger (1983) viewed the development of the modern family rather pessimistically: "Put differently, the family ceases to be an institution in the full sense of the word: instead, it becomes a project of individuals, thus always susceptible of redefinition, reconstruction, and obviously, termination. Being part of a family is replaced by participating in a personal life-style." (p. 132). This is part of what has happened. Individuals have more choices and opportunities now than before. Family practice is an arena where individual life projects may collide. This is particularly the case in a rich country such as Norway. On the other hand, we also see deep-rooted relational and collective dimensions in family practices in Norway. Family relations are important as they often represent lifelong relationships and people strive to make committed relationships. So far, we can conclude that the family has changed but has in no way been replaced by alternatives.

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Chapter 4
Family Therapy and Philosophy: Inspiration and Frustration

Harald Holm Nilssen

Introduction

In a discussion late one night at the Central Hotel, Johan Nilsen Nagel—Knut Hamsun's protagonist in *Mysteries*—replies to a challenge from the town doctor. "My way of thinking," Nagel says, "is briefly this: What would it profit us, after all … even from a practical viewpoint, if we stripped life of all poetry, all dreams, all beautiful mysteries, all lies? What is truth, can you tell me that? You see, we only advance by way of symbols, and we change these symbols as we progress. However, let's not forget our drinks" (Hamsun 2001, pp. 161–162).

I think many people with ties to the family therapy profession in Norway can relate to Nagel's romantic and relativistic views—especially when delivered in an animated polemic against the scientific and linear-minded[1] Dr. Stenersen. Nagel's claims are quite in tune with a profession where one is likely to encounter: (1) avoidance of the truth predicate (declaring a sentence true or false), (2) a heavy emphasis on feelings, and (3) a strong belief in the liberating potential of linguistic structures to affect personal change. The question is the degree to which romanticism and relativism—so fascinating in Nagel's character—shall be permitted to dominate a profession that ought to operate under equal standards of quality and efficiency in order to maximize favorable client outcomes.

[1]"Linear" denotes causality and predictability and in family therapy is understood as a contrast to "circular."

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Part 1

My Journey to Family Therapy and Norway's Family Counseling Service

I came to family therapy by way of blue-collar labor and philosophy. Relatively late in life, after earning two craft certificates and working as an automotive electrician and mechanic, I entered the University of Oslo. In the spring of 2002, I obtained a *cand. philol*. or master's-level degree in philosophy, with additional studies in the history of ideas and literature. In ethics and practical philosophy, I felt drawn in particular to linguistics and the philosophy of mind, due to their applicability in service institutions and agencies where insight into human nature and behavior is prized. During my student days, I therefore took a course in philosophical conversation under the aegis of NSFP.[2] The idea was to return to the roots of philosophy: to Socrates, walking in the market square of Athens. I wanted to learn his philosophical approach and conversational techniques. By facilitating conversations with *the other*, I thought, we philosophers could spark reflection and understanding, thereby helping people reach the goal that Socrates articulated in several of Plato's dialogues: self-knowledge.

In my youth, I had been an activist consumed with global justice, so to me, the idea of applying philosophy in such manner also seemed a way to transfer expansive ideas of social solidarity into a new context—if only in microcosm. I thus gained a coherent frame of reference more suitable to my skills and social outlook at the time. My search for a professional outlet for all of this led to a job as an employment services adviser for people capable of working but who lacked firm employment. Although the position allowed me to use many of the skills I had learned at university, I thought I would prefer a more client-centered form of change work and therefore began training in family therapy and systemic practice. This new focus would prove a continuing source of inspiration, but also of frustration.

Family Therapy Education: Constructivism and Anti-psychiatry

While being trained in family therapy, I discovered that words such as right and wrong and normal and abnormal were problematic. Moreover, as previously alluded to, I encountered for the first time an almost absolute refusal to use the truth predicate, except at what we might call a subjective level. Underlying this refusal was an epistemological understanding that all reality is composed of mental constructs and that mankind does not have access to a so-called objective world.

[2]Norsk selskap for filosofisk praksis [Norwegian Society for Philosophical Practice].

A passage in the textbook *Kaos og Kosmos* [*Chaos and Cosmos*] may be illustrative in this regard:

> When the structure's originator is the individual, and not an objective reality, we can never know, principally speaking, if what we believe we understand is correct or not. Yes, it is pointless to speak of truth (Bjartveit and Kjærstad 2001, p. 28).

In my primary family therapy textbook, this position was referred to as constructivism:

> One rejects the possibility of depicting reality as it is in itself. Reality is constructed by the observer (Hårtveit and Jensen 2002, p. 58).

As I understood it, it was in fact admissible to talk about right and wrong, normal and abnormal, but only in relatively minor and limited contextual circumstances, discourses, or language games. Thus, it would be a problem to compare different sentences by assigning each of them a truth value; they could after all appear in different, incommensurable contexts. It would also be difficult to isolate a cause–effect relationship in the different contexts or systems, because all the components possessed significance and identity by virtue of their interaction with the other components. Such a systemic, circular, holistic approach made it difficult to point out that one individual, for example, could be a cause of pain and trouble for himself and others in the system or context to which he belonged. Not coincidentally, I quickly detected a pervasive "Cuckoo's Nest factor"[3] in family therapy education: a strong opposition to a dominant psychiatric method characterized by mapping, assessments, clarification in relation to inclusion/exclusion criteria, diagnosing, and individual treatment. The educational thrust instead was that most problems, if not all, had a relational origin that could be traced back to some form of rupture in human communication and interaction.

Change and Second-Order Cybernetics

My education left me, in short, with an almost private notion of truth, a framework of understanding and opinion based on exclusive language games and other insular contexts, and an inclination to explain away individual responsibility by practically removing *causality* from my vocabulary. These factors along with an aversion to cataloguing individuals through diagnosis would in any case tend to promote an alliance between client and therapist, I thought. With the therapist in a non-expert role, an appealing symmetry would define the relationship. What was true for the client must be true for the therapist. Nor did the challenge to therapists to assume a "not-knowing" position come as any surprise, though I did often find myself muddling this injunction with Søren Kierkegaard's mantra of meeting *the other*

[3]I have chosen this expression from the 1974 film *One Flew Over the Cuckoo's Nest*, starring Jack Nicholson.

where the other is, and with Socrates' insistence to his dialogue partners that there was nothing he knew. Second-order cybernetics, meanwhile, became easier for me to understand in this light. Instead of being primarily objective and evaluative, the therapist was to see himself as a part of the system and as someone who himself risks undergoing change, though perhaps secondarily to that of the client.[4] That cybernetics should serve as a metaphor for change work was interesting to an auto electrician who had worked a great deal with control technology. Initially, I thought *cybernetics* must have been a printer's error in the family therapy syllabus, but it soon made sense. Imagine being able to view second-order change as positive feedback—much as manipulating a voltage input to a regulator in a car with the purpose to modify the alternator's charging output! Similarly, the following somewhat ridiculous example of a second-order intervention that I found presented in one textbook (an example I have since recognized as irresponsible trickery) became easier to understand in the context of a family therapy worldview suffused with ponderous jargon and a somewhat peculiar overall lexicon. By way of introduction, the textbook recounts a fortress siege that is causing distress to both parties—hunger on the one side and impatience on the other. Eventually, the fortress commander decides to throw his garrison's last remnants of food—a bull's cadaver filled with grain—over the wall to trick the enemy into believing his men can hold out indefinitely. As a result, the siege is abandoned (Watzlawick et al. 1996, p. 13).

Constructivism + The Legacy of Descartes = Epistemological Skepticism?

We all know that change work is difficult, not least because demands for change often meet resistance. It is also reasonable to think that such resistance may be linked to the conservatism inherent in biology, heritage, psychodynamics, and determinism. But family therapy took a different view of change work and each individual's range of freedom, due no doubt to the profession's philosophical foundation. As I see it, a constructivist, hermeneutic and social constructionist approach to the field was able to spread due to (1) a subject-based philosophy and general epistemological skepticism stemming from Descartes,[5] (2) a Kantian division between objective and subjective worlds that unfetters language from the

[4]This calls to mind proximity ethics and the courtesy phrase "After you" which Emmanuel Levinas insists contains the whole of his philosophy (Levinas 1996, p. 203).

[5]The French philosopher René Descartes may be credited with founding what, in epistemology, is called skepticism. By systematically pointing out the existence of a mental–physical dualism, he created an epistemological gap between subjective mental phenomena and an external world. The only thing one can be sure of, according to Descartes, is that "I think." Most philosophy since Descartes has centered on trying to close the gap he opened between *res cogitans* and *res exstensa*, popularly called mind and body.

representation of reality,[6] and (3) a more linguistically based systemic tradition associated with postmodern philosophers who followed in the wake of the Austrian philosopher Ludwig Wittgenstein (Skauli 2009, p. 7). And as I have already touched upon, these positions provide a great deal of freedom for people to choose their own stories, identities, and futures—aspects of life devised ultimately through interpretive efforts engaged in to some extent by each of us.

The Therapy Room as a Space of Freedom

It was as if the philosophical foundations of family therapy could accommodate any and all therapeutic options in change work. For many students, this realization was an eureka moment, and for me, it suggested a bridge to Jean Paul Sartre's assertion that, while existence is something conferred, people must take responsibility for creating essence (meaning) in their lives (Sartre 1984, p. 15). Sartre's existential mantra, with which I had struggled since adolescence, finally began to make sense.

With the therapeutic edifice expanded in this way, you could also make use of methods appropriate to the opportunities, such as circular questioning or investigation based on anthropologist Gregory Bateson's communication theory and his understanding of the mind as an ecological system (Øhlgaard 2001, p. 151–153). You could also enrich understanding and interpretation of the human condition by applying hermeneutical approaches borrowed from textual interpretation and existential philosophy. An advanced methodology thus arose as an alternative to methodological traps based on linear, cause-and-effect reasoning and a broadly conceived positivism objectifying *the other*. This new and systemic alternative methodological approach was seen as the only fertile way forward in family therapy education and was accompanied by the popular phrase "paradigm shift."[7] The paradigm shift envisaged was from a psychotherapeutic technocracy of sorts to cooperation and complementarity.

The Profession's Three Philosophical Pillars

Because within philosophy as a whole there are many different approaches to epistemology, linguistics, and ethics, it may be helpful to assign a more specific philosophical term to the approach in each branch that I believe family therapy

[6]Both Bjartveit and Kjærstad (2001) and Hårtveit and Jensen (2002) cite the philosopher Immanuel Kant in clarifying a constructivist position.

[7]In the study of the history of ideas, a paradigm shift may be seen as the total replacement of one prevailing scientific view by another. The notion is thus poorly suited to conservatively minded people for whom change is seen primarily as a means to preserve. In politics, the concept is applicable to revolutionary changes, not reforms.

represents. It is perhaps safe to say that the family therapy profession rests on at least three basic foundations, describable as (1) epistemological coherence theory with strong elements of solipsism,[8] (2) a Kantian interpretation of Ludwig Wittgenstein, emphasizing exclusive language games, and (3) an ethical approach focused on proximity ethics.

In practice, these basic philosophical components often surface in the form of a relativistic perspective on people and reality, one easily aligned with the term *postmodernism.*[9] That is why many family therapists are seen as exhibiting little normative intent, tending instead to address matters of truth or untruth with questions such as the following (joke fully said): "What do you think?" and "Could you say more about this?" It is not altogether in the nature of family therapy to provide guidance or advice. Indeed, if advice is to be given to a therapist, it is likely to be about not giving advice!

A Paradox

Allow me to conclude this account of my fascinations and frustrations in family therapy education with a paradox that preoccupied me toward the end of my student days. It was simply this: that a field of practice and study which arose in the 1930s on a fundament of biblical teaching and Christian humanism had become, by the year 2000, a bastion of relativism.

Part 2

Fiction Versus Reality

I will now reflect further on family therapy's philosophical underpinnings and in the process highlight the premises I find most problematic—not simply out of academic interest, but because family therapy today, with its applied relativism, impresses me as being quite dysfunctional in certain contexts. At times, it even collaborates with the people it serves to produce a form of fiction, when a reality orientation and concrete guidance may be called for. Here, I speak not only as a philosopher, but also as the head of a large family counseling office in Norway.

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[8]A solipsist "holds that all conceivable propositions concern his own experiences. The most extreme solipsist will only conceive of his own present experiences; more relaxed solipsists will take of their own present and past experiences, present and future experiences, or past present and future experiences" (Dancy 1996, p. 136).

[9]"Postmodernism" belongs more to the history of ideas and literature than to professional philosophy, where it is little used. In family therapy, postmodernism and relativism can be spoken of as a pair of twins.

Constructivism + Social Constructionism = Relativism

So, something was amiss from my point of view in the postmodern, romanticist, free-form education of family therapists. Could it really be that rejecting linguistic representation of the so-called external world—Kant's "thing in itself"—makes possible the construction of multiple realities, discourses, or language games? And that these variants deserve equal standing in relation to conceptual pairs such as true/false, right/wrong, and normal/abnormal? In *Pragmatism*, the philosopher Hilary Putnam challenges his colleague Richard Rorty on this question:

> Rorty and I both believe, and we think that all reasonable people who read good newspapers closely believe, that there are almost certainly no American prisoners of war still alive in Vietnam. Some people in our country (including, understandably, some relatives of soldiers who were listed as Missing in Action during the Vietnam war) believe that there are American prisoners of war still in Vietnam. Is Rorty going to say that the notion of "objectivity" doesn't apply in such a case? Is he going to say that the two sides are "playing different language games" and that there is no objective fact as to whether there are American prisoners of war still in Vietnam? Is he going to say that the sentence "There are no American prisoners of war still in Vietnam" is "true in the language game Rorty and I play" and false in the language game certain others play, and that is all there is to it? (Putnam 1996, p. 34–35).

Similarly, as far as I am concerned, it is questionable whether the truth value of "It is wrong to hit children" can be said to vary by context. Shall we perhaps say that it is true for Norwegians, but not true for parents from other cultures who strike their children in the act of parenting? Even if you believe there is an epistemological gap between the world as it is and the world as we talk about it and think about it, and even if you believe that the labels "right" and "wrong" are context-dependent, it would be a dubious intellectual exercise to defend assaulting children on such grounds.

It is also worth noting that someone who endorses epistemological coherence theory is not necessarily obligated to assign equal truth value to sentences in different language games. An influential philosopher of the last century, W.V. Quine, viewed the scientific foundation of Western civilization as a better contextual system for acquiring knowledge than other approaches, present and past, in the history of ideas. He was pursuing the original Socratic tradition of seeking knowledge and wisdom when he wrote the following:

> Science is seen as pursuing and discovering truth. … Such is the idiom of realism, and it is integral to the semantics of the predicate "true" (Quine 1998, p. 67).

Pragmatism and Evidence-Based Practice

If family therapy had used Kant's insights in another way—instead of directing it backwards at the radical skepticism of Descartes—it would have been possible to adopt a different perspective accommodating an alternative approach to the relationship between language and reality. This would have created major constraints,

however, on mental entrepreneurs such as two of Norway's modern family therapy pioneers, Hårtveit and Jensen (2002), and not least on the authors of *Kaos and Kosmos* (Bjartveit and Kjærstad 2001).

Of Kant, Putnam writes:

> However, Kant was himself subject to a confusion. The confusion was to suppose that the description, which is shaped by our conceptual choices, is somehow, for that very reason, not a description of its object "as it really is". As soon as we make *that* mistake, we open the door to the question, "Well, if our descriptions are only *our* descriptions, descriptions shaped by our interests and nature, then what is the description of the things as they are *in themselves*?" But this "in themselves" is quite empty – to ask how things are "in themselves" is, in effect, to ask how the world is to be described in the world's own language, and there is no such thing as the world's own language, there are only the language we users invent for our various purposes. (Putnam 1996, p. 29).

Charles Sanders Pierce and his supporter William James—having read Kant, and in particular his *Critique of Pure Reason*—stood on the German philosopher's shoulders to establish what would come to be called American pragmatism. This pragmatism may be characterized in simple terms as "Kant without *the thing in itself*," a perspective which emphasized, as Putnam put it, "the primacy of practice." According to the tenets of pragmatism, linguistic structures such as sentences can and must be linked to activities and practical purposes; they are not to emerge from each individual in a way that invites skepticism as to whether descriptive language matches the way things are in reality. To get a satellite to the moon, we are dependent on a series of true sentences. To achieve good outcomes in therapy, we are dependent on effective methods. When Oscar's friend says, "Oscar likes fish," the statement is probably based on one or more of the friend's observations, or experiences, in different situations involving hunger and food. We can then say that the phrase "Oscar likes fish" is true if and only if Oskar likes fish. To create observation sentences of this kind requires a process that distinguishes between what we might call fact, theory, value, and interpretation (Putnam 1996, p. 14). Saying a sentence is true can therefore be viewed as a means of developing a better, more effective practice. This occurs through an almost pragmatic and thus programmatic commitment to collectively rooting out false hypotheses posed by humans in the course of their practical lives interacting with one another and the world they share. One shall speak therefore not only of contextually contingent truth, but also of universally true sentences grounded in fact. To use the words of William James:

> 'The true', to put it very briefly, is only the expedient in the way of our thinking, just as 'the right' is only the expedient in the way of our behaving. (…) Experience, as we know, has ways of boiling over, and making us correct our presented formulas. (Putnam 1996, p. 8.)

If someone reading this were to associate pragmatism with what today is termed evidence-based practice, I would not deny such a link.[10] When we drop Kantian

[10]I see evidence-based practice as a compound of three parts: research communities, practice fields, and knowledge based on accumulated expertise. The clue is to make the research community cooperate with the practice field in a systematic way by picking up best practices and

references to "the thing in itself," we can for example apply an approach called *deflation*, after which we can again speak of a notion of truth that lends itself functionally to use of the truth predicate, at least minimally, to help solve problems and create improvements both locally and globally.

Language and the World: There Is also a Correspondence Theory

A theory of correspondence for word and phrase meanings could be the greatest constraint on the free form of family therapy that has emerged from the systemic educational system. The entire constructivist ideal rests on the claim (previously referred to here as epistemological coherence theory) that language does not represent reality. But what if language and the world actually cohere more than some members of the family therapy profession like to believe? At the beginning of the twentieth century, Bertrand Russell based his central criticism of coherence theory on the fact that it permitted multiple perceptions of reality and thus undermined the ability to say something was right or wrong, true or false. He declared that an external standard—an objective reality that produces facts—was needed in order to state that an impression was true (Russell 1912, p. 202). As a young man under Russell's strong influence, Ludwig Wittgenstein devoted many years to creating a systematic representation of the relationship between language and the world and presented it in his *Tractatus Logico-Philosophicus*. One metaphor he devised included a gramophone with its needle, a grooved record, and a loudspeaker. The needle picked up irregularities in the grooves on the record, and the needle's motion was physically transformed into sound through a loudspeaker. Here, we may speak of a firm connection (Wittgenstein 1995, p. 20). Also worth mentioning is the ancient description of a relationship between language and the world given in the book of Genesis, in which God, having named all things, creates Babelic confusion by allotting people different languages. So archaic a tradition should perhaps not be discarded casually. Although Wittgenstein's work in the latter part of his career[11] is treated as a cornerstone of constructivism in family therapy, it is important to recall one of the most quoted paragraphs in his *Philosophical Investigations*, the first part of which reads as follows:

(Footnote 10 continued)

testing hypothesis drawn from what is working in therapy. Best practices can probably best be picked up by using standard client feedback systems on a broad scale.

[11]The phrase "the latter part of his career" refers to what many philosophers call "the late Wittgenstein." This latter phrase is used because Wittgenstein's philosophical thinking can be divided into two main periods that many scholars see as contradictory: one of them (early Wittgenstein) positivistic and the other (late Wittgenstein) linguistic, with a particular orientation to usage.

> For a *large* class of cases – though not for all – in which we employ the word "meaning" it can be defined thus: the meaning of a word is its use in the language (Wittgenstein 1963, p. 20 e).

Are there parts of the language, then, to which coherence theory does *not* apply? Given also Wittgenstein's more mystical statements in *Tractatus*—including the closing sentence, "What we cannot speak about we must pass over in silence" (Wittgenstein 1995, p. 74)—it would be wrong to say that Wittgenstein did not keep the door open to a pragmatic, evidence-based epistemology, and perhaps even in *some classes of cases* to a correspondence theory.

First Preliminary Summary

Why have I delved so deeply—in an article about family therapy in Norway—into the different epistemological approaches of modern philosophy? The answer is that I worry the knowledge base underpinning family therapy training and practice is too narrow and that the discipline too often finds itself in controversial, even dysfunctional, philosophical positions. It displays an excessive commitment to certain epistemological approaches that by their nature tend to close off other constructive ones (such as increased reliance on evidence and science). At worst, the profession gives the impression of rejecting opportunities to acquire more of what might be termed objective expertise, thereby undermining the possibility of services such as Norway's Family Counseling Service to expand individual treatment and counseling. An unbalanced systemic approach to family therapy, with greater reliance on a relativistic rather than an empirical basis, appears to rule out more scientific or linear methodologies that would better explain the root causes of various problems in life. For example, an emphasis on dysfunctional associations in early childhood as predictors of events and conditions in adulthood could be dismissed as irrelevant in family therapy. My contention is that many students of modern systemic family therapy may find themselves at a loss when called upon—in the real world—to explain or advise on matters relating to biology, pathology, and behavioral research. If I am right, that is a shame for our clients. It means the family counseling service's role in society and the complex tasks assigned to it are being undermined. Suffice it here to cite the duty therapists have to detect risks to children whose parents are struggling with psychiatric disorders, substance abuse, or violence. In such cases, a more objective understanding of people is often required, along with an observational vantage point. The larger concern, though, is the educational establishment's apparent espousal of one particular approach to change work, an approach termed systemic in opposition to interventions based on for example diagnostic criteria. This is actually a betrayal of the establishment's own relativistic ideal of assigning equal value to different language games, discourses, and social structures. Accordingly, the whole constructivist and contextual approach appears to lose substance and evaporate. This paradox will loom still larger as I turn to a discussion of the "not-knowing" demeanor that therapists are urged to adopt.

The Problematic "Not-Knowing" Position

In late 1988, Odd Arne Tjersland attended a conference in northern Norway arranged by Tom Andersen and his colleagues. He then wrote an article under the heading *From Universe to Multiverses,* which summarized his reflections on a variety of topics raised "in the Arctic":

> At the Sulitjelma conference, Goolishian/Anderson repeatedly declared the necessity of setting aside all ideas, hypotheses, opinions and images of the client prior to the conversation. Such constructions are *our* constructions, and they prevent us from seeing the client's subjective world. They also prevent us from creating a new story, a new reality, in cooperation with the client. Goolishian conveys the same when he says: I have stopped asking the client about things I know; I just ask about what I do *not* know, what I do *not* understand (Tjersland 1989, p. 11).

In retrospect, it appears that Goolishian and Anderson's ideas on commencing therapeutic interaction with the blankest possible slate, first advanced in 1988, received wide acceptance in Norwegian family therapy. In an article almost 20 years after Tjersland's *Tabula rasa* summary, one of the leaders of the family therapy training program at Diakonhjemmet, Randi Bagge, wrote—of not knowing—that in spite of critical voices, "there is power in the term" and "it creates energy." She elaborates by asking the question "What gives the 'not-knowing position' its power?" The No. 1 answer she provides is consistent with my own views on epistemology as presented above: "For one thing," she writes, "it is an obvious position. I cannot know anything about other people" (Bagge 2007, pp. 113–114). Once again, we are given grounds for a therapeutic approach based on solipsism,[12] a radically skeptical epistemological standpoint often expressed when philosophers consider "the problem of other minds" (Dancy 1996, p. 67). Before addressing this last aspect, however, I will try to reflect on the phenomenon of not-knowing helpers, because, as previously mentioned, the first time I encountered the not-knowing position in family therapy, it reminded me of Plato's dialogues and Søren Kierkegaard's words on the art of helping.

Both Therapy and Counseling?

Are Goolishian, Anderson, and Bagge reinventing the wheel when using the expression "not-knowing position" as a conversational approach so warmly? Can we for example compare their approach to Socrates' frequent allusions to his own ignorance and Kierkegaard's admonition to meet the other *where the other is* in the art of helping? I want to reflect on these questions because many therapists in the field, like myself, can be a bit confused when a "not-knowing position" is mentioned.

[12]The term is discussed and explained in footnote 8.

Socratic Approach: The Midwife Method

In Plato's dialogues, Socrates knows his interlocutors well. They were selected by Plato for their expertise, their professions, and their accomplishments to enable Socrates to investigate a concept or theme in the best possible way for the reader, but also in a way that leads his conversational partners toward true knowledge. Absolute knowledge or truth is already present, but it belongs to a world that is not necessarily accessible to people. Socrates' role is to attempt to unveil this immutable, absolute world by applying a profoundly rational method that is both probing and argumentative. Many of the dialogues can be interpreted, if somewhat tritely, as a sort of wandering and shepherding through shadowy valleys with the goal of emerging into light. An example of the Socratic method is found in the *Theaetetus* dialogue. Here, the discussion centers on what learning or knowledge (episteme) can be said to be. Two mathematicians are selected as interlocutors because mathematics was considered the form of knowledge closest to the absolute knowledge or truth that Socrates believed people should pursue. It is in this dialogue that we encounter the famous passage where Socrates says he is the son of a midwife. Thus was created the metaphor of Socrates as a practitioner of midwifery, liberating things hidden in what Trond Berg Eriksen describes as the "soul's box."[13] Socrates says that midwives of this kind must themselves have given birth in order to be qualified and as such, the way I interpret it, having acquired knowledge that is generalizable to the other. Only then can they determine whether a woman (which is to say an interlocutor) is pregnant and, if so, has progressed far enough to give birth. Having given birth oneself also suggests access at one time to the aforementioned soul's box (Platon 2004, pp. 134–37). As I understand Plato's description, this Socratic approach to the art of helping is predominantly methodological—a means to achieving a goal. At the risk of seeming too categorical, I would suggest that Socrates had some idea of his objective and where it lay when he embarked into the realm of dialogue. One could almost say he was pretending not to know.

Kierkegaard and the Art of Helping

Somewhat the same, I think, can be said of Søren Kierkegaard and his thoughts on the art of helping, which appear in *The Point of View for My Work as an Author* (1908). In this book, Kierkegaard reveals his presence behind a variety of pseudonyms and insists on being regarded as a religious writer. As I interpret it, the art of helping he describes has mostly to do with teaching and perhaps ultimately with leading someone to God:

[13]Trond Berg Eriksen, professor at the University of Oslo, often used this expression when lecturing about Plato.

> If one is truly to succeed in leading a person to a specific place, one must first and foremost take care to find him where he is and begin there. This is the secret in the entire art of helping. … In order truly to help someone else, I must understand more than he – but certainly first and foremost understand what he understands. If I do not do that, then my greater understanding does not help him at all… But all true helping begins with a humbling. The helper must first humble himself under the person he wants to help and thereby understand that to help is not to dominate but to serve, that to help is not to be the most dominating but the most patient, that to help is a willingness for the time being to put up with being in the wrong and not understand what the other understands (Kierkegaard 2009, p. 45).

This excerpt is followed by a discussion of hypothetical encounters—first with a person impassioned about something, and then with someone in love—in light of the above-mentioned principles. Kierkegaard then addresses how "becoming a Christian" can be such that one is subjected to the same process or art of helping as described above.

When reading the Kierkegaard extracts, I find many methodological similarities with Goolishian/Anderson/Bagge (referred hereafter as G/A/B). Symmetry, humility, and pacing are all present, as is a tolerance for incomprehension and mistakes; we here tell also the benefits of curbing one's own "greater understanding." But while Kierkegaard describes his method as way forward based on clear pedagogical principles, the G/A/B triad appears to treat not knowing as the goal in itself or as if the means were everything and the end did not matter.[14] Kierkegaard's position strikes me as an opening gambit to find accord with the person to be helped, with movement toward a fixed goal dependent in any case on the helper's possession of *superior* understanding. As I have mentioned, Kierkegaard's idea of the helping art may be compared to Socratic midwifery, as both are strong on methodology and both represent pedagogical resources useful in achieving a goal. For G/A/B, the means are themselves a goal; what occurs is not counseling but the therapeutic co-production of a new version of reality that is necessarily tentative given a helper who cannot know anything about other people: who only can get acquainted with the specific clients when communicating in the therapy room.

The Not-Knowing Position and Solipsism: No Man Is an Island

A few years back, two Norwegian psychologists (sisters; Ihlen and Ihlen 2003) gained renown for publishing a book entitled *På seg selv kjenner man ingen andre* (roughly an inversion of the expression "It takes one to know one," i.e., "Knowing yourself

[14]A popular quote that criticizes this postmodern approach is taken from *Alice's Adventures in Wonderland*. When Alice asks the cat in the tree, "Would you tell me, please, which way I ought to go from here?" the cat responds "That depends a good deal on where you want to get to." This advice was paraphrased in a song by George Harrison as "If you don't know where you are going, any road will get you there" and was later employed in mocking rebukes of postmodernism (Caroll 2013, p. 54).

does not help you to know others").[15] With this postulate, however, they run straight into John Stuart Mill and his argument for the opposite: "the argument from analogy" (Dancy 1996, p. 68). According to Mill, we can in all likelihood acquire an understanding of other people's mental lives by examining our own and then assuming that the others feel and experience things in quite the same way. Mill refers, by way of example, to the sensation of pain when he writes the following:

> I am conscious in myself of a series of facts connected by an uniform sequence, of which the beginning is modifications of my body, the middle is feelings, the end is outward demeanor. In the case of other human beings I have the evidence of my senses for the first and the last links of series, but not for the intermediate link. I find, however, that the sequence between the first and last is as regular and constant in those other cases as it is in mine. In my own case I know that the first link produces the last through the intermediate link, and could not produce it without. Experience, therefore, obliges me to conclude that there must be an intermediate link; which must either be the same in others as in myself, or a different one; … by supposing the link to be of the same nature … I conform to the legitimate rules of experimental inquiry. (Mill 1867, pp. 237–238.)

The argument advanced by Mill nearly 250 years ago is based on induction and could also be classified as intuitive. Either way I think most people in their everyday lives identify with the content of the argument and often find it appropriate to refer to themselves when interacting with other people. We gain access to the minds of other people by thinking that they, like we ourselves, cohere sequentially in terms of body, emotions, and behavior.

Cartesian skepticism tells us that experiences and emotions are only fleetingly associated with a person's behavior. The relationship of inner experience to behavior may differ from person to person, even if the inner experience is the same and vice versa. From that perspective, Mill has a weak argument against Descartes and the Cartesian's premise that the subject's self-consciousness is a metaphysical foundation of sorts. Wittgenstein, for his part, believed a more permanent link could be established between mental states and behavior by focusing on collective human language games. This opportunity to banish Descartes' radical skepticism hinges on what is often called Wittgenstein's private language argument (Nilssen 2010, pp. 232–238). Paragraph 293 of *Philosophical Investigations* is relevant to J. S. Mill and the discussion above and gives a taste of the argument:

> If I say of myself that it is only from my own case that I know what the word "pain" means – must I not say the same of other people too? And how can I generalize the *one* case so irresponsibly?
>
> Now someone tells me that *he* knows what pain is from his own case! – Suppose everyone had a box with something in it: we call it a "beetle". No one can look into anyone else's box, and everyone says he knows what a beetle is only by looking at *his* beetle. – Here it would be quite possible for everyone to have something different in his box. One might even imagine such a thing constantly changing. – But suppose the word "beetle" had a use in these people's language. – If so it would not be used as the name of a thing. The thing in the box has no place in the language-game at all; not even as a something; for the box might

[15] I refer to Heidi and Bente-Marie Ihlen, who published a book by that title in 2003.

> even be empty. – No, one can "divide through" by the thing in the box; it cancels out whatever it is.
>
> That is to say: if we construe the grammar of the expression of sensation on the model of "object and designation" the object drops out of consideration as irrelevant. (Wittgenstein 1963, p. 100 e).

If after this one wishes to embrace Wittgenstein's more behavioristic approach, one might also use his words to say that the basis of the not-knowing position seems to vanish as irrelevant. We *can* learn something about others. And we can also make judgments. That means being able to say something correct or true, on the basis of behavior, about what Wittgenstein calls "the genuineness of expressions of feeling," as he writes explicitly in Part II of the above work:

> Is there such a thing as "expert judgment" about the genuineness of expressions of feeling? – Even here, there are those whose judgment is "better" and those whose judgment is "worse".
>
> Correcter prognoses will generally issue from the judgment of those with better knowledge of mankind.
>
> Can one learn this knowledge? Yes; some can. Not however, by taking a course in it, but through "*experience*". Can someone else be a man's teacher in this? Certainly. From time to time he gives him the right *tip*. … What one acquires here is not a technique; one learns correct judgments. There are also rules, but they do not form a system, and only experienced people can apply them right. Unlike calculating-rules. (Wittgenstein 1963, p. 227 e.)

As I interpret Wittgenstein, it is possible for someone to master knowledge of the human condition, which is to say to become an expert at proposing hypotheses, interpreting information and behavior, and formulating true sentences respecting the interior states of other people. If this excellent authority on people happens to be a therapist, we must of course speak not only of his or hers ability to build alliances, but also of their observational skills and of asymmetry in their therapeutic relationships. Were they to scrub themselves of all prejudice before each new therapy session, there would be some justification in concluding that they had vacated his profession.

Second Preliminary Summary

Why has the family therapy profession paid so little attention to this positivistic aspect of Wittgenstein, which is probably his best-known attribute among philosophers in general? Why should his defenses of exclusive or closed language games and relativism be so popular while the many gripping adjacent passages about mental states and behavior go unsung? It may be because those passages clear the air of much mystique and romance. Family therapy, I think, has been so determined to brand itself as an alternative discipline that it tends to reject a great deal that smacks of science, positivism, expertise, guidance, and counseling.

Therapeutic asymmetry in my view can also be associated with what I like to call French anti-power language, particularly that of the philosopher Michel Foucault, in whose writings power is linked to societal oppression. Psychiatric and therapeutic approaches, which seek to provide expert professional help, are seen in that light as tools for those in power to keep people down and to lock a particular social system into place. If I am right that such conspiratorial beliefs are rife in parts of the family therapy profession and that these may help explain the ascendency of the not-knowing position, the effect of which could be stifling. This may impact therapists to view the people they serve as victims and therapy as some kind of counterforce exerted on their behalf. The question to be resolved is whether the profession and the public it serves would be better off with less ideology and a more pragmatic, flexible attitude.

I would now like to explain why I believe it is better, in many cases, to have a well-informed therapist than one who professes not knowingness.

The Informed Versus the Not-Knowing Therapist

By Tjersland's account of Goolishian/Anderson, violating the not-knowing position could be as simple as asking new clients about their lives in a digital survey before a first consultation, c.f. the objective of this book about the use of systematic feedback. That is also my interpretation, because such a practice would automatically cast the therapist in the role of observer and even expert. But what is wrong with that, if the survey's form and point system can be said to provide useful information? According to the Norwegian agency's statement of purpose (act relating to family counseling services [Lov om familievernkontorer] 1998, Sect. 1), "the family counseling service shall provide therapy and counseling when difficulties, conflicts, or crises exist in the family." It is certainly the case that most people who seek out such services do so because they have problems. Would it not be helpful for many of them to describe their situation in advance to their helpers in a somewhat systematic and structured way, if only to expedite and improve the forthcoming treatment? The center of focus could be infidelity, emotional emptiness and communication difficulties, or problems with the children; it could be violence, foreign culture, anger, substance abuse, or a psychiatric disorder. If there is a large staff of therapists at hand, would it not be helpful to improve the treatment repertoire through specialization, so resources can be allocated with greater effect? The simple ability to differentiate by gender may prove beneficial to a course of treatment. Special skills related to mental illness, addiction, foreign cultures, and developmental psychology are also strengths in treatment. At-risk children are another important area of focus. Having the ability to interpret preliminary information would perhaps make it easier to detect varying levels of neglect. The embrace of a not-knowing position out of excessive reverence for symmetry and

client collaboration could prove naive and perhaps even irresponsible. In any case, it would be foolish for a therapist to allow some postmodern ideological position to keep him or her from offering effective treatment as a result of purging themselves of knowledge before each client session and feeling guilty when called upon to act like an expert. The therapist who follows such a regime could also risk missing out on the digital treatment opportunities that appear to be emerging.[16]

Proximity Ethics and Second-Order Cybernetics Go Hand in Glove

And now I have come to the final subject to be addressed in this chapter. It, too, has to do with the not-knowing position, which in this context I view as only an extreme version of second-order cybernetics. The therapist, as mentioned, is said necessarily to be part of the system in question, thus eliminating a perspective "as from outside."[17] What are the ethical implications of such an approach? Referring to that 1989 conference "in the Arctic," Tjersland reported that the three participating therapist groups "convey different ideals when it comes to therapeutic style. The Milan group highlights the distanced, neutral expert; the Galveston group [Goolishian/Anderson], the more empathic, understanding, talkative, involved therapist; and the Tromsø group [Tom Andersen et al.], the warm, caring, and neutral therapist" (Tjersland 1989, p. 12). I interpret the styles which Tjersland ascribes to the Galveston and Tromsø groups, and perhaps especially the latter, as a form of proximity ethics like that found in K.E. Løgstrup's book *The Ethical Demand* [*Den etiske fordring*]:

> The demand implicit in every encounter between persons is not expressed but is and remains silent. … And since the demand is implied by the very fact that an individual belongs to the same world in which the other person lives, and therefore holds something of that person's life in his or her hands, it is a demand to take care of that life (Løgstrup 2000, pp. 43–44).

The demand or challenge that Løgstrup devised was an attempt, in keeping with his other writings, to find alternatives to a modernistic mindset. As he also believed that having the life of another placed in one's hands created a power relationship, it may be said that his proximity ethics arguably belong under what I would call the postmodern umbrella.

[16]I assume here that in-person therapy sessions are required for a not-knowing position to be maintained.

[17]The term comes from John B. Watson, the founder of classical behaviorism, which is arguably the antithesis of constructivism and not knowing.

Proximity Ethics Challenge: An Inadequate Therapist

If there is merit in linking Løgstrup's proximity ethics to a second-order cybernetics defined by symmetry and a commitment to therapeutic involvement, it could severely strain the altruism of many so-called systemic therapists. In my own office, for example, taking Løgstrup at face value would mean holding well over 100 lives in our hands at any one time. Such an obligation—to distribute care and affection that widely, while presumably holding some in reserve for our "one and only" as well as any children and grandchildren—may be impossible to fulfill. A family therapist who wishes to integrate theory and practice may also discern a paradox with regard to creating the best possible conditions for his or her own family life. At worst, this type of proximity ethics in family therapy can produce a sense of falling short or, conversely, a sense of omnipotence due to a tendency in some cases to regard the client relationship as one of dependency. That being the case, one should perhaps avoid relying exclusively on a therapeutic approach that imposes such strong ethical obligations; one should perhaps forego, moreover, some of the vocabulary associated with second-order cybernetics and the not-knowing position. In sum, it might make sense to ease up a little on the admonition to engage symmetrically as a mere participant in therapy for fear of committing "the instrumental mistake"[18] of being a spectator or observer.

Courtesy, Respect, and Sound Methods May Be Enough

Is it enough to simply say that we need strong client–therapist alliances in combination with specific therapeutic approaches and that these must emerge from a deep understanding of custom, courtesy, and respect? I believe so. In particular, when the emphasis is placed on *respect*, meaning (in Latin) "to look back at." This implies to regard *the other* anew—repeatedly—after hypotheses and judgments are already made.

Conclusion

In this article, I have attempted to highlight aspects of what Tone Kummen, in her history of Norway's Family Counseling Service, describes as an epistemological change of course which became more and more pronounced in the 1980s under the influence of US and European trends (Kummen 2016, p. 51). I have posed a

[18]The phrase is from the Norwegian philosopher Hans Skjervheim and his book *Deltakar og tilskodar* (1996) [*Participant and spectator*] and is cited by Tor Johan Ekeland in his discussion of the technification of interpersonal relations in therapy (Skauli 2009, p. 7).

number of questions about the origins of this change and examined some of the effects it has had on education and practice. Philosophically speaking, the direction chosen seems to have been poorly grounded, given the evolution in philosophical thought over the past 350 years. I refer in particular to the large-scale systematic effort by philosophers to overcome Descartes' skepticism and the "mind–body problem" he bequeathed to the world. One could almost say that the family therapy profession has been selective in its application of philosophy, so as to justify favored therapeutic approaches and give the field a *rationale*. It seems to me that mainstream systemic family therapy in Norway has cut itself off from other branches of psychotherapy by creating unnecessarily sharp dividing lines between what I have characterized as a somewhat romanticized therapeutic approach on the one hand and more systematic or scientifically rigorous therapeutic styles on the other. These mainstream systemic approaches, moreover, are also, and in many ways, difficult to reconcile with the practical needs of clients and society. To emerge from its isolation, in my view, the profession would be well served to relax its philosophical vows somewhat and open the door to more normative practices. A more pragmatic, adaptable attitude would better enable the profession to fulfill its mandate and surmount the challenges we family therapists face daily. By using feedback in a systematic way and on a broad scale—so that our clients can tell us what works—could be the best starting point and the best way to solve these challenges in the future.

In closing, let us return to Johan Nielsen Nagel's debate with the town doctor at the Central Hotel in Knut Hamsun's *Mysteries*: How did the conversation end? What was Dr. Stenersen's reply to Nagel's thoughts on life, poetry, and truth? "Maybe you're right, in the main," he said. But by then, the doctor had been without his spectacles for a while. Earlier that evening, they had fallen to the floor ten times and finally been crushed.

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Part III
Practice-Oriented Research and Routine Outcome Monitoring

Chapter 5
The Systemic Therapy Inventory of Change—STIC: A Multi-systemic and Multi-dimensional System to Integrate Science into Psychotherapeutic Practice

William M. Pinsof

The purposes of this chapter are to present the Systemic Therapy Inventory of Change (STIC) system and delineate the rationale for its use as a "one-stop shop" to scientifically investigate and empirically inform the practice of psychotherapy. More specifically, the STIC embodies a multi-systemic and integrative perspective that is consistent with the principles of family systems thinking and practice. As such, its use brings those principles to the broader practice of psychotherapy research and practice.

The STIC System

The STIC measurement and feedback system currently consists of three components.

The STIC Initial

The first is the STIC Initial, which is a questionnaire that clients fill out before the first session. It includes a detailed demographic questionnaire (that can be adapted to different national and cultural populations) and six system scales focusing on the different familial systems that comprise an adult or adolescent's intimate life context. The six system scales embody the multi-systemic component of the STIC. The Individual Problems and Strengths (IPS) Scale measures individual adult or

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adolescent symptoms and well-being on eight factors. The Family of Origin (FOO) Scale taps on six factors' adult clients' recollection of what their family was like and when they were growing up. The Relationship with Partner (RWP) Scale assesses partnered adults' (or adolescents) couple functioning on seven factors. Family/household (FH) targets parents' or adolescents' experience of their current family or household on eight factors. Child Problems and Strengths (CPS) delineate a parent's perception of a child's functioning on seven factors. Lastly, the Relationship with Child (RWC) Scale asks a parent about his/her relationship with their child on three factors. The STIC Initial takes a partnered parent about 45 min to fill out.

As evident in the above paragraph, each system scale contains dimensions or factors that constitute subscales for their scale. These factors can be thought of as the assessment or diagnostic criteria for each scale. For instance, The RWP Scale includes a trust subscale and commitment subscale that, respectively, measure the extent to which the partners trust each other and are committed to their relationship. Each system subscale uses a five-point Likert-type scale and can be thought of as a continuous variable. The STIC scales generate scores for each of their subscales as well as a total score (the average of the subscales) for the scale.

The STIC Intersession

The second STIC system component, the STIC Intersession, consists of briefer versions of five of the six system scales. The FOO Scale is currently only part of the STIC Initial and is used primarily as a set of moderator variables to predict the course of certain therapies (our goal is to include a briefer version of it in the next iteration of the Intersession, because we hypothesize that it may be a mediator as well). The Intersession also contains three alliance scales that, respectively, measure alliance in individual therapy (The Individual Therapy Alliance Scale), in couple therapy (The Couple Therapy Alliance Scale), and in family therapy (The Family Therapy Alliance Scale). These three scales derive from the Integrative Therapy Alliance Perspective (Pinsof 1994; Pinsof and Catherall 1986; Pinsof et al. 2007), which brings a family systems' perspective to the theory and measurement of the therapeutic or working alliance. The STIC Intersession takes a partnered parent seven to nine minutes to complete.

Clients fill out all demographically appropriate system scales in both the Initial and Intersession formats, regardless of the type of therapy in which they are engaged. Thus, a partnered father in individual therapy would fill out all of the system scales, whereas a husband without children in couple therapy would only fill out IPS, FOO, and RWP on the Initial, and IPS and RWP on the Intersession. The rationale for this procedure is that in designing the STIC, we wanted to bring an integrative and multi-systemic perspective to the study of family, couple, and individual therapy. This permits testing hypotheses such as to what extent does individual therapy with a depressed spouse affect her marriage, her family, her

children, and her relationship with her children. Clients only fill out one alliance scale in their Intersession—the one that fits the kind of therapy they are in. Thus, a partnered adult in individual therapy would just fill out the Individual Therapy Alliance Scale.

The STIC Online Data Collection and Feedback System

The STIC online feedback system, the third component, presents the "clinical intelligence" of the STIC System. It is designed to give therapists relevant and usable information that can influence their clinical decision-making and be shared directly with clients. To facilitate this process, the STIC has been normed, which means that a signal value is attached to any client factor or subscale score that tells the therapist whether that score is in the normal or the clinical range. It also tells the therapist how far (in standard deviation units) it is into the clinical or normal range. Thus, a husband's score on the partner positivity factor (intimacy, fun, friendship, love) on the RWP Scale may be two standard deviations into the normal range, which means he is as happy with his partner as he can possibly be (the top score in the normal range). In contrast, it may be four standard deviations into the clinical range, which means he is about as unhappy with his partner as he can be (the lowest score in the clinical range for the factor). The therapist can tell at a glance whether or not this aspect of the couple's relationship is problematic from the husband's perspective. At the simplest level, the normed score tells therapists whether or not and how much they need to worry about and attend to this aspect of a couple's relationship.

The continuous nature of the STIC scales reflects the STIC developers' commitment to the concept of a multi-factorial and multi-dimensional, as opposed to a categorical assessment system. Each targeted system (individual, couple, family) has a STIC profile that constitutes their "assessment" or "diagnosis" at that moment. The fact that the STIC has been normed and that a client's score on a scale or subscale can be conceptualized as falling in the normal or clinical range is purely a heuristic or shorthand device to tell the therapist whether something is a problem for the client. It is not meant to be a label or categorical assignment device. The STIC developers have debated many times the use of terms other than normal and clinical (like problematic/non-problematic) but ultimately settled on normal and clinical distinction due to the fact that the clinical cutoffs were determined by the intersection of the normal and clinical (help-seeking) sample score distributions on that scale or factor.

The online feedback system collects data from the clients and feeds it back to therapists in real time. The client portal offers the STIC to clients in English, Norwegian, or Spanish, whereas the therapist portal only offers STIC feedback to therapists in English or Norwegian. Potentially, both STIC portals can be configured in any language.

A unique set of features comprise the therapist portal and feedback system. First, therapists receive a notifying e-mail from the system the moment the clients complete their STIC. In this sense, the data are "hot." If the client has endorsed a risk item (homicide, suicide, physical/sexual abuse), the e-mail indicates "high priority." Second, when therapists open the e-mail that includes a link to the therapists' website, the first thing that they see is the Feedback Report, which was designed to provide therapists with "everything they need to know in 90s" (determined in user studies) about significant changes in any major factor (system or alliance) since the previous session or since the beginning of therapy. The Feedback Report especially focuses on the current status of the "Big Six," the six most clinical (furthest into the clinical range) factors for the case at the beginning of therapy. The idea of the Big Six came out of our own clinical experience as well as the feedback we received from initial users of the STIC that six was probably the maximum number of problems that a therapist could consistently track with a case. Delineating the Big Six at first and then presenting them at the front of every Feedback Report maximizes the likelihood that the therapist never loses track of the current status (better, no change, worse) of the major presenting problems from the beginning of therapy. Therapists can also add new factors to the Big Six list for regular tracking as well as other critical problems that become clear over the course of therapy. If therapists have time, they can go further into the case material and explore any changes or domains not mentioned in the Feedback Report.

An Evolving Measurement and Feedback System

The STIC system, like all modern information technologies, is an evolving measurement and feedback system (Bickman et al. 2012). STIC v1 was a paper and pencil set of questionnaires that clients filled out on Scantron forms before every therapy session. STIC v2 presented the STIC as an online questionnaire that clients could fill out on virtually any information technology platform (mobile phone, tablet, computer). In addition to the changes in data collection format (paper and pencil to online) and the sophistication of the scales (norming, etc.), we have "discovered" various uses of the STIC that were not initially envisioned when we started this research program. Below we detail the various functions or roles that the STIC has taken on over the course of its development. Specifically, we discuss the STIC system as a research tool and as a clinical tool.

The STIC as a Research Tool

As well as a measurement and feedback system to provide therapists with useful data about their clients, the STIC v2 is a research tool that can be used to address a wide variety of questions and hypotheses. At the most basic level, the STIC can be

used to evaluate the outcome of therapy from a multi-systemic perspective. It can evaluate two types of distal outcome questions. The first is the extent to which clients in therapy changed on the five STIC scales. Did the clients improve on the five STIC scales, which, respectively, measure individual, couple, and family functioning, as well as child functioning and the quality of the parent's relationship with the child? More specifically, did the clients change on the specific dimensions or factors on each of the five scales?

The second distal outcome question concerns whether the STIC scales and factors in the clinical range at the beginning went into the normal range at the end. The first question asks did the clients improve—did they get better? The second asks did they return to normal or non-distressed functioning—did they recover?

In regard to the validity of the STIC scales and factors, a recent study found that they correlated highly with well-established, gold-standard measures such as the Beck Depression Inventory (Beck et al. 1961), The Beck Anxiety Inventory (Beck et al. 1988), the Dyadic Adjustment Scale-Revised (Busby et al. 1995), The Family Assessment Device (Epstein et al. 1983), and the Strengths and Difficulties Questionnaire (Goodman 1997), a measure of child functioning (Zinbarg et al. in press). These data suggest that the STIC scales together constitute a valid outcome battery not only for the multi-systemic and multi-dimensional evaluation of psychotherapy, but also for the evaluation of the extent to which treatment has effectively addressed specific disorders such as depression; anxiety; and couple, family, and child distress.

The STIC has a virtually unlimited capacity to test hypotheses about the moderators and mediators of therapy. STIC data can be used to address a host of moderator questions like to what extent does initial client status on a variety of demographic and system variables predict outcome in different systems. For instance, to what extent does the degree of disturbance in a child predict the outcome of his/her parents' couple therapy or to what extent does paternal depression predict the outcome of family therapy.

In regard to therapy mediators, STIC data can be used to address the extent to which therapeutic alliance ruptures (sudden and significant drops in a client's alliance with the therapist or a significant other) predict or are associated with poorer outcomes and the extent to which ruptures that are subsequently repaired are associated with better outcomes. In this regard, using STIC couple therapy data, Goldsmith (2012) found that, among other things, alliance ruptures occurred in over half of all cases in a sample of cases in couple therapy and that when ruptures were repaired those couples had better outcomes than couple cases in which ruptures had never occurred. In regard to non-alliance mediators, the STIC can be used to address questions like to what extent does improvement in wives' depression predict the outcome of couple therapy or to what extent is amelioration in adults' depression in individual therapy associated with improvement in their marital functioning.

We are currently in the process of examining a sample of over 1000 complete cases to see whether we can determine change trajectories for particular types of clients on particular scales and factors. We are using latent growth curve analytic

techniques to identify distinct trajectories linked to particular groups or classes of clients. Our ultimate hope is to be able to use STIC Initial profiles and/or early change trajectories (e.g., first three sessions) to identify predicted change trajectories for each case at the beginning of therapy. Not only are such data useful to show the shape and timing of change for different clients on different dimensions, but they can ultimately be used to inform clinical planning and decision-making. For instance, cases with predictors' scores that place them in a poor trajectory class can be offered additional and/or specialized services with potential to move them into a change class with a better trajectory.

The STIC as a Clinical Tool

In developing the STIC, our initial goal was to create a research instrument that could illuminate how clients change in therapy and a clinical tool that could be used to give therapists, over the course of therapy, specific data about which of their clients' problems were getting better, worse, or not changing at all. Over the last ten years, our clinical research group at The Family Institute at Northwestern University and our Norwegian colleagues have been exploring and elaborating the STIC system's utility as a clinical tool. Specifically, we have begun to elaborate the use of the STIC as a clinical tool to facilitate collaborative assessment, treatment planning, progress evaluation, and termination assessment/planning.

The Collaborative Use of the STIC

A major evolution with the STIC system has occurred in regard to its use as a tool to facilitate collaboration and alliance building between the therapist and the clients. Initially, we imagined that therapists would receive STIC feedback and use it to evaluate their clients' progress in therapy. In other words, the STIC feedback would inform therapists' clinical decision-making. The therapist, after receiving the feedback, would decide how to use the feedback. Sharing the feedback with the clients was an option, but something that we thought should be done under certain very carefully and judiciously selected circumstances.

Approximately five years ago, I was consulting on a case with my colleagues at the Modum Bad Psychiatric Center in Vikersund, Norway. For several years, they had been using the STIC system in their inpatient family program in which whole families come to Modum Bad for three months of intensive, multi-systemic treatment (see Chap. 9). In preparing for the live consultation interview with the parents from one of their families, the staff asked whether I would show the couple their STIC data during the interview. I said "sure," not knowing what exactly I was agreeing to. After some initial getting-to-know-you conversation with the couple, I invited them to look at some of their STIC data with me. I had my laptop computer

in front of me linked to a projector that displayed their STIC data on a large screen we could all easily see. I began by showing them a change graph depicting the wife's deterioration on the Negative Affect factor (depression and anxiety) over the last three weeks, since they had arrived at Modum Bad. After explaining what Negative Affect meant and clicking on one of the data points which showed them the actual questions with the wife's answers for that date, I asked the wife how she understood her change on this factor.

The wife responded by saying, "Since I arrived at Modum, I have felt like I could finally feel my feelings. I have been sad for so long, but I felt that because of my husband's problems and the need for me to be strong, there was no room in our life for me to be sad. But being here, I have felt relieved that my husband is finally getting the help he needs and there is room for my sadness." As she said this, she started to cry softly. Through her tears, she added, "that line on the screen shows the journey into my heart."

At that moment I asked the husband how he was feeling, seeing his wife's tears and hearing her story. He said that he felt sad too, sad that he had made her sad as well as their children with all of his problems. I asked him, "Was it you or your problems that made them so sad?" He said he did not see any difference between who he was and his problems. I asked his wife what she thought about that and she turned to her husband and said, "You are not your problems. You are the man I love, but I hate your problems." I asked him, "So how are your problems going at this point?" He responded, "I think better, but I am not sure." I asked whether we could look to see what the STIC data had to say about that and he replied "Sure."

At that point, I went back to the website and clicked on the line graphs for his IPS Negative Affect and IPS Open Expression, two of his factors that were furthest into the clinical range when he came into therapy at Modum. Negative Affect had gone from +3 into the clinical range to −0.5 into the normal range, and Open Expression had gone from +3.5 to +1 in the clinical range. Both factors had changed significantly ($p < 0.05$) and Negative Affect had even gone just over the clinical cutoff into the normal range. I asked him what he thought about that. He replied, "I guess I am doing better." I then asked what he thought the graphs were saying about him. He said, "That one says I am less depressed and the other says I can speak up for myself when I need to." I asked, "Does that feel right to you? Is it accurate?" He responded, "Since I just filled it out, it's better." We all laughed at that moment. I then asked his wife whether she thought his line graphs were accurate and she concurred.

What this experience taught me was that I could use STIC data with couples as a powerful therapeutic intervention and that I could treat them as co-investigators into their data. I did not have to interpret it for them, but we could interpret it together. It also taught me that seeing STIC data could evoke powerful emotions in clients. Lastly, it showed me that STIC data could also be used to validate change and inspire hope.

Since that time, my colleagues and I have perfected various strategies for using STIC data with clients, a number of which will be elaborated below. But the important breakthrough of that moment was that I did not have to be the STIC

expert, nor did I have to be the center of STIC decision-making. The STIC data could be shared with clients and used as a collaborative tool to facilitate the co-creation of a new empirically informed reality (Weingarten 1991). I have come to believe that this collaborative use of STIC data with clients also increases and strengthens the therapeutic alliance.

Collaborative, Empirically Informed Assessment

The STIC has great potential as a tool and multi-systemic assessment. The STIC provides two "clinical profiles." The first pertains to all of the scales for a particular client or case that are in the clinical range. For instance, a partnered husband, the most demographically loaded client, may be in the clinical range on 10 of the 39 factors or subscales on the six STIC Initial scales. A wife with no children may be in the clinical range on 8 of the 21 subscales on her three STIC Initial scales (IPS, FOO, and RWP). For each client, the specific scales in the clinical range constitute his/her full clinical profile. For each case, the clinical profiles of the clients in that case constitute the case's full clinical profile. The individual client or case's clinical profile can be thought of as their unique clinical fingerprint or signature. Clinical experience suggests that there is a high correlation between a client's full clinical profile and their description of their presenting problems. However, the STIC clinical profile should never be thought of as a complete or definitive clinical picture of the client or the case and must always be supplemented and informed by the clients' personal narratives. This belief is at the core of the clinical use of the STIC in which the clients and therapist co-interpret and co-define the meaning of their scores.

The Big Six and the Big Three

As discussed above, in order to simplify the clinical picture for therapists and clients, the Feedback Report that therapists get as soon as the clients submit their STIC form does not initially present the full clinical picture for each client. Instead, it presents the Big Six, the clinical subscales for each client that are furthest into the clinical range. When therapists look at the full case (after they have confirmed seeing each client's Feedback Form), they are presented with the Big Six for the case, which for a couple presents the top three (the three most clinical subscales) of each partner's Big Six. The therapist can move from that case, a conjoint data display presenting the Big Three for each partner, to looking at the data for each partner and seeing his/her Big Six. In other words, the website is layered, and therapists can dig down as far as they want and have time to.

Individual Versus Couple Versus Family: Whom to See?

A major assessment function of the STIC is the determination of what is conventionally thought of as the modality of therapy. Instead of "modality," which tends to imply as set of practices and inclusion criteria, our group prefers the term "contexts of intervention" (Breunlin et al. 2011; Pinsof 1994; Pinsof et al. 2011; Pinsof et al. in press). A context of intervention specifies who is directly involved in therapy at any particular time, but does not prescribe or connote any practices or interventions. To exemplify this function, think of a partnered female who presents for individual therapy. In examining her initial STIC data, the therapist sees that she has more couple (RWP) subscales than individual (IPS) subscales in the clinical range. This means that she is reporting relatively more distress in regard to her partnership than her individual functioning.

These data lead the therapist to hypothesize that couple therapy may be more appropriate for this woman than individual therapy. The therapist further hypothesizes that the couple problems may be causing her individual problems or vice versa. In the first session, the therapist mentions to the client that she has more subscales in the clinical range on her couple as opposed to her individual scale and asks what she thinks about that. She says that her marriage is terrible and she is thinking of leaving her husband. The therapist then asks her whether she and her husband have tried couple therapy. She responds that they have been in couple therapy for ten months, her husband is refusing to attend, and things have gotten worse between them. Together, the therapist and client decide that at this moment, seeing her individually makes the most sense.

However, if she had told the therapist that they had not tried couple therapy because her husband refused to, the therapist might suggest that she tell her husband that she has decided to consult with a family psychologist who said that he would like him to come in for a conjoint session so that he could understand his perspective on his wife's problems and their relationship issues. In other words, the invitation is not for "couple therapy," but for him to join them so his perspective could be factored into their work. Frequently, when this occurs and the husbands realize that what they think is important and that the therapy is not going to be husband-bashing, they agree to participate in couple therapy.

If the partnered female above, who presented for individual therapy had two children, a 12-year-old son and a 10-year-old daughter, she would also have filled out FH, CPS, and RWC. Let us assume that three of the eight FH subscales were in the clinical range and that most of the seven CPS and three RWC subscales for the daughter were also in the clinical range. In contrast, none of the CPS and RWC subscales for the son were in the clinical range. This picture would lead the therapist to ask about the children, with particular emphasis on the problems with the daughter. If the mother said that she and her husband could not agree about what to do with their daughter (reflected in the FH clinical subscales), who had always struggled in school and had few friends (reflected in the CPS clinical subscales), the therapist might recommend family therapy with the husband and the children as a

first step. That therapy, if successful, might lead eventually to couple work to help the parents get aligned in regard to their children, which might ultimately position them to address their marriage.

Creating an Empirically Informed Problem Narrative

The STIC Initial data, in addition to influencing the decision about who to include in the therapy and, correspondingly, which systems to focus upon, also can be used to influence the decision about what to work on in what order or sequence. The Big Six for each client in a case usually track well on to each client's verbal presentation of his/her primary presenting problems. We recommend that therapists share the initial Feedback Report with the clients and use it as an opportunity to both identify their major problems as targets of treatment and to also plan the order of intervention—what will be addressed first, etc. We focus below on identifying the targets of treatment and will address collaborative planning in the next section.

The first thing that the Initial Feedback Report presents is the Big Six for each client who filled out the STIC Initial. The Feedback Report also presents risk (homicide, suicide, abuse, etc.) items that any client in the case reported initially. Figure 5.1 presents the STIC Initial Risk Items and Big Six for Tom (blue) and Sarah (red-pink), who presented for couple therapy.

The Big Six for the couple (case) includes the three most clinical subscales for each member. Figure 5.1 shows that Sarah endorsed a suicidal thought risk item from the Negative Affect subscale on IPS. In terms of the Big Six, Sarah's score on Negative Affect is the furthest into the clinical range (the Big Six is rank ordered from the most to least "clinical"), followed by Tom's Open Expression. Both of these scales come from their Initial IPS Scale which is presented in Fig. 5.2. The

Risk Items Endorsed

Client	Scale	Subscale	Question	Answer
F/Jul 1, 1953	Individual Problems/Strengths	Negative Affect	Thought about ending your life	Rarely (2)

Initial Subscales furthest into the Clinical Range (Big 6)

Subscales furthest into the clinical range (from most to least severe).

Client	Subscale
F/Jul 1, 1953	Negative Affect - IPS
M/Sep 15, 1950	Open Expression - IPS
F/Jul 1, 1953	Trust - RWP
F/Jul 1, 1953	Sexual Satisfaction - RWP
M/Sep 15, 1950	Self-Misunderstanding - IPS
M/Sep 15, 1950	Negative Affect - IPS

Fig. 5.1 Initial Risk Items and Big Six to Tom and Sarah

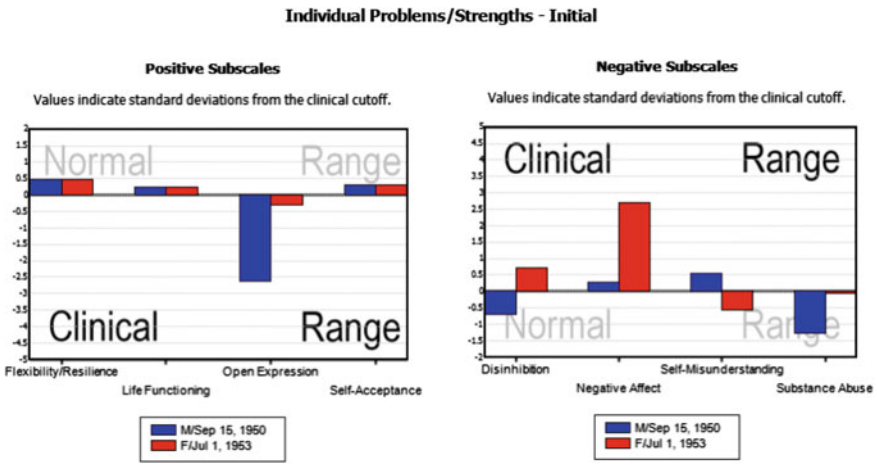

Fig. 5.2 Tom and Sarah's Initial Scores on Individual Problems and Strengths

bar graphs for each of the Initial Scales are part of the Feedback Report and can be scrolled down to from the Big Six. Figure 5.2 graphically depicts what the Big Six reports; that is, Sarah is very depressed and Tom feels that he cannot express himself or his feelings. It also shows that Tom experiences problems primarily in regard to himself as opposed to his marriage—his IPS Self-Misunderstanding and Negative Affect are number five and six in the Big Six. In terms of couple functioning, two of the Big Six (numbers three and four) come from the Sarah's RWP Scale: Trust and Sexual Satisfaction. Figure 5.3 presents Tom and Sarah's Initial RWP scores.

These two graphs complete the Big Six or major problem overview for Tom and Sarah, telling us that they are most troubled at this moment individually, but that relationship problems are the other area in which they are struggling. In working with Tom and Sarah, the therapist showed them the Initial Feedback Report in the second session. In the first session, Sarah linked her depression and suicidal thoughts to a recent crisis in their marriage that had to do with a trust rupture. Tom said that he had always had terrible trouble expressing his thoughts and feelings and that the trust rupture had to do with confiding in their adult daughter that he was unhappy in the marriage. Their daughter had come to Sarah and told her about Tom's unhappiness and Sarah felt very betrayed that he had not spoken directly to her. Sarah and Tom agreed that his difficulty expressing himself directly to the person that he was angry at or displeased with was a major problem for him and their relationship. They also agreed that his communication with their daughter behind Sarah's back was very disturbing, if not traumatic to Sarah. As Sarah looked at the graphs in the second session, she started talking about how violated she felt about Tom's failure to be honest with her and also about the fact that he was unhappy with her. She said that she also felt that he had withdrawn from her sexually in the recent months and that had left her feeling even more abandoned. In

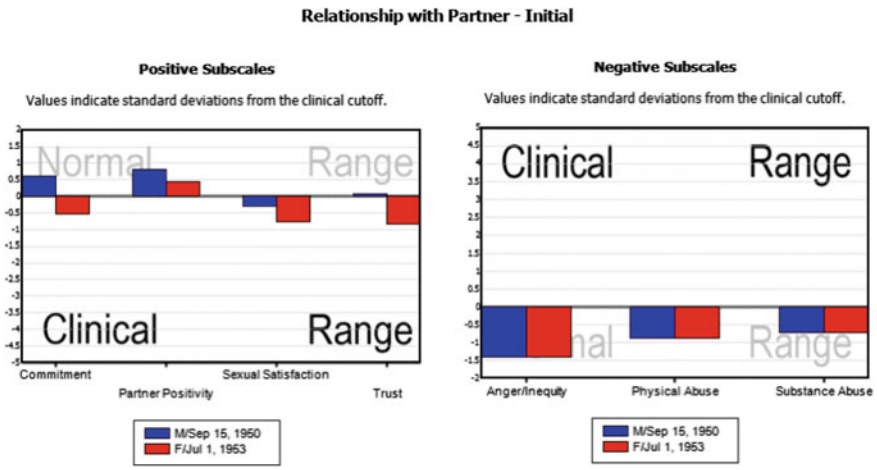

Fig. 5.3 Tom and Sarah's Initial STIC Relationship with Partner (RWP) Scores

talking about what should be addressed, Tom and Sarah both felt that his lack of honesty and openness was the biggest problem that had created this crisis, and that his marital unhappiness also needed to be addressed. They both acknowledged that the covert communication with the daughter had left Sarah feeling great disappointment and despair, and that those feelings needed to be addressed as well. The conversation with the therapist used their descriptions of their problems from the first session with their STIC data to weave an empirically informed problem narrative in their second session.

Creating an Empirically Informed Intervention Plan—What to Address When?

After creating an empirically informed problem narrative, the next step delineates an empirically informed intervention plan. In the last half of the second session, the therapist moved from problem description to intervention planning. Sarah and Tom felt that Sarah needed to talk to Tom about the trauma of his betrayal and he needed to understand and take responsibility for it. This would entail Sarah talking and Tom listening openly and non-defensively. Ideally, this work might alleviate her depression and begin restoring trust. Next, Tom would need to address the factors in himself and his marriage that prevent him from expressing feelings honestly and directly. Tom acknowledged this had been a problem for him and that it had more to do with himself than his relationship with Sarah. Tom, Sarah, and the therapist discussed that perhaps Tom should pursue individual therapy for this problem, but everyone thought it best to do the work with Sarah. If that did not work, it could be

pursued in individually. They also agreed that pursuing the sexual problems should wait until Sarah's depression and anxiety diminished and some trust had been restored in their relationship.

Empirically Informed Progress Evaluation

As well as using STIC data to inform assessment of the system and the planning of therapy, STIC Intersession data can inform progress evaluation and, and if necessary and appropriate, the replanning of therapy. Figures 5.4 and 5.5 present Intersession data for Tom and Sarah from their 11th session. On IPS (Fig. 5.4), Sarah's Negative Affect has gone into the normal range and Tom's Open Expression has improved significantly. Also, not surprisingly, Tom's Self-Misunderstanding has increased, which reflects his growing curiosity and appreciation of his lack of understanding about himself. This is an example of how on certain subscales (e.g., Self-Misunderstanding), getting worse actually reflects progress, a not uncommon finding. When shown these data, Tom commented that he felt he had just begun to understand himself and why he did what he did.

In seeing his improvement on Self-Expression, Tom acknowledged that, while he was more comfortable being himself, he still found it hard to express anger or critical feelings to Sarah (or anybody else for that matter). That led into a conversation about his catastrophic expectations about what would happen if he got angry at Sarah. Initially, he said that he was afraid she would fall apart. The therapist encouraged him to check that out with her, to which she replied: "You

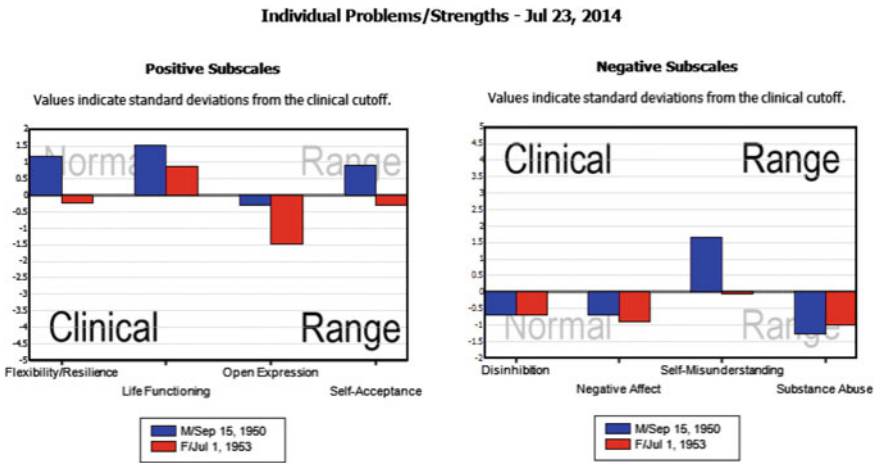

Fig. 5.4 Tom and Sarah's IPS Intersession Data from their 11th session

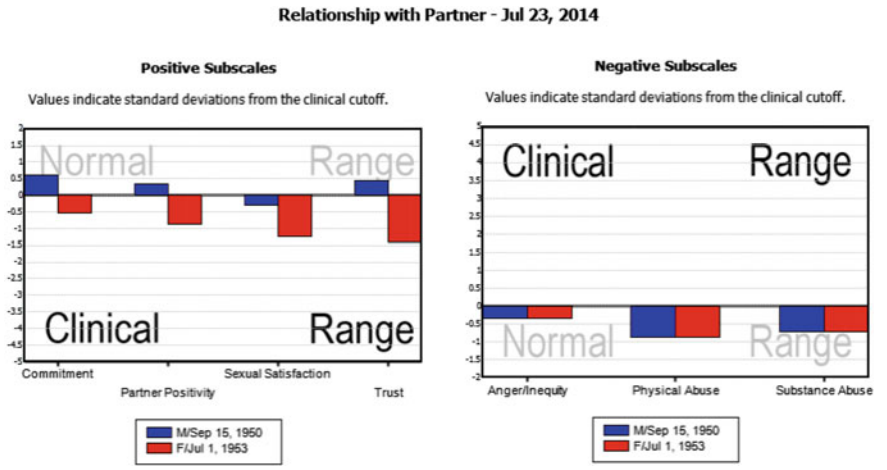

Fig. 5.5 Tom and Sarah's RWP Intersession Data from their 11th session

don't have to worry about me falling apart. I might get defensive, but I'd much rather have your anger at me out there than you talking to other people about me." At that point, Tom said: "I don't really get angry at anybody. I hate getting angry at people. My dad was a scary screamer, angry all the time."

This led the therapist to ask Tom about his relationship with his father, which ended with Tom saying that at the age of 14 he decided that he would do everything he could to never be like his dad. This led into a conversation about how Tom had cut off his awareness and expression of anger as a way to reject and differentiate himself from his father, but that maybe he had "thrown out the baby with the bath water." The conversation turned to the destructive versus the constructive use of anger, as opposed to getting rid of anger altogether. Sarah even said, "I want you to get angry at me. I'd prefer that to the alternative." All three agreed that Tom would try before the next session to be aware of his anger and to express it in a non-destructive way to Sarah.

Before the next session, the therapist saw each of their Feedback Reports. Tom's Anger/Inequity on RWP had gone a standard deviation into the clinical range (another "deterioration" that is a sign of progress) and his Open Expression went into the normal range. Interestingly, Sarah's trust and commitment both improved significantly as well. In the session, the therapist commented on these changes and briefly showed them their data. Sarah's commented, "He did his homework. He got angry at me about how I came home from work in a bad mood and yelled at him. He told me that it pissed him off and wasn't fair. I told him you're right and told him about my problems with a colleague at work. I felt closer to him because he got angry, we talked about it and then he really listened to me."

Collaborative, Empirically Informed Termination Assessment/Planning

Tom and Sarah continued their progress. The more expressive he became to her (including anger), the safer she felt. Without even addressing the sexual intimacy, their Sexual Satisfaction Score on RWP for both went into the normal range, reflecting their sexual reconnection. After several sessions of continued progress and consolidation of the changes, Tom and Sarah found that they did not have that much to talk about in their sessions, because they were now talking about their issues with each other outside of therapy. Most of their clinical subscales at the beginning of therapy were now either in or approaching the normal range. After the therapist showed them their STIC progress and discussed his sense of increasing superfluousness, Sarah and Tom both said, "maybe we should stop for now—we are in the best shape we've ever been in." The therapist said that he agreed with them, they had made great progress, and that his sense was that their relationship was now stronger than it had ever been. "You're more honest with each other, more direct and much more connected. It is a pleasure to see the two of you together." Sarah said that their daughter even said their relationship seemed much better and that they had made lemonade out of lemons. Tom, Sarah, and the therapist agreed to one more session, a check-up, six weeks down the line. If the gains were persisting and they were still connected, it might then be time to end this episode of therapy.

At that check-up session, Tom reported that in the past six weeks they had had several fights and that after each one they felt closer and more connected. He said that he really understood the difference between good and bad anger and that he felt that he could be "good angry" with Sarah and she loved him (not necessarily at the moment) more for it. Sarah said that she felt more trusting and committed to Tom and their marriage after this crisis than before. It had made them stronger. The therapist verified and supported their progress and desire to stop for now. As they left the session, he assured them that if they got in trouble in the future, his door would always be open to them. Tom and Sarah hugged him as they walked out the door.

Empirically Informed Multi-systemic Therapy

The story of Tom and Sarah's therapy illustrates the use of the STIC as a clinical tool to empirically inform assessment, treatment planning, progress evaluation, and termination decision-making. The STIC data are used collaboratively to inform, but not dominate the therapeutic process. The use of scientific data in this way creates a new form of therapy that continually integrates scientific data from the beginning to the end of therapy. The fact that the STIC is multi-systemic ensures that each client's experience is seen, addressed, and integrated into the decision-making process that plays out between and within the clients and the therapist. That the

STIC is a client-focused, as opposed to a therapist-focused measurement and feedback system, reflects its prioritizing of client experience (quantitative and qualitative) as "the bottom line" of therapy.

The Clinical-Research Loop

The description of the clinical use of the STIC, presented above, constitutes what we consider to be the optimal use of the STIC as a clinical tool. We believe (hypothesize) that using the STIC in this way improves both the efficiency and effectiveness of the therapy. Toward that end, we are in the process, at the time of this writing, of concluding a four year randomized clinical trial (RCT) in Chicago and Norway, comparing cases in which therapists use the STIC as a clinical tool versus cases in which the same therapists do not use any form of feedback. The study looks at individual and couple therapy and uses (along with the STIC Initial) a set of gold-standard measures (described in Zinbarg et al., in press) to assess outcome for both groups. All cases are randomly assigned to one of the two treatment groups. The same groups of therapists work in both treatment groups. The results of this study should be available in the coming years. This RCT illustrates the confluence of the clinical and research use of the STIC.

The STIC System as a Comprehensive Clinical and Research Tool

This chapter has illustrated how the STIC system can be used as a valid and reliable research tool to illuminate the change process and evaluate therapy. It has also shown how the STIC system can be used as a clinically meaningful tool to facilitate empirically informed collaboration between therapists and clients over the entire course of therapy. It also illustrates how a multi-systemic and multi-dimensional instrument can be used to inform and study family, couple, and individual therapies. No longer do therapists and clients have to rely on empirically supported manualized therapies that were validated in a laboratory and then prescribed as "best practice." With comprehensive systems like the STIC, they can bring science into practice in a way that enhances their creativity and collaboration and makes their clients stronger and more confident in the process.

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Chapter 6
The Norwegian Directorate for Children, Youth and Family Affairs' Efforts to Implement Feedback in Routine Couple and Family Therapy

Marianne Bie

Introduction

The Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) was established in 2004. The Family Counselling Services (FCS "Familievernkontorene")[1] had until then been organized alternately in municipalities and counties but is now state-run or organized in a Church foundation and directed under this Directorate. FCS is an important part of Norwegian family policy and financed by the Norwegian Federal Government. This means that the FCS—as typical in the Scandinavian welfare state model—is a public service financed by taxes so that clients can get help free of charge. Clients make direct contact for appointments with FCS without referrals, and the services do not involve the use of psychiatric diagnoses. The services are intended to be both preventive and to help in conflicts. FCS offers services such as couple workshops, parent counseling, couples' therapy and family therapy, and mediation. FCS meets with people in all phases of family life from childhood to old age who present with a variety of concerns or problems. Parents with children are prioritized, especially with respect to children's situation in families with conflicts and violence. The FCS offer mediation by law to all couples who break up with children under the age of 16 years (see also http://www.bufdir.no/en/English_start_page/).

I will in this chapter share the Bufdir's experiences of implementing feedback in routine couple and family therapy. By the time the implementation started, there were fifty-one FCS offices. Today, as a result of organizational changes, some FCS

[1]"FCS" refers to the total service and "mother organization," while "FCS offices" refer to the single offices throughout Norway.

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offices have merged into larger units and today forty-two FCS offices are situated in five regions and are located in towns or cities throughout Norway. There are about 400 therapists in FCS, including psychologists, social workers, and health providers with family therapy training. Altogether, services include 30,000 clinical cases and over 100,000 clinical consultations every year.

Before 2004, FCS had been characterized by a certain degree of self-determination and low degree of public governance. The FCS Regional Directors were aware of the need to document the quality of services to ensure adequate and continued funding (Skauli 2009). At the same time, Government's Proposition No. 1 in 2005–2006 mandated a project for user-oriented quality improvement:

> The most important quality criterion for FCS is that the users are satisfied with the service. Bufdir will develop a system of quality assurance and quality improvement for family counselling with emphasis on the user perspective. The aim is to arrive at a system, which after testing may be of general application in the service.
>
> (St.prp.nr.1. 2005–2006, Barne-, og familiedepartementet p. 53, Barne-, ungdoms- og familiedirektoratet 2010.)

This resulted in a developmental project encouraging FCS offices to try out various kinds of user involvement before choosing one system for FCS. The objective in this project was to select a quality system that could be integrated into the daily work and that could provide a basis for measuring the quality of the service. In particular, "quality" should be measured from the clients' point of view according to the principles of user involvement. And the services were urged to develop or choose a feedback system that enabled the therapists on a regular basis to learn about the progress and process of therapy. Consequently, the project "User-oriented quality development" was initiated in 2010. This project was part of Bufdir's long-term strategy for developing and implementing the services and products based on the best available knowledge.

The process leading to this decision was organized in two phases. The first phase involved the establishment of the status of knowledge. The guidance to this development was that the system should be used routinely without interfering too much with the therapeutic practice, and it had to be convenient to use and not time-consuming (Skauli 2009). Through meetings and via responding to a questionnaire, all FCS offices had the opportunity to give input to the development based on their local experiences. The second phase involved getting an overview of the available client feedback systems as a basis for which to choose. In order to have a bottom-up process, the FCS offices were invited to search for available feedback systems and were encouraged to try them out in their units. One feedback system (the ORS/SRS—Duncan et al. 2003; Miller et al. 2003, as presented below) was already being used for training and was being assessed at some FCS offices (e.g., Vestfold) since about 2001.

Evidence-Based Practice in FCS

As part of establishing the status of knowledge, a literature review of research on couples' therapy was carried out (Skauli 2009) and it was concluded that to improve quality of clinical work with couples and families, frequent monitoring by the client was recommended to be the most promising method.

"The Norwegian Study"

Simultaneously, one of the psychologists at a FCS office, Morten Anker, conducted an RCT in a naturalistic setting, focusing on outcome and feedback processes. This trial included 250 couples and investigated the effect of feedback on couples' outcomes at two FCS offices by providing feedback with Outcome Rating Scale (ORS) and Session Rating Scale (SRS) (Duncan et al. 2003; Miller et al. 2003) versus treatment as usual (TAU) (Anker 2010). The couples in the feedback condition achieved nearly four times the rate of clinically significant change and maintained the differential effects at follow-up, including a 46% lower marital separation rate compared to the TAU group (Anker 2010).

Decision to Implement KOR in All FCS Offices

[2]The promising results of Anker's RCT study and the results of the developmental project made it clear that in order to frequently monitor all clients in FCS, the measurements had to be valid and easy to use for the clients and for the follow-up by the therapists. The leader team in Bufdir made a decision in 2008 to implement ORS and SRS as the feedback system for FCS. To understand the Norwegian term "KOR," the American term PCOMS will be presented below.

PCOMS, the Measures ORS and SRS, and the Norwegian Term KOR

The Partners for Change Outcome Management System (PCOMS) (see also http://www.pcoms.com/about-us) is a client feedback program for improving the treatment outcomes of adults and children participating in a behavioral healthcare intervention (see also Chap. 7 for more information). PCOMS is designed to

[2]KOR is the Norwegian acronym for SRS and ORS.

improve the retention of participants in treatment and to assist them in reaching reliable and clinically significant change. PCOMS, which is integrated into each treatment session, consists of two brief scales that measure robust predictors of therapeutic success:

- The ORS, which assesses the client's therapeutic progress (through ratings of psychological functioning and distress) and the client's perceived benefit of treatment.
- The SRS, which assesses the client's perception of the client–therapist alliance (i.e., the quality of the relational bond with the therapist and whether the therapist shares his or her goals and means).

The ORS and SRS were designed to be simple to use instruments (Duncan et al. 2003; Miller et al. 2003). Each of the instruments contains of four items, which are rated using a 10-cm visual analog scale (see Fig. 6.1). There are also ORS and SRS adapted for children, called Children Outcome Rating Scales (CORS) and Children Session Rating Scales (CSRS), and for the very small children, the instruments are called Young Children Outcome Rating Scale (YCORS) and Young Children Session Rating Scale (YCSRS). The children's CORS and CSRS show a grumpy face on one extreme, a smiley face on the other. In the use of YCORS/YCSRS, the small children can choose from a sheet with four faces that fits best to their experience, or draw a face by themselves. These cannot be measured, but it gives the youngest children an opportunity to participate and give their opinion together with their family. In Norway, the acronym KOR is the term used for the system PCOMS, including the ORS and SRS and the way of using them. In this chapter, KOR also includes CORS/YCORS and CSRS/YCSRS.

The scales are available for downloading from www.heartandsoulofchange.com and http://scott-d-miller-ph-d.myshopify.com/collections/performance-metrics/products/performance-metrics-licenses-for-the-ors-and-srs.

The therapist administers the ORS at the beginning of each treatment session, and the SRS is administered toward the end of the session. Client ratings for both measures are discussed on a session-by-session basis to maintain the client's engagement in treatment, to optimize the client–therapist alliance, and to provide a means for transitioning into the treatment session by focusing on client-identified concerns. If client ratings indicate no improvement or poor alliance, the therapist may choose to modify the type and amount of treatment. By measuring the client's scores and filling manually into a graph or into a data system, as described later in this chapter, the therapist gets visual views of the clients' subjective consideration of change. When using a data system, this provides feedback messages from the algorithms in the electronic program. This feedback can be used by the therapists to study development of their own cases, as well as pointing to which skills the therapists should pay more attention to develop.

PCOMS is approved by the American registry SAMSHA as an evidence-based method (NREPP, SAMHSA's National Registry of Evidence-based Programs and Practices http://legacy.nreppadmin.net/ViewIntervention.aspx?id=249).

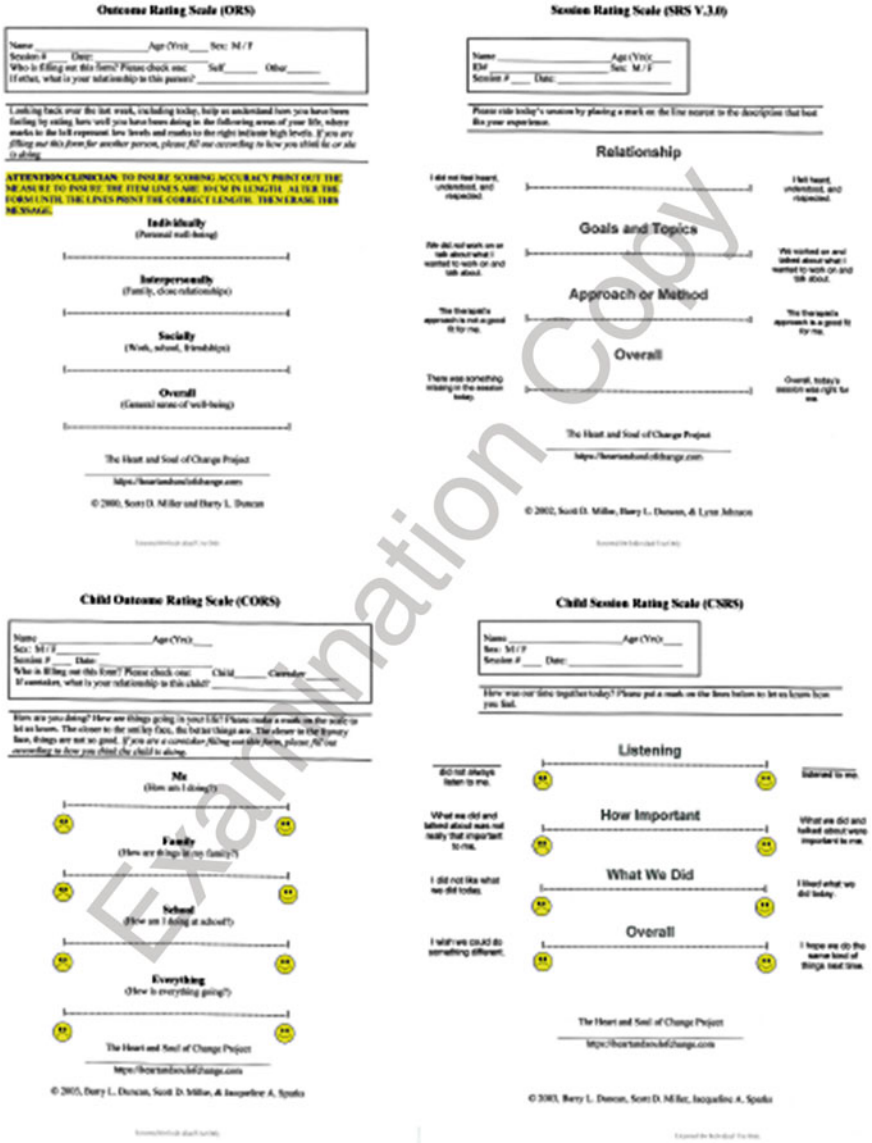

Fig. 6.1 The ORS and SRS versions

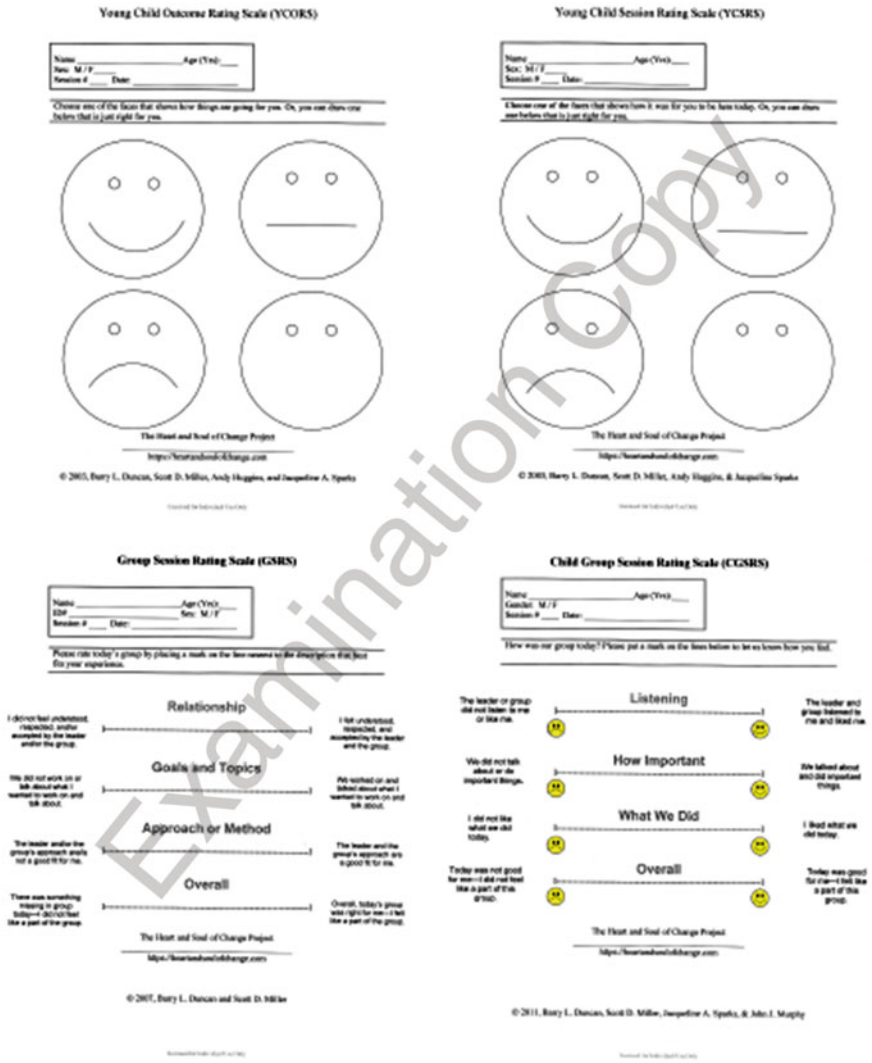

Fig. 6.1 (continued)

Clinical Cutoff of the ORS

Duncan et al. (2003) determined the clinical cutoff of ORS to be 25 for grown up people based on a quite large sample of $N = 34{,}790$. These authors have reported that between 25 and 30% of clients at treatment intake present scores above the clinical cutoff, meaning that they are in a non-clinical range at the start of treatment. The clinical cutoff for younger clients (aged 13–18 years) is set to be 28, and for

children (aged 6–12 years), the cutoff is 32. Putting each session's score into a graph enables tracking a trajectory of the clients' subjective experience of change throughout treatment. Based on 300,000 clients Duncan et al. (2003) produced algorithms capable of plotting an average trajectory of change over time based on the initial score on the measure. This means that a computer-generated "expected treatment response" (ETR) trajectory can be calculated based on the intake score, something that gives the therapist an indication of the predicted course of treatment with this client. Clients who show a prediction of "no change" or "deterioration" should in particular make the therapist aware. When treatment is successful, the ORS scores should increase over time. An increase in total score at the ORS of at least five points indicates reliable change (RCI).

Electronic Systems for Administering and Scoring the KOR Measures

A critical implementation success criterion was making use of an electronic analytic tool to process the KOR data and to get feedback messages to the therapists based on algorithms (for algorithms, see https://heartandsoulofchange.com/content/resources/viewer.php?resource=blog&id=81), something that contributes to documentation and overview for the therapists. Today, there are several available electronic systems that enable the client to complete the KOR on a computer, tablet, or smart phone (e.g., My Outcomes, Fit Outcomes, Open fit, Better Outcomes, CheckWare). When Bufdir started the implementation in 2009, there were just a few such electronic systems available. Bufdir bought licenses for a system called "My Outcomes" for registration of the scores, but the clients still had to complete KOR in paper versions. The therapists used a ruler to measure change in centimeters and millimeters and then registered the scores in the electronic My Outcomes system. At that time (2009), My Outcomes had some weaknesses, which have been addressed. The next step for Bufdir started in 2011 to establish an electronic system based on KOR to be integrated in the FCS journal system. This electronic system will be used to collecting and systemizing important clinical data, e.g., to aggregate trajectories demonstrating client's view of personal change.

Feedback to the therapists may include information that is clinically very relevant. This will in particular be the case when feedback indicates that therapy improvement is lacking, implying that the therapist needs to assess adjustments in the treatment approach. Frequent use of KOR data constitutes a tool for the therapist to monitor the development on progress and process in his/hers own clinical cases. A likely consequence of this way of collecting data is to help therapists and practitioners in general to improving their professional skills. All the analytic systems allow the user to aggregate the data by clinician or service levels for the

purpose of analysis and interpretation of the data in greater detail. The reporting options enable the clinicians and administrators to determine the effectiveness of their services compared to an international normative database and further compare the outcomes of therapists, treatment programs, and agencies (see also http://www.scottdmiller.com/fit-software-tools/). Bufdir has chosen an online system that can be accessed via laptops and tablets making it very convenient to capture scores from clients in the session, chart the results, and review with clients their scores compared to previous scores and ETRs. This system allows the user to chart and receive feedback regarding the progress of individuals, couples, families, and groups.

The Validation of ORS and SRS

An increasing body of research worldwide has contributed to validating ORS and SRS.

Studies have shown that the ORS/SRS measures are valid, reliable, feasible, and sensitive to change (Janse et al. 2014). Clinically, research shows that routine use of the ORS and SRS in treatment is associated with improved outcome, reduced dropout rates, and decreased the cost of and time spent in therapy (Anker et al. 2009; Miller et al. 2006; Reese et al. 2009). There is an ongoing project validating CORS and CSRS on Scandinavian data in addition to the general international validation (Miller et al. in preparation).

Implementation

Implementing KOR in the FCS: Model and Pilot Project

As mentioned previously, the leader team in Bufdir made a decision in 2008 to implement KOR. This was realized through an implementation model providing support, skill building, training, and supervision to build competence within the FCS. In order to implement KOR in a large organization such as Bufdir, it was of importance to have enough human competence and economic resources. Based on a statement in the Governmental Proportion, as referred to earlier, the project had high priority and hence sufficient resources were provided. The project leader of this implementation (identical with the author of this chapter) is situated at the central Bufdir administration in Oslo. Bufdir needed to have skilled persons to collaborate with the project leader in the role of council members and to teach and supervise. Clinical researcher Morten Anker and former project leader Geir Skauli were chosen to fill these roles, something that ensured competence and continuity. Barry Duncan contributed to training of trainers and in some of the skill-building conferences.

Pilot FCS Offices

Five FCS offices, one in each region of the country, volunteered to participate in the pilot project in 2009 (situated in Tromsø, Kristiansund, Bergen, Tønsberg, and Oslo regions). The strategy was to give the pilot FCS offices extra support for a period of nine months. Each FCS office chose one of their therapists as a coordinator, who would be available to support his/hers colleagues and help the leader of the FCS office in the implementation.

The Role of the Coordinator

The coordinators were supposed to keep close contact with the leader of the FCS office and have regular meetings related to the implementation. Coordinators would be instigators and inspirers of the KOR implementation in their FCS office. They were attending regular coordinator workshops and training conducted by Bufdir. Their tasks were to ensure that paper versions of the scales and materials were readily available for therapists. They were responsible for promoting use of the measures in relevant contexts at the FCS office. Further, they prepared training and supervision of therapists in groups and individually. Lastly, they were supposed to keep a log of experiences, questions, dilemmas, etc., and forward this to the project manager and coordinator meetings. In this way, the coordinators were also intended to build KOR competence in the organization.

Skill-Building Conferences

The support from Bufdir provided two days' skill-building conferences for all therapists and front-line personnel, and an extra day of skill building for leaders and coordinators, with a focus on implementation. Bufdir invited the leaders and coordinators to workshops three times during a period of nine months to discuss and share experiences from the implementation. These workshops turned out to be important in order to gather experiences and adjust the implementation.

Consultation

KOR seems simple and easy to use, but for the therapist to use the instruments without understanding the rationale may result in presenting KOR to the clients without a convincing enthusiasm. An important part of the implementation was therefore to offer enough support to the therapists to get started and to continue

integrating the scales into their own way of working with their clients. Bufdir organized consultation teams of two trainers with supervision competence to visit each FCS office three days during the nine month's implementation period. Consultation is a way to build clinical skills and insight and provides the opportunity to adopt new ways of working, to go slowly forward, and to receive feedback. In the pilot phase, some therapists responded rapidly and showed eagerness to use KOR. They were offered training and became supervisors for colleagues and others in the area. Their competence and eagerness have been extremely important for the implementation to succeed. By this model of implementation, there would be regular supervisions at each FCS office or workshop for coordinators and leaders every month. The aim was to keep the ideas warm and support the FCS office so that working with the scales became routine.

The evaluation of the pilot phase model was good, especially the use of coordinators to support the leader and colleagues in the implementation. The directors decided to use this model in further implementation. Because of the size of the organization and shortage of trainers and supervisors, Bufdir planned to carry out the implementation through four phases over three more years. New trainers from the FCS offices were trained at five-day workshops and contributed to the next steps of the implementation.

The Four Phases of the Implementation from 2009 to 2012

The implementation of KOR was carried through in four phases and started in 2009 with a pilot phase including the five first FCS offices that had volunteered and were eager to participate. The second phase started in 2010 with training of eleven FCS offices, followed by the third phase in 2011 with training of eleven new FCS offices. Finally, in 2012, the remaining nineteen FCS offices started training. During this period, Bufdir arranged six 2-day skill-building conferences for about 400 therapists, three 5-day "training of trainers" (TOT) for trainers and supervisors, educated 16 supervisors, trained 53 coordinators, arranged 24 leader and coordinator meetings, and gave about 150 supervision days to the agencies.

KOR Supervision

[3]KOR supervision is a meta-theoretical approach. Traditionally, supervisors are guided by a particular treatment model or theoretical orientation. KOR supervision is guided by outcome and alliance feedback provided by clients (ICCE 2012).

[3]Supervision is used here as a term for both supervision and consultation. According to KOR, we did supervision in order to teach/train/inspire in a new way of working. After a while, KOR would

The supervision consisted of three levels:

Level 1: When organizations are implementing the scales as a routine, it gives the therapists direct client guidance in all kinds of cases.
Level 2: The electronic system remarks feedback messages with advice to the therapist to help the therapist to get aware of risk cases.
Level 3: The development in the cases shown by the scores gives the therapists and teams a more systematically way to choose cases for supervision.

Implementing an Electronic System

From 2014, the work started to prepare implementation of the new electronic system in the FCS electronic journal system. The Norwegian company CheckWare was chosen to deliver the system. There are strict rules in Norway to collect, store, and send sensitive data. In order to take care of this aspect, a risk and vulnerability analysis had to be conducted by an external company with expertise on this area. The solution turned out to be challenging both technically to get different data systems to communicate and in regard to clients' security, storage of, and access to the data. Our experience was that dialogue and discussions with experts involved led to new knowledge and helped achieving a better electronic system. The full benefit of the implementation will not be achieved until this is accomplished. It seems reasonable to believe that the online system will be available, tested, and approved by December 2016.

In the long-lasting process of KOR implementation, we realize that the establishment of this important electronic system has turned out to be the Achilles heel for the whole Bufdir organization. Problems with getting an updated electronic system (licenses, economy, and time) have slowed down the implementation process. When the system is ready for use in 2017, we therefore need to repeat and renew parts of the implementation. This is needed partly due to natural turnover; therapists, coordinators, and leaders have changed throughout the organization during the years of implementation. Hence, new therapists need to be trained and new trainers have to be educated. Like all organization developmental processes, implementation is not done without the implementers continuously being aware and caretaking of the ongoing processes, as well as their readiness to give support where it is needed.

(Footnote 3 continued)

be a part of clinical consultation. Clinical consultation is obtained when the therapists bring the ORS and SRS graphs and messages together with their clinical cases to an external supervisor or to a discussion in the treatment team.

Positive Experiences

Implementing KOR in the organization has led to new clinical experiences and a greater awareness of client factors and feedback in change work. Therapists experienced the use of feedback as a tool for their own development as they attempt to become a more effective therapist. Through the use of feedback, the organization is about to get a system for documentation of the client's experience of change in the FCS. KOR has been used in couples' therapy, family therapy with children, and individual therapy, with children, youth, or grown-ups. Using KOR with children and young people (CORS and CSRS) is experienced as fun and very useful. Children and young persons might have difficulties to express their feelings with words in therapy. The scales therefore help children to express themselves beyond words and thereby sharing experiences with their parents. When the children have scored themselves, therapist and parents help the child by verbally investigating the content of the score and putting words to the experience. In this way, the measures contribute to developing supportive dialogues (Bie 2007). When using KOR in family therapy, the therapist asks the parents to score the children, as the children scores for themselves. Looking together with the therapist on the scores afterward gives an opportunity to systemic conversations and coherence for the child. When the therapist investigates the scores, the history behind and the differences in view between the child and the parents is coming forward. We experienced that even children who did not utter a word during the session expressed their distress through scoring the CORS (Bie 2007). Other children were eager to show their experiences on the paper scale and added drawings explaining and symbolizing their feelings. The children in general found it easier to talk about the mark on the CORS and point at the paper than answering questions about their distress. In this way, CORS became a new way of having conversations with children. By using KOR, the therapists get help to follow the client's progress and to terminate therapy when obtaining reliable and stable change.

In parent-cooperation cases, we experience KOR to be useful as a means to focus on the child's needs rather than the parent's disagreements. In couple therapy, it occurs to be useful to have a visual curve showing development from session to session. The therapist will thus be aware of change (or lack of change) and has the opportunity to do something different. Clients in general accept easily the reasons for using KOR, and few clients have objections filling out the scales. If they have objections and doubts using KOR, the user perspective is paramount and the therapist will not use the KOR with the client. However, mostly the clients express appreciation for the opportunity to give feedback and have influence over the service given.

Objections from the Clinicians

Change is more often than not challenging in an organization, even though change is considered as necessary for obtaining development and solving new tasks for the future. During the implementation, we ran into objections and protests from the therapists. Most typical was that objections and protests came before the therapists had tried using KOR with their clients. We made efforts to get the therapists to start using KOR by the mottos "Just do it," "Do it simple," and "Do it in your own way." There was always a space for listening to the objections and addressing them at skill-building conferences and in consultation. We experienced such discussions addressing the benefits in the use of outcome and feedback processes as important in the process of integrating KOR as part of clinical practice.

In the following, some of the objections that we met during the implementation are presented briefly:

> "Using ORS disturbs my way of starting a therapy session." "The paper comes between me and the client." "It doesn't feel right to use a ruler in the sessions."

These objections are about disrupting therapy in the way comfortable to the therapist. Using scales and a ruler has not been a part of his/her way of being a therapist and it requires ability to adjust and include a new way of working.

> "I doubt as to whether ORS is suitable to cases involving violence, grief, severe drug abuse or with psychiatric cases."

Situations like this are addressed in consultation by showing examples and focusing on the clinical autonomy in the actual case. When clients meet us overwhelmed by feelings and severe experiences, they first and foremost need to be listened to and met in a human way.

> "Can my results be unfavorable to me or used against me by my manager?"

> "Is this a part of New Public Management?"

> "How will the data be used?" "Who will have access to my data?"

These are important questions in order to feel comfortable using KOR, and for the organization to be reliable and have secure routines for handling sensitive data. We meet these questions in consultation, followed by showing and explaining how this will be handled in the data system, for instance the possibility to follow one's own development as therapist without having any access to other therapists' data. The risks are identified and assessed in the "Risk and vulnerability analysis" and efforts to secure misuse are taken through a secure login procedure for the clients and strict access to identifiable data in the journal system. The data are secured by guidelines so that they are not to be misused as a tool for public management connected to individual therapists.

> "KOR gives me nothing new. I am already asking about change and how we work together. How then can KOR help me develop myself as a therapist?"

This question can be answered by referring to research showing that the same therapist had better results using KOR, compared to treatment as usual (Anker 2010). When Anker asked the therapists prior to presenting these results, the therapists did not believe there was any effect for using feedback. Hence, research strengthens the arguments that FCS should continue working in a client directed and collaborative manner by the use of KOR.

Problems and Challenges that Occurred in the Implementation Process

When looking back at the implementation process, there are matters we would have done differently if we could start all over again. We were aware of the need for support from leaders at all levels, and we assumed that decisions in Directors' meeting in Bufdir would make the leaders obliged to lead the processes in their own units. This did not happen for all units. Some leaders and even Area Directors chose, for different reasons, to cancel participation in trainings and consultations. This created an uncertainty within the organization and with the therapists and made space for protests and resistance in using KOR. Other leaders took leadership at once and said: "We are going to do this, we start at once and we are going to be really good doing this." The result was that in their FCS offices, everyone uses KOR regularly.

From 2009 until present, the natural turnover of therapists as well as leaders and directors has been an implementation challenge. Turnover in management has been particularly challenging as the top leaders in Bufdir have changed once, the department leader in the Directorate has changed four times, and leaders for the section responsible for the implementation have changed five times. In addition, there have been changes in organizational structures. Sections in Bufdir have been divided, FCS offices have been merged into larger units and new leaders have taken over at the FCS offices. The decision to implement KOR has been inherited and is an example of how organizations go on more or less independent of who is in charge. However, this continuity may have been possible due to that I as a project leader and the regional resource persons carried on with the implementation processes, believing in the ideas of KOR.

In advance, before starting using KOR with clients, several therapists imagined of how uncomfortable they would be using the measures. We experienced, however, that the hardest step was getting started, to do the introduction for the first time, helping the therapists to make clinical use of KOR. Then, it happened that the therapist was surprised by the feedback and became curious. Chow (personal communication, April 15, 2013) found that the number of times the therapist was surprised by the client's feedback was a significant predictor for change. He found that qualities such as openness, receptivity, and willingness to receive a variety of feedback influenced the client's outcome. Our experiences are in agreement with

Chow's findings. The therapists' experience of being surprised seems to be important in order to be motivated for using KOR.

The Importance of Adequate KOR Introduction

We became increasingly aware of the importance of how the scales were introduced in order to get a good feedback process. This led to rehearsal in training situations, and we discovered that small nuances were of great importance. First and foremost, the therapist had to be convincing that he/she really wanted feedback and help from the client both in ORS and in SRS. The therapists discovered that both negative and positive feedbacks were gifts.

Clinical Autonomy Versus User Involvement

When the State is introducing a way of working which interferes with clinical practice, therapists may feel their clinical autonomy threatened (Ekeland et al. 2014). This is also addressed by Utvåg et al. (2014) who in particular discuss how the professional's fears of reduced clinical autonomy lead to objections and protests. However, these authors address that the field is also characterized by the strong position of user involvement regulated by law and professional guidelines. In this way, implementing KOR addresses the question of power and influence in therapy. The therapist's objections against implementing KOR seem to oversee that one of the main objectives for the State's decision to make use of the KOR within FCS was the emphasis on the user perspective, giving more power to the weakest part, namely the client (see also Chap. 8). In their early works, Duncan et al. (1997) refer to this as the therapist "Stepping off the Throne." They highlight the importance of the clients' own theory of change in order to obtain lasting change. Hence, in order to strengthening the client's positions, the therapist needs to step down from the expert position and give more power to the client.

Looking into the Mirror of Implementation Research

The term "Implementation" was introduced by Rogers in 2003 (Sørlie et al. 2010). Rogers confirmed that not all practitioners are equally interested in taking innovations in use. While some are early out (early adopters), others (late adopters) adopt one more hesitant attitude and first change practice when innovation has been recognized and widespread. There are also practitioners who reject new methods (refusers) even though many others have taken them into use (Sørlie et al. 2010).

Through our implementation, we have realized that open dialogues with both clients and therapists are of crucial importance. The implementers' ability to listen in order to understand drives the implementation on. The therapist's objections must not be viewed as resistance, but as a protest in order to understand and be sure of the quality of new ideas (Sundet 2014). This demands patience and "stayer" ability from the people involved.

Implementation consists of systematic work for practical developmental or execution of an intervention with known dimensions. Implementation is the link between research and practical training (Sørlie et al. 2010; Tilden et al. 2015). For developmental work, interactions must go in both directions in order to inform practice by research and research by practical experiences.

Lessons Learned

Implementing KOR in FCS has so far lasted for seven years. Looking back to the beginning in 2009, it is clear that we were not prepared for such a long-lasting process and the challenges which occurred. For organizations that want to implement KOR, we specially recommend to be aware of the time it takes. Another important issue is obliging leaders at all levels through the control line in the organization. A high competence by the project leaders on clinical research and practice concerning outcome and feedback should be valued. The implementation includes developmental work and to choose crossroads, and as such, it has contributed to organizational development. We have had the opportunity to participate in inspiring and supportive national and international networks addressing outcome and feedback in psychotherapy. Barry Duncan and Scott Miller have been available for discussions, training, and supervision, something that has meant a lot when standing in a long-lasting and challenging process. We have experienced that starting the implementation through volunteers is important and that skill-building conferences, research, and sharing ideas need to be an ongoing process. We still think the project model is good for our mission. And as such, we realize that KOR implementation is not over with, but elements of it need to be part of a rather long-lasting process.

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Chapter 7
Feedback as Means to Enhance Client–Therapist Interaction in Therapy

Rolf Sundet

Introduction

The treatment context of this chapter is the Family Team at the Department of Mental Health for Children and Adolescents, Hospital of Drammen in Norway. Originally called the Family Unit, the current Family Team is part of the Ambulant Family Section at this hospital department. In 2002, we started to use two simple measures of outcome and process: Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) (Duncan and Miller 2000). The background for starting to use these measures was found in the following: (a) The rationale for using measures of outcome and process as a way of supplying feedback to therapists fitted with some central ideas of the Family Team (that of following the perspectives, ideas, and preferences of the family in building a tailored therapy) and (b) as a response to the growing demand from both service user organizations and Norwegian Health authorities for creating an accountable practice.

When we started, we did not have a very explicit and well-formulated plan for the use of these measures. It was more a project characterized by the idea that "the road is built while walking." Fifteen years later, we can look back and present central experiences and ways of working with service user feedback. These 15 years can be divided into three different periods. The first was a period of getting to know these measures and how we could use them. The forms of practices and ideas of use that developed during this period were more or less implicit and unformulated. After four years, the author was given the opportunity to pursue a Ph.D., which involved a qualitative study of the therapeutic practices of the Family Unit, including studying

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the use of ORS and SRS, constituting the second period. Finishing the Ph.D. in 2009 Sundet (2009) led to the commencement of the final period, now with increased understanding and evaluations of the use of ORS and SRS. The following years have expanded our understanding and ideas about using outcome and process measures and what has become known as routine outcome monitoring (ROM) (Boswell et al. 2015) as a core aspect of the Family Team practice.

The ORS is used for monitoring the outcome of therapeutic work. In the understanding of the Family Team, outcome is defined as what is happening concerning the well-being, goals, and preferences of the service user. We want to ask the question, as a result of therapy, are there improvements in well-being and suffering from the service user's relationship perspective?

The SRS is used by the Family Team as a means following the recommendations of psychotherapy research and family therapy to track the development of therapeutic processes, especially the therapeutic alliance (Bordin 1979; Friedlander et al. 2011). The client is asked, "In our current meeting and session, have you been heard and respected? Are we working on the goals that you have specified, in a manner that is within your preferences? Overall, how was our meeting and session today?" These questions are important for the therapists because it appears that therapists are poor in predicting the progress and process of therapy (Walfish et al. 2012). However, feedback from the client to the therapist on these two scales can be a help for the therapists to be better oriented to the development in the service users' life and the effects of what one is doing together in therapy.

After a small detour through the history of the use of ORS and SRS in Norway, the first part of the chapter will present the main conclusion of the qualitative study done regarding the Family Team. Furthermore, inspired by the work of Barry L. Duncan and Scott D. Miller, a closer look at the Family Team's version of client-directed, outcome-informed (CDOI) therapy (Duncan and Miller 2000) will be presented, with a focus on the main experiences and understanding of our work with ORS and SRS. This will be done by looking separately at the "CD" and the "OI" of CDOI.[1] The aim is not to give an explication of the CDOI, as Duncan and Miller (2000) have discussed this way of working. Instead, it is the aim to explicate how we have come to understand CDOI, known as KOR in Norwegian, given our experiences of having made the ORS and the SRS central to our work. This part serves as a foundation for the last part of the chapter—what could be added to the client–therapist interaction that is facilitated by feedback. Attention will be given to the potentially novel aspects of this way of working. The importance of following the client and being challenged by data is suggested as being central to what could be seen as new.

[1]Thanks to Alicja Olkowska and Scott D. Miller for suggesting this distinction.

A Very Short History of the Introduction of Routine Outcome Monitoring and Service User Feedback in Norway

In the clinical domain within Mental Health Services in Norway, the dominant system of feedback has been what is known as CDOI, developed by Barry Duncan and Scott Miller (Duncan and Miller 2000), and built around ORS (Miller et al. 2003) and SRS (Duncan et al. 2003). Emanating from a student group attending an advanced family training program in Oslo, in the beginning of the new millennium, the use of OSR and SRS and the ideas of CDOI spread as a bottom-up process into more and more clinical organizations in the Norwegian mental health services. At one point, a network was set up as part of the Regional Centre of Children and Adolescents Mental Health, East and South, under the leadership of Anne-Grethe Tuseth. In this Norwegian context, a teaching program for implementing ORS and SRS was created, a manual was translated (Duncan and Sparks 2001) into Norwegian, a book was written (Ulvestad et al. 2007), and a DVD was produced with ideas and practices related to the use of OSR and SRS. After 2000, other feedback systems have been introduced in Norway, as this book shows and exemplifies (see Chaps. 5, 8, 9, 11, and 12). The focus of this chapter is the use of ORS and SRS and the practices, ideas, and perspectives that the Family Team now presents as content for CDOI. Much has been written on CDOI so the discussion here is abbreviated, but with a focus on our experience. The starting point for this is to summarize the findings from a study of our practices of ORS and SRS.

Client-Directed, Outcome-Informed Therapy in a Family Therapy Context

ORS and SRS are both one-page measures consisting of four items each in the form of 10-cm visual analogue scales. The ORS invites the service user to score and give feedback on the current feelings of the service user concerning her or his well-being (item 1), close relationships (item 2), work, school, and friendships (item 3) and the general sense of well-being (item 4). The paper-and-pencil version that the Family Team uses informs the clinicians on a session-to-session basis about the development of the therapeutic work. Scores are computed by simply applying a ruler and measuring each item marked from left to right with a maximum high level score of 10 and a minimum low level score of 0. Accordingly, the total possible score is 40, and the continuous development of the outcome of therapy is expressed by physically drawing a trajectory on a supplementary sheet of paper. Scores below 25 are seen as the range where a need for therapy is indicated. Clinically, significant change toward recovery is expressed by an increased score of more than five points; recovery is expressed by a movement from below 25 to above 25. Scoring within a range of five points of the initial score indicates that service user is not making

significant progress, and a decrease of more than five points from the initial score indicates deterioration (Miller et al. 2003).

The SRS, also composed of four visual analogue items and which is completed at the end of each session, was formed from Bordin's (1979) concept of the therapeutic alliance and invites the service user to assess and give feedback about the session. Item 1 invites evaluation of the emotional bond, while items 2 and 3 concern agreement on goals and methods. Item 4 invites the service users to score the overall experience of the session.

The Outcome Rating Scale and The Session Rating Scale as Conversational Tools

Sundet (2009) explored family therapy practices developed by the Family Team within the Department of Child and Adolescent Mental Health, Hospital of Drammen, Norway, with the aim of describing and better understanding these practices. The study was carried out in order to investigate the following research questions:

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

Four therapists and ten families were interviewed, and the interviews were analyzed using a modification of grounded theory. The analysis generated sets of categories specified by subcategories that supplied answers to the two research questions. The question of what comprises helpful therapy converged on three overarching concepts: the helpful conversation, the helpful participation, and the helpful relationship (Sundet 2011). The SRS and ORS were evaluated as feasible for clinical use, but involved difficulties that had to be attended to in the actual clinical situation.

ORS and SRS were described as conversational tools that gave rise to different conversational types and processes, an extension of their use beyond monitoring practice and supplying feedback on process and outcome (Sundet 2012, 2014). From the perspectives of the therapists, OSR and SRS opened up conversations that gave feedback on the outcome and process of therapy. In addition, there was added value in that these measures also allowed for conversations that created structure, for conversations characterized by the not-knowing position (Anderson 1997), for externalizing conversations (White 2007), and for conversations that brought forth a product or result (see Table 7.1).

From the families' perspectives, these measures also invited different conversational processes (see Table 7.2). They initiated *processes of communicating,*

Table 7.1 Therapist's perspective

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

Table 7.2 Family's perspective

To communicate	To focus	To structure	To explore
To express and tell	To visualize	To give direction to the work	To discover
To state areas of acceptance and change	To make distinct	To state thematic content	To deepen

inviting family members to express anything that came to mind and, more specifically, about areas of acceptance and change. With this, the ORS and SRS were confirmed to function in the expected manner, supplying feedback to therapists about the outcome and process of therapy. In addition, many family members reported situations in which they had difficulties verbally formulating why they had scored as they did. The score became a visualization of nonverbal impressions, and further discussion in therapy gave these responses verbal content. This was a *process of focusing* the therapeutic work, moving from nonverbal impressions to verbalization of important material for the family. Third, the different items on the SRS and ORS represented different directions in which the conversations and work could be moved. Through questions about the scores, a *process of structuring* was set up. Conversations about the scores gave direction to the work, in addition to themes within this direction. For instance, a low score on item 2 of the ORS led to conversations about an internal conflict in the family and how to deal with this. The therapeutic work was then built around the continuously accessed feedback about this work. This meant that the treatment plan was continuously changing, directed by the feedback from the family. This changing movement represented the therapeutic work.

The use of the ORS and SRS also set up *a process of exploration.* The questions asked about the scores led to the discovery of previously unexplored areas. When this happened, knowledge about a theme could be deepened and transformed into new options for meaning and action. With this, the idea of the measures as conversational tools emerged as an important aspect of therapeutic work in the Family Team. Here, tools are seen as something that mediates; by way of the tool, we increase the probability of bringing something forth. The clinical experience of the

therapists working within these conversational processes has led to the formulation of three guidelines for practice.

The first guideline specifies that, as conversational tools, the ORS and SRS provide opportunities for questions, not answers. The scores on the ORS, the trajectories of the ORS scores over time, and the scores on the SRS have to be given meaning within the conversations between the family members and the therapists. In this view, clinical validity, reliability, and feasibility are not inherent properties of the measures, but are always created within the conversational domain of the therapeutic work.

The second guideline states that when the service user is not improving or is deteriorating, the therapist needs to do something different. The Family Team gives priority to therapist change, in the sense that in order to do something different, the therapist needs to change her or his way of thinking, perspectives, and/or ideas about how to work and what to do. Such changes are experienced to have emotional effects in our clinical practice through experiencing them as possibly painful for the therapist. These changes in the therapist's manner of working are then guided by prompts, ideas, and the theory of change of the service users. This means to combine the professional skills and knowledge of the therapist with responses from the service users. For the Family Team, this is found to be in accordance with a pluralistic position (Cooper and McLeod 2011) in which all kinds of therapeutic tools and manners of working can be braided together, guided, and constrained by the service users' responses.

The third guideline is that when a disagreement on how to proceed with the therapeutic work arises between service users and therapists, a process that gives priority to the service users' perspectives, ideas, and preferences is set up. This, however, needs to take place within ethical boundaries. For instance, if a mother or father wants to use physical punishment as a manner of changing behavior problems in the child, the therapists will state that this is outside their ethical boundaries and that they cannot take part in these practices. What they can do is to take part in conversations on the idea that physical punishment is seen as a good strategy for solving behavior problems.

The CD of the CDOI—The Question of Service User Participation

Our experiences with ROM and the use of ORS and SRS have helped us to expand our understanding of psychotherapeutic work. One way of closing in on this understanding is through the concept of a family-based practice (Sundet 2011). Central in this is the intertwining of the concepts of the helpful relationship, the helpful participation, and the helpful conversation. It is outside the scope of this chapter to present this way of looking at the content of psychotherapeutic work. Instead, as stated in the beginning of this chapter, another path will be taken in

order to make more visible how we have come to understand our use of ORS and SRS, as well as CDOI. This will be done by looking separately at the "CD" and the "OI" of CDOI.

In our work at the Family Team, we identify two perspectives on the role of theory in psychotherapy. In the first, the uniqueness of each case and how it develops is paramount. Duncan and Miller cite Milton Erickson, who has said, "I think any theoretical-based psychotherapy is mistaken because each person is different" (Zeig 1980, p. 131 in Duncan and Miller 2000, p. 10). Furthermore, Duncan and Miller (2000) pointed out de Shazer's (1994) work that searched for a pattern to Milton Erickson's successful cases. However, the pattern was created, most of the cases ended up as miscellaneous. They seemed to be one-time idiosyncratic interventions that never were repeated. The conclusion drawn from this is that, "…Erickson simply listened carefully and then did what his clients told him" (Duncan and Miller 2000, p. 11). This leads to the following questions: First, what should psychotherapy be based on? Second, what function do theory and research serve for psychotherapists? In the second perspective, theoretical coherence is emphasized. Wampold and Imel (2015) concluded that central to the contextual model is "…a cogent explanation for the disorder and concomitant therapeutic actions" (Wampold and Imel 2015, p. 59). This again means that "… one of the common factors is the systematic use of some set of specific ingredients, delivered in a cogent and convincing manner to the client and accepted by the client" (Wampold and Imel 2005, p. 59). With this, theory becomes an important part of psychotherapy, but not by specifying a deficit that must be changed or repaired by a specific ingredient, "…the Contextual Model posits that the specific ingredients in all therapies induce the client to do something that is salubrious" (Wampold and Imel 2015, p. 60).

The experiences within the Family Team support both of these perspectives. On the one hand, we do not find that any one theory gives the families that attend the Family Team and their therapists the answer to how to understand the predicament and suffering that the family experience, and the challenges and obstacles the therapists experience in working together with the families concerning their predicament and suffering. On the other hand, the therapists find that theory is necessary and helpful, and this means that the therapist may need many theoretical sources in their work (Sundet et al. 2016). The question becomes what should guide our choice of theory and what does that theory do for us in our work?

The attention to "the CD" in this part of the chapter gives us some partial answers to these questions. The starting point for therapeutic work within the Family Team is always dialogues about the preferences, perspectives, ideas, and prior experiences that the families bring with them concerning therapeutic work. This includes their theories of change (Duncan and Miller 2000). Here, the theory of change does not mean fully explicated and formulated theories in a scientific sense, but rather ideas on what would or could be helpful. The next experience that is central to the work of the Family Team is that the best way to continue the work is to follow the family and their ideas. This means that theory is also something that becomes more and more explicated during the therapeutic work and that part of the

job of the therapists is to introduce their knowledge base so that joint ideas of change can be developed, broadened, and fitted to the predicament and suffering of the family. To do this, feedback from the family members is of the utmost importance. "Are we on track?" becomes the recurring question from the therapists. This also means that what theory does for both the families and their therapists, in addition to creating meaning and understanding, is to suggest therapeutic actions. Theory gives ideas on what to do. What are possible relevant actions given the predicament and suffering? Again, feedback becomes central because it is in the tracking of effects of these actions that we can get a picture of whether or not we are reaching the goals of changing the predicament and suffering. This will be addressed more fully below when looking closer at "the OI."

In Norway, service user participation is required by statute. It is literally a crime not to let the ideas, preferences, aims, and needs of the client be taken into account when making and implementing treatment plans. Therapists who do not take these into account can be prosecuted. The argument of this chapter is that the concept of "CD" coincides with such service user participation. For the Family Team, this means to continuously include the service user in conversations about how their preferences, needs, and important cultural elements can be realized in practice. Our therapy shall be fitted to these preferences, needs, and cultural elements, that is, the responsibility of the therapist. However, with this comes the situation of when the client and therapist disagree—when they see aspects of therapy and the client's life, aims, and means differently.

From the perspective of this chapter, it is the responsibility of the therapist to uphold the alliance, as well respectfully listening to differences, so the clients do not experience infringement and violation. This means that therapists' change becomes a central responsibility of the therapist in relation to differences of perspective and opinion on what therapy is and how to do it. At times, this means that the therapists have to partake in ways of working and being together that may be contrary to his or her beliefs and professional perspectives. Does this mean that one must be a mindless therapist whose only job is to do what clients tell him or her to do? Of course not. The perspective of the Family Team is that conversations are one of the three cornerstones of a helpful practice, the other two being the helpful relationship and helpful participation (Sundet 2011). There will always be conversations, and within these, there will always be differences—differences of perspectives, opinions, preferences, intentions, goals, and more. To attend to and work with these differences are central parts of the therapeutic work.

American sociologist Richard Sennett makes a distinction between two types or classes of conversations—dialectical conversations and dialogical conversations. "In dialectic conversations, the verbal play of opposites should gradually build up to a synthesis;… the aim is to come to a common understanding" (Sennett 2013, p. 18). Dialectic conversations are about establishing common ground. Here, the difference between the perspectives of the clients and their therapists, seen as thesis and antithesis, is at some point transformed into something that is different from these two positions, a synthesis. A third, new state is reached and the participants develop a sort of emotional rest, tranquility, or acceptance of this new situation or

state. In therapy, one could imagine this as negotiations on how to proceed together (Strong et al. 2011). For instance, what is the aim of the session and what tasks should be used in reaching this aim? Strong et al. (2011) suggested that negotiations are at the core of such conversational transactions. "…we develop our sense of being 'on track' with each other, by being responsive to each other's initiatives and reactions, in negotiations and inter-subjective modifications…" (Strong 2010, pp. 384–385). Through such conversational processes, a third state can arise, either as a deliberately reached conclusion or a spontaneously arising state of agreement.

Dialogic conversations do not resolve themselves by finding common ground as in a dialectical conversation: "Through the process of exchange, people become more aware of their own views and expand their understanding of one another" (Sennett 2013, p. 19). Therefore, in dialogical conversations, difference is approached in another manner. We can still talk about negotiations, but we are not referring to them as a process that produces a new goal, state, or resolution to whatever problem is under discussion. Now, the negotiations conserve or secure a difference. Think of a conversation between parents and a therapist on the use of systematic exposure training. The parents had experienced that prior trials with this technique had led to increased suffering and symptoms for their child. Therefore, they wanted to see whether there were other treatment options. The therapist upheld that he believed that systematic exposure still would be the best option, but accepted after awhile, due the negative experiences of the family, that they would seek out other options. The family accepted the perspective of the therapist by saying that they would reconsider using it again if other options were not found, but at the moment they preferred searching for the other options. By this, the difference of the family and the therapists was conserved. This implied an emotional difference also. There existed an emotional tension between parents and therapist due to the different views and preferences. All the involved parties were made aware of this tension by the fact that one part of the difference, the preference of the therapist, was abandoned. At the same time, both the tension and the upholding of different perspectives implied an acceptance of this situation. In a dialectical conversation, one would expect that this tension and difference would be solved by establishing a third option. In our example, working within the described tensions of a dialogical conversation led in the end to a third option that they all could agree upon. As such, the dialogical conversation developed into a dialectical one. In other such predicaments, where participants hold different views and preferences, the upholding of difference can lead to each participant becoming more aware of their own views and expands their understanding of one another. Again and again, in for instance therapy with divorced couples having fights about what is the best and most secure rearing practice for their children, accepting that they do things differently may lead to the child being brought out of the war zone that such fights often are. There is no resolution of the difference in the sense that they agree on rearing practices. Instead, they accept each other's way of doing things, both with new understanding of the other, but maybe still with a fear that the other's solution is not good enough. Acceptance and tension are both present.

The Family Team has found that in working with differences—differences between us and the family members, between us and the therapists, and between the family members—the use of ORS and SRS is of the utmost importance. The Family Team has found that any spontaneous or reflected understanding of and decision about the process and outcome of the therapeutic work must be corroborated by actual feedback from the family members. This is not because we are bad therapists, but rather, it is because therapists are people. We are, as a species, bad at such clinical judgments (Meehl 1954). Secondly, because clinical judgments are defined as part of professional knowledge and competence, there is a possibility that we use the theory of the method to explain good outcome, while outcome failures are explained through the theoretical concepts of the therapy applied. Typical examples here are the concepts of resistance and lack of motivation, while a new option is the patient's lack of mentalization capacity or ability. These types of judgments are seeds of infringement and violation. As responsible professionals, we need to take seriously the idea that we are dependent upon prompts, ideas, and directions from the clients. We are dependent upon the response of our clients to our responses of their responses ad infinitum.

In the work of the Family Team, we do not experience this as problematic tension. In fact, the Family Team is part of The Ambulant Family Section, Department of Child and Adolescent Mental Health, Hospital of Drammen, where there is one other team. This team works with the Parent Management Training—Oregon (PMT-O) model, which is an evidence-based method (Patterson 1982). What we see is that flexibility is a characteristic of both of these teams. There is an agreement that therapy must be fitted to the family. The difference is that in the PMT-O Team, the family is invited into a specific method with clear rationale and concomitant therapeutic actions, which are executed flexibly and in collaboration with the family. At the same time, when preferences, problems, and/or diagnostic issues arise that do not fit with the rationale and concomitant therapeutic action of PMT-O, the Family Team can be invited in and PMT-O is terminated. Likewise, in the Family Team, when the preferences and needs of the family fit with the rationale of PMT-O, this team can be invited in and contact with the Family Team is terminated. This means that the Ambulant Family Section has diverse manners of working that can fit a larger variety of the client population compared to if there was only one of these teams working. The demand that is on the therapists in both teams is to accept both that there are limits to one's own way of working and that there are other ways that can helpful.

At the time of this writing, we are also implementing the use of ORS and SRS in the PMT-O Team. The preliminary conclusion is that these measures should be used in a different manner in these two teams. In the Family Team, they are used with "CD" and "OI" (see below) of CDOI. In the PMT-O Team, ORS and SRS are used to support and develop how the family and therapists can best apply and use the principles, rational, and therapeutic actions of PMT-O. What both teams have in common are the necessity of tracking the effects and the outcome of what we are

doing. Again, we are dependent upon the responses of our clients and not only as prompts for how to secure "the CD"-manner of working, but also regarding the "OI," that is, the effects of our therapeutic work.

The OI of the CDOI—The Question of Being Informed by Data

There are now computerized systems for the use of ORS and SRS, such as the Partners for Change Outcome Management System (PCOMS) (Miller et al. 2005; International Center for Clinical Excellence 2013) and the Feedback-Informed Treatment-Outcomes (FIT-Outcomes) (Miller and Bertolino 2011). In these systems, outcome data can be aggregated to a group level, enabling therapists to compare themselves with their own usual outcome and with those of their colleagues. The therapist's team or institution can also track its outcome over time, so that levels and developments can be traced, enabling the leaders and stakeholders of the institution to make comparisons with other institutions' outcome. The Family Team has not had access to such a system. Instead, the ORS and the SRS are used in a paper-and-pen version.[2] This means that our conclusions on the continuous outcome of the therapeutic work are made through conversations with the family members. This is consistent with the Family Team's emphasis of using the measures as conversational tools. At the same time, we lack and cannot get the feedback supplied through the aggregation of data across cases, therapists, teams, and sections within the Department of Children and Adolescents Mental Health. This must be kept in mind in the following discussion regarding our experiences with "the OI" of CDOI.

Elements of CDOI in an ambulant family therapy team, as it was presented in the beginning of this chapter, can be clinically exemplified in the following manner. Take, for example, a father who was not used to talking in the context of treatment in a public healthcare unit. Talking about the scores of ORS "got him going," which, through *a process of communication*, led him to be able to state what he wanted for this family. In another family, a young girl was not able to verbalize her feelings. *A process of focusing* was initiated through the scores, which made her able to move from the "non-said" to the "said," expressing feelings of shame. In a third family, life was in full upheaval, with multiple challenges and problems in their lives. *A process of structuring* was initiated through the conversations around the scores on the ORS, which moved the family from chaotically expressing a multitude of issues to agreeing on the theme they felt was most important to work on in the present moment—how to be able to start the morning without a quarrel. A final example is the family who, through discussion about the trajectory that was drawn from the ORS scores, set up *a process of discovery* concerning their twins

[2]The Ambulant Family Section is now working on implementing such a computerized system.

and their ability to keep a caring relationship with both of their grandparents who were currently ill. In this process, the parents' view of their children was moved from seeing them as nonsocial and worrying about lack of empathy, to stories of empathy, concern, and involvement in family issues in a productive manner. The mother's words in the end of this process concluded, "I do not know where I have been. I have only seen problems and that has clouded my view. It is like not being able to see the forest because of all the trees. Thank God I discovered these other sides of my twins."

In all of the above examples, it was the scores, the outcome reported in every session, that signaled no-change or detrimental development that became the starting point for the conversational processes. This is what OI is all about and also exemplifies our first guideline—the ORS and the SRS give opportunities for questions, not answers. It is the conversations and their development that clarify what the outcome is in every session of therapy. The answers are given by the service users in the conversational processes. Here, feedback is about the conversations that the scores on ORS and SRS lead to. Scores on these scales must be given an interpretation—a specific and concrete meaning contextualized to the actual life of the client and the events within the processes of therapy that service users and therapists create and are part of. To be informed by data means here that this is done through conversations about the data—individual scores on ORS and SRS. At the same time, the scores on the ORS and the trajectories that can be drawn over time, and every single score on the SRS, also function as a "warning signal" (Lambert 2010).

Seeing the scores in themselves has potential effects. The scores are signals about either being "on-track," meaning that everything is in agreement with the desired goals, or "not-on-track," meaning either that nothing is happening or the experience of the family members is one of deterioration in well-being and development. These two modes of CDOI, the generation of conversations and the "signal-effect," together point to the importance of the second rule of practice—under conditions of failure to make progress (either no-change or deterioration), the priority of the therapist becomes to change something about therapy, as defined above. The outcome for every session leads to questions about how to continue the work. Are we "on-track"? If not, what changes in the manner of working does this induce in the therapists? Often at the point of identifying not being "on-track" is the experience of being at an impasse or a situation where the therapist is uncertain how to proceed. The conversational input from the family or the "warning signal" becomes the occasion for searching both conversationally with the family and in parallel to one's own professional knowledge base.

Searching for and within theories that can give ideas to or suggest therapeutic action becomes a central part of the work of the therapists. Likewise, research-based knowledge becomes such a source, where one important part includes theory-specific methods that have been tested in randomized control trials and established as having an effect on the group level. We are back to the situation where one option in the Family Team is to invite colleagues from the PMT-O Team, in addition to including elements from other forms of theory-specific

therapies, such as cognitive therapy (Beck 1995). These become important sources for getting out of the impasse or finding new avenues to give both therapists and families hope. Therefore, in the work of the Family Team, "to be outcome-informed" is more general in that the information is not limited to ROM. This has led to two particular metaphors concerning how to group psychotherapeutic methods and practices.

These two metaphors are grounded in experiences we have in working with the special target groups of the Ambulant Family Section. These are, first, families that have tried other forms of therapy and did not find them to be helpful. Second, it includes families who are in need of a more intensive process (more and longer sessions for instance), and that one can be ambulatory in nature (work in people's homes or at school for instance). Third, the Family Team can be useful in therapy processes where collaborative problems have risen in the relationship between families and their prior therapists. In all of these groups, the experience of the Family Team is that the third guideline is fundamental—when a disagreement on how to proceed with the therapeutic work arises between service users and therapists, the perspectives, ideas, and preferences of the service users are given primacy. This has led to two metaphors of "yes"-oriented and "no"- or "hesitation"-oriented methods. First of all, we have those methods that depend upon the "yes" of the client. This implies "yes" to the method offered by the therapist and its theoretical rationale, explanations, and suggestions for practice. In the Ambulant Family Section, the work of the PMT-O Team exemplifies this group of methods. These methods are characterized by clearly stated theoretical underpinnings. They consist of theory-specific factors that illustrate how to understand the problem and its etiology, as well as how to move out of or be healed from the disorder or the predicament one is in. The model theoretically specifies the path to remoralizing and healing in a clear manner.

The other group of methods is characterized by the client saying "no" or being hesitant (Rober 2002) to the manner of working that the therapist suggests. This can occur either in the initial therapy contact when goals are specified, or it can happen during the therapeutic process of working with the client's problems or predicament. In both groups of methods, feedback is necessary, but is used in different ways. In the first situation, feedback is used in order to secure the client's participation in what the theory-specific manner of working specifies. The feedback is a means to help the therapists to be better off helping the client to accept and attend to the demands of the method. Straying from this, protesting or being hesitant will, at worst, be interpreted by the therapist as a lack of motivation and, at best, as a poor fit between method and client that could point to the need to change the method. The "no"- or "hesitation"-oriented methods are, by definition, theoretically and practically pluralistic (Cooper and McLeod 2011). In the Family Team, the aim is, through the responses of the client, to build a manner of working therapeutically that fits with the preferences of clients. The field of psychotherapy is seen as a huge toolbox, concerning ways of explaining and understanding both the suffering of people and how to meet such suffering in a remoralizing or healing manner. It is framed within a trial-and-error-oriented way of working, where feedback, especially

the "no" or hesitations to suggested ways of working, is the decisive and necessary part of the work. It is through a "no" or hesitations that we know where not to go. In our daily practice, these metaphors help us retain and accept the differences between the Family and the PMT-O teams, and, through this, create space for the diversity of practices that characterizes the Ambulant Family Section.

Continuous conversations around feedback are the driving force of this manner of working. For example, in our practice, we meet children and adolescents who refuse to do systematic exposure training with their anxiety or OCD problems. The trial-and-error-oriented manner of working has given us experiences that instead of focusing on exposure-based interventions (Dobson and Dobson 2009), there is a focus on areas of intentions, aims, wishes, and desires of the child or adolescents, regarding what they would like their life to become. Interviewing the above-mentioned teenager who refused to do systematic exposure training on what led her back to the classroom that she had refused to go into, she said, "My desire became greater than my fear." The path to change was not systematic exposure training, but rather, it was a focus on important life issues and her desires and hopes for the future. At best, we can say that exposure was an end result, but was still trivial compared to the focus on desire and hopes. The work of the Family Team is best identified as part of the "no"- or "hesitation"-oriented group of methods and ways of working. Feedback from the service user becomes of the utmost importance here, because the therapeutic work is dependent upon catching every sign of a "no" or a hesitation. This points to where not to go in the therapeutic work. Conversations on where to go and how to proceed can gradually be developed. This is learning by doing.

Fundamental to the work at the Family Team is the notion of collaboration. In this area of our practice, CD is self-evident, and OI is invaluable. Again and again, our experience is that clinical judgment is biased and unreliable. This is especially important in collaborative work. Sundet et al. (2016) suggested an understanding of collaboration built around the concept of turn-taking. Arising within developmental psychology (Bateson 1975; Stern 1985; Sundet 2004), turn-taking points to the mutual responding and responsiveness that is at the base of infant–caretaker interactions. As a metaphor for psychotherapeutic interactions, it states that the first step to any psychotherapeutic effect is the establishment of turn-taking—mutual responding to each other's responses. This way of thinking about the starting point and necessary condition for a psychotherapeutic venture circumvents the notion of motivation, and it places the responsibility for establishing such turn-taking to the therapists. Here, responsible means "to be response-able" (Haraway 2008, p. 71). The task of the therapist is to be able to respond to the service user in such a manner that the turn-taking, the process of mutual responding, can continue. The importance is that when a stop or an impasse in the process of turn-taking, either as verbal or nonverbal transactions, happens, the job of the therapist is to find a way of responding to the service user that makes it possible for her or him to respond back. Here, feedback from the service user about both the continuous outcome of our collaborative work and how the therapeutic alliance develops is invaluable and necessary. When such turn-taking is established in a stable and repetitive manner,

the next step is that the content of this turn-taking becomes a process of negotiating the goals and tasks of the collaboration. "What is it that we want to achieve together?" In the therapeutic context, this is equivalent to the goals and task parts of the therapeutic alliance (Bordin 1979).

The last step in the process of collaboration is that the turn-taking becomes a process where the differences in lived experience, position, perspective, knowledge, and preferences of the participants in the collaborative endeavor are used in order to reach the agreed upon goals, through the tasks one has chosen to apply. This is referred to as "putting differences to work" (Sundet et al. 2016). Sennett's (2013) concepts of dialectical and dialogical conversations are two examples of what we mean by "putting difference to work." In the above example of the girl with a social phobia, the perspective of the therapist on the use of exposure training was challenged by the mother who insisted that there must be other ways of reaching the goal of helping her back to the classroom. As stated before, in this example, a period of living in the tension of a dialogical conversational process happened. After awhile, the difference between the mother and the therapist initiated a search of the therapist for theoretical sources other than those related to exposure-based interventions, which led to a synthesis, a third state that fitted both the mother and the therapist. For the therapist, this was rooted in descriptions from developmental psychology that underlined the importance of affect regulation and increasing the agency of the girl, to a practice where her goals and suggested tasks were systematically followed (Stern 1985). This included inviting friends to alternative classrooms. These actions increased her desire for more contact with peers, which led her back to her classroom. Her increased desire seemed to displace her anxiety. Running through this kind of collaborative work is the result of the therapist's dependency upon feedback from the family members. Collaboration and other aspects of the therapeutic relationship must always be constrained by the outcome of our work together. The OI must be braided in with the CD. That is, what CDOI is all about. One of the temptations that we found in our collaboratively oriented work is to be satisfied with good collaboration and therapeutic relationships. Our experience is that this is a necessary condition, but is not enough. As a father stated, "It is not enough to sit here and talk friendly; sooner or later, we have to do something also."

What Could Be New in Client–Therapist Interactions as a Result of Feedback?

This chapter has given a description of a version of CDOI, known as KOR in Norwegian, developed in the Family Team. This has been done, for descriptive reasons, by separating the "CD" and the "OI" in CDOI. It must be underlined that in actual practice, these two components cannot be separated. They are mutually interdependent. Given the description of these two components, is there something that could be deemed "new" concerning therapeutic client–therapist interactions?

What is the new and how do we know it is new? For whom is it new? The new can be seen as something that is outside, or that disturbs, the traditional way of thinking. It changes our traditional and accepted ways of attending to and understanding a phenomenon, or engaging in a practice. Is there something new along these lines in the above? Let me therefore summarize what could be deemed as possibly new (for some therapists).

To summarize the previously presented experiences, research gives us, at the moment, a strong argument for the use of client feedback and ROM, at least in cases that are not on track. Second, there are clear signs that supplying information to therapists on outcome over the course of therapy is important. Third, there are indications that conversations around and about the feedback with the service user are important both for outcome and for the experience of the therapist as being responsible (Sundet 2014). This puts service user participation at the core of therapeutic work, and as such, participation means that therapist responses are subsumed under or constrained by the service user's response. In the work of the Family Team, this has led to the three guidelines that the ORS and SRS give opportunities for questions rather than answers, that impasses create therapist change, and that service users' perspectives and preferences are given priority. This means that therapist change is a necessary activity and skill in any therapeutic endeavor.

Failure to progress in therapy, as documented through ROM, should elicit from the therapist a change in the therapy process, which is needed before client changes. This does point to the relationship between the client and therapist as being asymmetrical and egalitarian. It is asymmetrical because clients and therapists are in different positions and roles, with different perspectives and knowledge. There are different demands, and service users and therapists have different responsibilities. It is also asymmetrical because in the end, it is the voice of the service user that decides if he or she has been helped, been remoralized, or reached the goals of therapy. These differences point to the fact that in a collaboration, putting differences to work is central. Furthermore, the relationship between service user and therapist is egalitarian because no position is superior. No voice has more value compared to others, and no voice should be marginalized. By working within a team that tries to follow the above, our experience is certainly that we are in opposition to some perspectives that uphold the idea that helpful practice seems to depend upon the client always subsuming him or herself under the rationales of the therapy offered. The division onto two groups of methods—"the yes-oriented" and the "no"- or "hesitation"-oriented—is our way of creating the relationship between theory-specific and eclectic and pluralistic manners of working as a supplementary relationship and not one of opposition. At the same time, it gives space and opportunity for the family members to partake in creating their own therapy.

The third guideline implies that it is an important skill of the therapists to be subsumed under the perspective and preferences of the client, and as such, to be a therapist is to acknowledge one's dependency upon the responses from the client. We uphold that for many, this will indicate a new manner of being together with clients that will have obvious consequences for how the interactions and

conversations between clients and therapists are carried out. Parallel to this, the exposition of the OI above points to the fact that the situation is more complicated than simply following either the client or the therapist. Following theory-specific treatment principles and practices offered by therapists has a sound evidence base. People are helped by following the therapists. This definitely violates the beliefs of those who think that therapy is only a singular event consisting of one-time idiosyncratic interventions that are never repeated. One way of relating to this is to acknowledge the randomized clinical trials and naturalistic studies to support the notion that psychotherapy is helpful both under experimental conditions and in actual clinical practice (Lambert 2013).

However, this can also be viewed from another perspective. It can be stated that when you have an evidence-based method, it is also shown in the evidence that some are not helped. This means that in a responsible clinical practice, one must be prepared for the situation that a particular way of working will help some and not help others, and the big question is what to do about those who are not helped. It is through our accepted and preferred ways of working that we help people (Wampold and Imel 2015). We need to believe in what we do and we need to have expectations that we will be helpful. When we meet clients that are not helped by our preferred and believed manner of working, these clients represent something new. On the one hand, they violate our beliefs, but on the other, they represent an opportunity for us to learn something new.

To be outcome-informed (OI) means, in this chapter, to embrace two sources of knowledge. One is the nomothetic knowledge that points to what is generalized and what is found to be the case on a group level. This knowledge source invites both therapists and clients to act within a set of principles, a rationale, and the consecutive forms of practice. Feedback from the client, as idiographic knowledge, is used to help the therapist design and bring forth the principles of treatment in new manners that fit the client. Our experience from the PMT-O therapists' work is that it sometimes seems that there are almost unlimited ways of realizing the principles and rationale of PMT-O. Therapists' creativity within the model is therefore the core of this way of working.

At the same time, there are also limits. There are situations where one has left the rationale and instead invites new, principally different manners of working. Given the set of principles one has been working within, our experience is that when leaving these, uncertainty arises. This is where we find the use of "no" and hesitations so important. A new manner of working is set up where we are naturally in a not-knowing position (Anderson 1997). A not-knowing position is not a knowledgeless position. It is a position where it is open to what will be helpful, and we need to set up a process of discovery together with the service users. The therapists still have their nomothetic knowledge with them, but what can be of use must be discovered together with the clients. Again, the idiographic aspect of knowledge is necessary and invaluable.

In the last instance, it is the response of the clients that determines where to move on. This is a process of moving about and finding our "how" to go on (Shotter 2008). Australian narrative practitioner Michael White (2007) called this process

"loitering." It might seem aimless and haphazard, or what the Boston Change Process Study Group (2010) calls a sloppy, uncertain, dynamic, and potentially creative process, but it gives rise to discovery. Here, feedback is not used in order to be kept within a set of theory-specific principles, but rather, it is used in order to generate new principles or discover which other principles would fit the client. This is where we think that we all easily can be intimidated by the new. Whatever position we take, there will be positions that are experienced as new in the sense of violating some belief or principle that we hold. This means that in being confronted with theory, there will always be challenges that seem paradoxical or irrational, but which find their way in the actual practice of the service users and therapists. It is the view of the Family Team that dilemmas cannot be solved—they must be lived. In such a position, I, as a therapist, am completely in the hands of the client. It is through the responses of the client, both on the standardized feedback forms that we use and through the conversational responses and interpretations they offer us on these, that we can find grounds for continuing the path that we are on. One important skill that seems to be decisive and necessary in order to be able to work in this manner is to follow the client. What does this mean?

To Follow the Client and Be Challenged by Data

What do we mean by following the client? Either by working within a theory-specific or a theory-pluralistic manner, the response of the client will be decisive for how the therapist proceeds. The general understanding argued for in this chapter means that we need feedback in order to assess whether what we are doing actually leads toward the preferred or stated goals of the service user. In the theory-specific group of methods, the "yes"-oriented methods, the principles and rationale of the therapy, will always set limits for what kind of adaptation or fit that the client can do and still be within what the method demands. At the same time, it must be repeated here that the experience with PMT-O sometimes gives the feeling that there are almost unlimited ways of realizing the stated therapeutic principles, but this is qualified with the experiences that although this feeling is there, there are limits. There are actions within the session that bring the therapeutic work outside of the theory-specific boundaries of PMT-O. In the following, I will therefore focus on what "following the client" in the theory-pluralistic way of working implies—"the no"- or "hesitation"-oriented methods and practices that this chapter argues for as a supplement to the "yes"-oriented methods.

Following the family has the superior aim of establishing a manner of working therapeutically that fits with the preferences and personal and cultural beliefs of the clients. The slogan for this work is "tailoring treatment." To manage this, it is of the utmost importance to have a focus on the ideas, perspectives, understandings, and theories of change of the client, together with stated goals. This is to establish a joint focus, but one that is always governed by the perspectives of the client. It implies focus on two levels—on the verbal, meaning-oriented level, and on the

expressive–affective level of the body. The first can be seen as a meaning-oriented macro-level and the second a bodily micro-level showing itself in the gestures, tone of voice, and other aspects of body language. On the macro-level, verbalized joint understanding is at the core of the work. The job of the therapist is to make certain that he or she has an understanding of what the client communicates or wants to have an understanding of. This means that the conversational processes of therapy are more directed at what the client and therapist can understand together, rather than for the therapist to create some theoretically based understanding of the client. The hermeneutical triangle where two (or more) persons struggle to understand a third state of affairs is a more fitting model here, compared to a classical psychological orientation where the job of the therapist is to create or give an understanding of the client (Torsteinsson 2005). The asymmetry of the relationship shows itself through the fact that it is, in the end, always the material of the client that is in focus. We consider the therapist's contribution in such conversational processes in order to not exclude her or his perspectives, generalized and personal knowledge, or clinical experience. Rather, the role of the therapist is to put these into play in the conversational meetings and, through the responses of the clients, gradually build up an understanding of what needs to be understood to bring about the goals and the preferred state of the client.

On the micro-level, "to follow" especially means to allow oneself, as a therapist, to be moved by or be in resonance with the affective expressions of the client. The concept of attunement is descriptive of this state of affairs (Stern 1985). Our experience is that hesitations, in particular, express themselves through gestures, tone of voice, facial expressions, and other bodily responses. These are vital signs that point to both important directions that either should be followed or avoided, and signs of themes that need to be investigated conversationally together. We follow the perspective on conversations that in each moment, the participants respond toward each other on the basis of anticipated responses of the other (Shotter 2010). Especially important for the therapist is to follow the anticipations she or he has about how and where the conversation should go. When these anticipations are disqualified or not confirmed, one should seek help from the client on where to go. Rupture and repair, and disconnect and reconnect (Safran and Muran 2000; Tronick 2007) are therefore key conversational elements in this kind of work.

At the same time, we acknowledge that sensitivity toward hesitations and other responses that can guide us is not enough. Therefore, this way of working is dependent upon using standardized measures such as ORS and SRS. This is beneficial partly because the scores on the ORS and SRS serve as signals about when we were not able to follow the client, and partly because they serve as conversational opportunities. This brings us to ROM as a procedure and tool for gathering data on ourselves as therapists and on the work done in the unit, team, and/or organization that we are part of. Data used for research purposes, but more importantly, data gathered over time, can become new sources of feedback. The data give rise to opportunities in comparison with oneself ("Am I performing as I usually do with these kinds of problems?"), with colleagues ("Why are my outcome

different from my colleagues'?"), and other teams/organizations ("We have higher/lower end results than does team/organization XX—why?").

The collection of outcome and process data through the use of ORS and SRS means accessing a perspective where I, as a therapist, can see myself from the outside through the pattern of the aggregated data on my work. The data aggregated will make possible comparisons with my outcome in prior cases, as well as with the expected development from the data based on large numbers of clients. Research suggests that we, as therapists, are not particularly good at assessing the effects of our own work (Walfish et al. 2012). We need to have a belief in our way of working, but we also need to be confronted with the possible lack of effects of what we do and the idea that we may be partaking in the process of therapy in manners that are not helpful.

As stated above, we need to do this at every moment in therapy and, at the same time, accept that this vigilance is not enough. We need feedback from the outside. We need to be in resonance with the clients at every moment of therapy, and at the same time, we need to receive help from the outside to assess whether we actually are on track with seeing the client from the inside. More precisely, in the language of this chapter, we need outside information from the clients and from comparisons with our prior results and the results of other therapists. This is needed in order to be able to understand something together with our clients and bring therapeutic actions to life that fit the client in a helpful manner. Working as a therapist, therefore, implies a paradox or an existential dilemma where we are both doomed to follow the client and, at the same time, also be doomed to fail in this. It is through the repair and rectification of these failures that we become part of a successful therapeutic collaboration. The work of the Family Team suggests that without formalized feedback and routine outcome monitoring, it is not possible to come out of such a dilemma in a productive manner.

Closing Remarks

The use of and work with OSR and SRS in Norway are deeply indebted to the work of Barry L. Duncan, Scott D. Miller, and Jacqueline Sparks. Their original work with CDOI and the continuation of this work in their new separate institutes continue to inspire and guide the work with ORS, SRS, and ROM in the Norwegian context. This means that what has been described and presented in this chapter is a version of their work. At the same time, when ideas are imported into new contexts, there might arise new forms of practice and different interpretations of the original work. Furthermore, it is hoped that the original work spurs the search for new theoretical sources and information on how to deal with the demand for research-based practices. Any newness in this chapter will certainly be a replication of the original ideas, while at the same time being a supplement where the repetition also includes differences (Deleuze 1994). This chapter is therefore an invitation to let the ideas presented inspire and be a point where the reader may create her or his

own versions of this work. They are not offered as something that should be replicated, but rather, as something that, in the end, will elicit new forms of practice that can still be seen within the landscape of ideas that CDOI represents.

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Chapter 8
Does Feedback Enhance User Involvement in Therapy?

Camilla Jensen Oanes

Introduction

User involvement is a notion that is infrequently used within the contexts of family therapy. However, terms closely related to the process of user involvement are more commonly used. One example of such a notion is the concept of *multivers* (Andersen 2004). Multivers refers to the many different perceptions of truths and realities that may exist side by side within the same family. In Andersen's view, these perceptions are equally legitimate and should be taken into consideration when working with families.

A second example of notions related to the term user involvement is the concept of *not-knowing position* (Anderson 2005, 2007; Anderson and Goolishian 1992). This concept refers to a philosophical stance that the therapist takes when meeting with the client, a stance characterized by not knowing more about the client than what the client knows about him- or herself. To clarify the not-knowing position, theoreticians and practitioners like Tom Andersen and Harlene Anderson lean on the work of philosophers, such as Gadamer (2010), who emphasized the inescapability of our preconceptions and how our integration of new knowledge always depends on—and will be interpreted through—our preexisting system of meaning. In order to take a not-knowing position in the meeting with clients, the therapist needs to be open, receptive, and sensitive to the meaning of what the client wants to share in the session *as well as* to the therapist's own preconceptions. This is in my view a prerequisite in order to maintain the fluidity between the persons involved in the process of co-creating meaning.

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A third notion is the client-centered perspectives founded on the works of Carl Rogers (e.g., Rogers 1949) and continued by various writers and practitioners who inspire therapists today. The client-centered perspectives include the emphasis on believing in the client's ability to decide not only what to work on, but also how to best work on an issue (Cooper and Dryden 2016). Feedback from the clients is intrinsic to this process (McLeod and McLeod 2016; Sparks and Duncan 2016).

Multivers, the *not-knowing position*, and *client-centered perspectives* represent important bricks in the epistemological foundation of family therapy theories and practices. These notions refer to ways therapists may act, be or think to give space for the client to develop his or her own understanding of the situation, the problem, and the future. Working together with clients in such ways may inherently accentuate client or user involvement. Furthermore, these theoretical concepts do not emphasize models, manuals, or techniques per se—rather they suggest broad theoretical frameworks facilitating the development of a joint venture between the family and the therapist in how to approach their challenges in a tailored, idiosyncratic, and creative way. Within these approaches, change and meaning are constructed by the participants together, in a social setting. This position rejects the idea of *seeing the world as it is*, that is, as an objective reality. Rather, in a social constructed world we *see the world as we are*. Our different ways of giving meaning to the phenomena around us are considered equally legitimate. Each of us bring our knowledge to the session, and together we create something new. The need for consensus is toned down while the recognition and respect for diversity are enhanced. Social construction of meaning is characterized by knowing something *together* that each of us did not know on our own. Knowledge is considered co-constructed and thereby local and negotiable. In a treatment within this frame of thought, user involvement may be seen as implicit and hence automatically taken care of.

User Involvement Through Structured Feedback

User involvement in health care is recognized by legislation in several countries as well as through various human rights statements (Pathare and Shields 2012). In Norway, user involvement is a legal right and defined as *the user's influence on the shaping of health services* (Lov om pasient- og brukerrettigheter § 3-1, 1999). The user is entitled to make decisions about his or her treatment while it is going on. This involves more than surveys about satisfaction with an offered treatment program. In order to make sure that the client is involved as intended by, e.g., the legislation, some form of written feedback is recommended (Sosial- og helsedirektoratet 04/2006). Such systematic feedback is also recommended by researchers and practitioners within the psychotherapy field (e.g., Duncan 2007; Lambert 2010).

Lately, different feedback procedures are seen in clinical use, where the clients' opinions on treatment progress and process are more formalized than what we can do in a conversation. Some theoreticians consider a feedback procedure to be a

vehicle for enhanced user involvement in therapy (Duncan and Miller 2000; Pinsof et al. 2012). Systematic feedback through formal procedures is becoming more common in the psychotherapeutic field as such, but is still not much in use in couple and family therapy compared with individual treatment. The exact reasons for these differences are not clear. One may argue that even though family therapists support the idea of feedback, they may perceive the use of *standardized* feedback procedures using quantitative questionnaires as belonging to the traditional individual assessment-diagnose-treatment practice that they find insufficient when dealing with families. Or one may say that structured feedback procedures are associated with more pre-constructed than co-constructed knowledge and thereby inconsistent with a social constructionist epistemological frame of thought. Furthermore, standardized feedback procedures may be conceived as a derailment of the process of co-creating meaning through a therapeutic conversation because such procedures rely on the roles of "user" and "provider" of mental health services.

Although I will not claim that every family therapist in Norway solely bases their practices on social constructionist theories and the co-creation of meaning, I believe the notions presented earlier are important parts of the theoretical sphere in which many couple and family therapists find inspiration. It is within such a frame of thought this chapter is situated. The focus of the chapter is an exploration of how the utilization of the feedback procedure STIC (will be presented next) offers opportunities as well as possible barriers for user involvement. Empirical data from a study conducted in 2010–2015 in Norway (Oanes et al. 2015b; Oanes et al. in review) offer an insight to how the experienced family therapists we interviewed met these opportunities both theoretically and clinically.

The Systemic Therapy Inventory of Change (STIC) Feedback Procedure

The Systemic Therapy Inventory of Change (STIC—Pinsof and Chambers 2009) feedback procedure provides the clients the opportunity to give the therapist a comprehensive picture of their situation both before and during treatment (see Chap. 5 for more details). Information is given through the web-based questionnaires *STIC Initial* (before entering therapy) and *STIC Intersession* (before every subsequent session). The questionnaire provides the therapist with information about the client's *family of origin*, *individual problems and resources*, *relationship with partner*, *family and household*, *child's problems and strengths*, and *relationship with child*. STIC Initial may be seen as a self-referral and represents an opportunity for the therapist to have considerable knowledge about the clients without yet having met them. The way family therapy is organized in Norway most families that are seeking professional help receive such help outside of hospitals, where referral or prior assessment is not needed. This means that many family

therapists may know very little about the family before the first meeting. The use of STIC represents therefore a change in normal practice for many therapists.

During therapy, feedback to the therapist is given before every subsequent session (*STIC Intersession*) on the same areas as with STIC Initial (except family of origin). In addition, STIC Intersession contains alliance scales based on Bordin's (1979) concept of the therapeutic alliance. The client reports on his or her view on how well the therapist understands his or her problems, how well the therapist understands his or her partner's problems, and how able the therapist is to help in solving the problem at hand. Further, the client is asked to assess the alliance between the therapist and the other participators in the session, as well as assessing the relationship between themselves and the other family members. The complexity of alliances in couple and family therapy is thoroughly explored elsewhere (e.g., Escudero at al. 2010; Goldsmith 2012; Horvath et al. 2010; Pinsof and Catherall 1986) and is outside the scope of this chapter.

STIC information is digitally processed and displayed in a report available to the therapist by graphically comparing clients' responses in each of the areas to normative data. Through the repetitive use of STIC Intersession, the development of each individual's responses may be followed over the course of the therapy, hence comparing each new data collection with previous collected data on the same individual/couple/family. In a family therapy context, each individual's responses in each area and on each question may also be presented graphically side by side for the whole family to see and comment upon.

Three Ways of Making Meaning from a Feedback Questionnaire Procedure

In addition to the digital processing of the STIC data, there is of course also human processing involved. This processing is done in (at least) three ways. One is the completions of the questionnaires (STIC Initial and STIC Intersession) done by the client in private. This processing calls upon the individual family members' perceptions of questions and how they contextualize their answers. Secondly, the therapist processes the information by examining the STIC report. The therapist's thoughts and hypotheses, formal training, and experiences will influence his or her interpretation. Thirdly, processing takes place when the therapist and the family together talk about the STIC information in the session. These many processes as well as the manner by which the therapist uses the STIC together influence the nature of user involvement in therapy. In the following sections, I will address some of the possibilities and discuss the consequences of the therapist' choices with regard to user involvement. But first a few words about the research project that comprise the base for this chapter.

The Study

Family therapists involved in a STIC feedback project in Norway (see Chaps. 9, 11 and 12 for more information) were interviewed about their expectations before starting to use the STIC feedback procedure and later about their experiences with the use of STIC. Inclusion criteria were participation in the STIC training program with the intention of using the STIC feedback procedure. A total of 36 therapists participated, comprising six focus groups at three family therapy sites. Each focus group was interviewed once. The interviews were transcribed verbatim, and a thematic analysis (Braun and Clarke 2006) was conducted.

Later we conducted focus group interviews concerning the therapists' experiences after approximately 18 months of using the procedure with their clients in naturalistic settings. Inclusion criteria were participating in the first focus group interview and ongoing use of STIC at the time of the second focus group interview. Of the originally 36 therapists, 15 fulfilled the criteria, comprising three focus groups at two therapy sites. Each group was interviewed once. The interviews were transcribed verbatim, and a thematic analysis (Braun and Clarke 2006) was conducted in the same way as for the first interviews.

Expectations About the Use of STIC

The therapists we interviewed were all experienced therapists. Their practices were formed from their formal education and training, the local therapy culture, and personal theoretical preferences. All the therapists recognized STIC as something that would inevitably have influence on their clinical practice. The majority of the therapists anticipated that the STIC would challenge their social constructivist views. Through the analysis, three guiding principles or values across all the diverse practices emerged as being either challenged or fortified as a result of using STIC. The first was *the balance between the therapist's professional knowledge and the client's experience-based knowledge in the work of co-creating meaning and understanding in the session.* By introducing a pre-created problem-focused questionnaire for each individual to complete, the therapists predicted the balance to be skewed toward a more formal and model-like focus in the therapeutic conversations.

The second value was *the importance of not understanding the clients too rapidly.* Connected to the theoretical concept of "not-knowing position" (Anderson 2007), this value was considered to be challenged through the amount of information available to the therapist *before* the first meeting. However, the information was also considered a potential help to get to the heart of the matter in a relatively short amount of time, and thereby avoiding time spent within a position of "knowing nothing" rather than in a genuine "not-knowing" position.

The third value was *the need for creating and protecting the focused attention and relational awareness in the therapeutic conversation.* This was described as a capacity more than a skill, and seemed to relate to the notion "relational receptivity" (Anderson 2012), and "therapeutic presence" (Geller and Greenberg 2002). According to Geller and Greenberg (2002), such therapeutic presence requires a dual level of consciousness in that the therapist lets go of theoretical knowledge and focus the attention on the client, and at the same time recognize that this knowledge inevitably will influence their intuitive responses in the therapeutic meeting. Such a position demands focused attention on listening as well as on self-observation.

The therapists—in different ways—expected these three concepts to be influenced by the use of STIC. Some of the therapists wanted to limit the amount of information they had about the clients before the first meeting, in order to keep an open and receptive attitude toward the clients. For them, the STIC information fell into the same category as referral information—the reading of which many of them deliberately postponed until after the first meeting, so as to avoid having too many hypotheses beforehand. Not only was this a practice in line with their theoretical platform, but it was also argued that user involvement was best achieved by not gathering a lot of information before the first session. Two main arguments were given for this stance. One was the importance of the client's choice of *to whom* they wished to give their personal information. The other argument was the respect for the client's choice of *when* to give what kind of information.

Experiences with the Use of STIC

The manner in which STIC was used varied between therapists and between the families each therapist worked with. The term "using STIC" therefore refers to a variety of practices. Two therapists could view the same practice as both including and excluding user involvement. Likewise, contradicting practices could be viewed as equal in terms of user involvement.

In the following, I will present the opportunities for user involvement that may develop during the different ways of using STIC presented by the therapists within the framework of the three values that were expected to be influenced by the use of STIC.

Feedback Procedures Give the Opportunity to Ask Difficult Questions

The STIC procedure asks specifically about risk behavior like substance abuse, sexual abuse, violence, and suicidal impulses. Many of the therapists reported in the interviews that within their normal practice they often found it difficult to ask such

questions, especially during the first meetings. Some therapists waited for a natural opening or hint in the conversation to address such issues. The usual way to recognize such moments were often through the therapist's clinical impression of the alliance. Assessments of the balance between creating a safe place and at the same time talk about difficult themes were carefully done within the therapist's own mind. A shared experience for the therapists we interviewed was that they in some cases waited in vain for such an opening, and felt that they interrupted the conversation by addressing those issues. STIC offered the opportunity of getting to the heart of the matter in each case in a more efficient way. By using STIC as a "contextualizer," waiting for the right moment to ask certain questions was no longer an issue. The therapists found that when the clients had answered a question on STIC, the theme was somehow opened for conversation.

Reigstad et al. (2006) suggest that themes important to the client often do not surface before the therapist actively asks about them. This is especially valid for themes concerning sexual abuse and violence. Some of the therapists expected that a feedback procedure like STIC would represent not only an opportunity, but also provide the courage to ask such questions. This expectation is in line with the findings in a previous study (Oanes et al. 2015a) concerning therapist's experiences with feedback procedures across professions and feedback instruments. Because the client had completed the STIC questionnaires before the session, it was natural for the therapist to address the STIC answers generally and the risk items or difficult items specifically. Sundet (2012) suggests that the feedback procedure Partners of Change Outcome Measure Scales (PCOMS) (Duncan et al. 2004) acts like conversational tools that bring themes to the surface. Because the feedback procedure is part of the "therapy package," the questions within the procedure are already there as part of the context and thereby made relevant. STIC may well act in the same way. Because STIC asks the questions, exploring the relevance of these questions is already part of the package.

Feedback Procedures Give the Opportunity to Explore Multiple Meanings

Our interview data revealed that many of the therapists used the STIC information as a gateway to explore how the clients had added meaning to both questions and answers. Simple questions like "Would you please tell me how you understood this question?" or "Could you please explain to me what you mean by this answer?" initiated such conversations. Through this approach, the feedback conversation became an opportunity to gain further insight into areas that the clients had reported as problematic. Many therapists found that this way to use STIC was compatible with their effort to take an open and curious stance toward the clients. The themes that the therapists and clients were curious about often corresponded with domains for which client responses were in the clinical range in STIC. The clinical

guidelines recommend that the themes mostly into the clinical range should be given most attention, and the therapists did not see this as being in conflict with user involvement. STIC was seen almost as an independent subject with the power to influence the conversation and setting the agenda. Such a view is in line with a social constructionist perspective, where everything has an impact on everything. Although the therapist and the family more often than not agreed with this agenda set by the STIC clinical guidelines, a few therapists found STIC to represent a violation of the free and uninfluenced conversation that they preferred to have with the family. STIC was also seen as a (at least temporary) hindrance for exploring new themes of importance for the family. This would typically be themes related to incidents during the last week, for example father getting a new job or daughter dropping out of school.

Many of the therapists reported in the interview that after having used STIC for a while, they found that they trusted their own hypotheses and interpretations of the STIC answers less and less. Rather, they became more interested in exploring the clients' ways of understanding the questions and answers in STIC. Many of the therapists found that this way of approaching the STIC procedure was the most meaningful for them, thus enabling them to integrate STIC in a social constructionist therapy philosophy. This may be seen as an indicator of the possibility to use a pre-defined questionnaire in ways that include and perhaps promote user involvement.

In order to explore the meaning behind responses to STIC, the therapists found that they needed some time to learn to become open enough in their approach to the clients in the feedback conversation. A position based on the therapist's interpretation ("it looks like you are doing better now?") seemed in some cases to provoke a defensive reaction with the clients, such as "I am not sure I understood the questions in STIC" or "What question made you think that?" A more open and exploring position ("I see that this answer is somewhat different from the one you gave last time—could you please tell me what this means?") did not provoke the defensive response in the same way. The therapists wanted to create an atmosphere where the exploration of the STIC information became fruitful for everyone involved. This was also helpful in order to maintain the balance between professional knowledge and experience-based knowledge as mentioned earlier in this chapter. This process may well be seen as a process toward a deeper user involvement in the co-creation of meaning. The feedback conversation serves as a necessity in order to understand the different family members' meaning system. Additionally, the feedback conversation is a therapeutic intervention through which personal growth and relational development may take place. However, it is not the procedure in itself that makes the feedback conversation meaningful. The therapist's relational skills and how these skills are put into play within the unique context of every therapy session contribute to how a feedback conversation develops. This is in line with Sundet (2012) and his analysis of how PCOMS may work as a conversational tool, facilitating and stimulating important conversations (see also Chap. 7). Although this opportunity is not solely dependent upon the use of a feedback procedure, the feedback procedure may be used as a vehicle toward

the sharing and exploring of meaning in the couple or family in ways that involves all participants in the session. Seen this way, the feedback conversation is an opportunity for user involvement in the exploration of the multiverse of the family —if the therapist chooses to use it as such.

Feedback Procedures Give the Opportunity to Share Information with Everyone in the Room

An important part of the STIC feedback procedure is the sharing of STIC information with fellow family members. By simultaneously displaying the family members' graphs in the session, the family members can easily discover each other's levels of distress and resources, as well as the development of each person's responses to the particular questions throughout the course of treatment. In the feedback conversation about the displayed graphs, the subjective truth becomes concrete when each family member presents his or her understanding and ways of contextualizing the questions and answers. By talking about one specific theme in STIC, and helping the family to accept different views on that theme, a metaprocedure may be established. This metaprocedure may act as a blueprint for the family that demonstrates and legitimizes the possibility of relating differently to each other. This is also a concrete way of recognizing that the same answer to a STIC question may originate through different rationales for two members of the same family. Likewise, the same answer may have different meanings for different family members. These nuances become evident in the feedback conversation and could play a major role in the continuation of the therapy because of a possible richer understanding of each other within the family.

To gather those people who experience a situation as a problem, or who may contribute to its solution is another of the pillars of family therapy. By sharing thoughts on a problem, it is hypothesized that the involved people may gain new insights or understandings of each other's points of view and thereby create better contexts in which to live together. This principle of epistemology is included in the STIC procedure. The opportunity is given to demonstrate and experience how openness may increase understanding.

Some of the therapists were concerned about the ethical aspects of sharing STIC answers with fellow clients. The therapists recognized this as a strong and potentially powerful intervention, and even though the family had given their consent to share, they may not have understood the consequences. The therapists also wondered about how not answering or answering deliberately wrong would affect both the continuation of therapy and the possibility for that client to later tell the truth. Would it be easier to lie on the web? Would it be more difficult to admit to that lie in front of the rest of the family when it had been written down or even displayed? These questions were asked out of curiosity as well as an attempt to anticipate

situations where clients may not be able to fully understand the sharing part of the STIC procedure.

Although anticipating difficult scenarios, the experiences with the use of STIC were mostly positive. Several therapists told stories about how family members changed their understanding of each other, and how the dynamics of the family was altered toward more support and sympathy. However, there were also examples of the opposite effect, where family members used the shared STIC responses to hurt or devaluate the other family members. Because of this, the therapists showed the family's STIC data with care and caution. This was especially the case if one family member reported suicidal impulses or a wish to end the relationship with the partner. The therapists took extra precautions in order to make sure that the family member had understood that such answers would be shared through a STIC procedure, and whether they still wanted to share that particular information. This was done by having a conversation with the client who had provided the information, before the session or during a break in the session. These experiences and the solution of them highlight that although the STIC procedure provides the *opportunity* to share, it does not automatically give the *permission* to share. The information—although given in a family therapy context—still belongs to the individual. This implies that sharing is not always the recommended option. The therapists wanted to protect the clients from potentially harmful consequences of the STIC procedure, and the sharing of data was considered as the most potent part of the procedure to go either way. The simultaneous display of the STIC information needs therefore a skilled guide. The therapist needs to use professional knowledge, experience and intuition in order to make the sharing of data a meaningful experience for the family. Additionally, the therapist needs to take advice from the client on how to proceed with therapy, an action that clearly represents user involvement.

One important aspect with this way of relating to STIC information is the value of signaling the recognition and acceptance of varieties and differences in the family. Such therapeutic actions are not easily manualized, and therefore open for tailoring to each client and family. The therapists found that a careful and sensitive attention to the alliance is needed as a base for this part of the STIC procedure in order to make sure that the sharing can be influenced by all participants. The open sharing of STIC data may contribute to user involvement by giving the family members the opportunity to ask each other and clarify how they understood the question and the thought process behind their answer. The same way the therapist acts as a role model for how to explore different family members' views, the sharing of STIC data may work as a practice for sharing other personal material within the family context.

A small group of the therapists reported the practice of *not* taking the opportunity to share data with everyone in the subsequent session. Their reason for this choice was that they perceived the STIC information as a disturbance to *them* in their interaction with the clients. Rather, they treated the information in STIC like a laboratory answer, which they used to calibrate their clinical impression of their clients. If the STIC answers differed from their impressions of the therapeutic

conversation in the first session, they more often than not dismissed the STIC information and relied on the information from the session or their perception of the session. The opportunity for user involvement through the feedback conversation was therefore missed. However, these therapists argued that user involvement was more taken care of by letting the clients—and not the STIC—set the agenda for the session. They found themselves to be more open to what the clients wished to bring into the session without previously having read the STIC information. Sweeney and Morgan (2009) recognize this way of relating to feedback from clients as one form of user involvement, although to a very low degree. In light of Walfish et al. (2012) findings about therapists' lack of correct judgments of clients' progress in therapy, one may say that not sharing information is an inefficient clinical practice in terms of user involvement. Here, the feedback becomes a one-way communication where the therapist receives, processes, and chooses whether or not to act based on the information. According to Walfish et al. (2012), there is a high risk for the therapist to misjudge when not including the accessible information, something that puts this into an ethical dilemma: choosing not to make use of available information that presumably has a higher credibility than one's own judgement.

However, there is a difference between monitoring *progress* and judgment of *processes* in the therapy conversation. The first may well be covered by postponing the exploration of the STIC information until after the session. In order to build a nuanced understanding of the therapy process however, it may be more fruitful to engage in the process of sharing STIC information. In a social constructionist perspective, the information will inevitably influence the conversation in the next therapy session with those clients anyway, and thus influence the process. By inviting all participants to share their views, a more nuanced understanding will probably develop on both progress and process as interwoven entities. This is in line with the STIC clinical guidelines, in which sharing STIC data is a vital part. Such a practice is also considered to involve a higher degree of user involvement (Sweeney and Morgan 2009) even outside a social constructionist or family therapy perspective.

The therapists emphasized the focused attention and relational awareness as a key philosophical and psychological state for them to be in, in order to help the clients communicate their thoughts and theories of change. This state seemed to go beyond the "not-knowing position" (Anderson 2007) by encompassing a capacity to detect and contain relational changes from moment to moment. This relational awareness has not been explored within the literature on feedback. Most therapists we interviewed discussed this notion, although in different ways. The therapists communicated a strong sense of obligation to enter such a state of helpful subjective presence. For some therapists, STIC was compatible and helpful in this way, for others the opposite.

Even though the feedback procedure offers opportunity to share information, the therapists may still choose *how* to make use of this opportunity in their own preferable way within their contexts. Such choices may challenge the therapist's

professional comfort zone as well as inspire professional growth and development (Oanes et al. 2015b). In family therapy, user involvement seems to be a highly regarded phenomenon. However, a consensus on "best practice" regarding how to integrate a structured feedback procedure like STIC, user involvement, and a social constructionist perspective is a complex matter.

There is a gulf between massive information gathering through STIC and the desire to diminish preconceptions that is described by Anderson (2007). The theoreticians and practitioners Anderson (2005, 2007, 2012), and Seikkula and Arnkil (2013) describe such an attitude as accepting and recognizing the other without reservation. According to Seikkula and Arnkil (2013), this attitude does not necessarily exclude access to information about the client through other professionals who know the clients from different contexts. Anderson (2005) states that one will always have hypothesis about the other (here: the client or family), but that it is possible to bracket these in order to occupy an attitude of preparedness to accept the unexpected. Hypotheses are welcomed in this perspective, but have to be rooted within the context of the meeting, and spring out from the relation with the specific clients (Anderson 2007). This attitude according to Anderson is a prerequisite for not understanding the clients too rapidly and not jumping to premature conclusions. Rober (2005) also points to this attitude by stating that there is a continuous stream of hypotheses within the therapist's inner dialogue, and the therapist should test these hypotheses by asking the clients about their relevance. The therapist then has to be willing to give up a hypothesis that does not fit the clients' views rather than trying to silence the stream of hypotheses in the first place.

The use of a feedback procedure such as STIC represented for the therapists both the information per se, and the activity of handling that information. The amount and type of information gathered through STIC Initial represented the risk of being more concerned with the STIC than with the family in the first session. This included the risk of taking for granted that one understood the questions in STIC the same way the clients understood them. There is also a risk in taking for granted that one understands the same as the client regarding the alternative for answering—like the concept of "often." The simplification is necessary in the questionnaire and at the same time invites to add more complexity through conversational exploration. The process of therapy almost always involves a process of constructing and deconstructing phenomena, nuancing and negotiating meaning. The amount of information that could be accessed by using STIC may be overwhelming for the therapists, representing a challenge for the therapist to be even more conscious about not understanding the client too fast. Herein lays both the opportunity to enhance and decrease user involvement, depending on how the therapist deals with the opportunity. The therapists we interviewed recognized both possibilities and their responsibility in the decision.

Conclusion

There is a close relationship between user involvement and central epistemological elements in social constructionist family therapy. Writers like Karlsson and Borg (2013) and Weinstein et al. (2010) emphasize how the client's sense of influence on the course of therapy promotes recovery and health. Such an approach to therapy is also recommended by writers and practitioners like Duncan and Miller (2000), proponents for a client-centered approach to therapy by referring to the client's theory of change.

A collaborative way of using the STIC procedure brings together both family therapeutic approaches, central elements within the concept of user involvement, and the significance of feedback. When the therapist emphasizes the feedback conversation in order to fully understand the STIC information, the use of a structured feedback procedure such as STIC is compatible with a not-knowing position (Anderson 2005) and the co-creating of meaning. The therapist needs to convey an attitude as well as practicing the philosophical base for the not-knowing position, in which the therapist does not know more about the client than what the client knows about him- or herself even though the STIC information is there.

The discussions and examples presented in this chapter suggest that user involvement is mostly prominent within the feedback conversation part of the STIC feedback procedure. Our study also suggested that the therapist's personal preferences on how to combine theories and practices, as well as clinical intuition, influence strongly on how a feedback procedure such as the STIC is used clinically. In a conflict situation, clinical intuition preceded the clinical guidelines, which recommend sharing the data. In a user involvement perspective, clinical intuition is challenging. Clinical intuition implies the risk of clients being understood and viewed by the therapist as an expert. This "besserwisser" attitude could result in harmful consequences, in particular if the clients mainly are assessed in light of their shortcomings.

The inclusion of a feedback procedure in therapy is no guaranty for user involvement. Feedback procedure offers opportunities to collect, explore, and share therapy relevant information and knowledge. In different ways, the three aspects of making meaning within the feedback procedure (client alone, therapist alone, and co-created meaning) mentioned earlier may promote or enhance the client's involvement in their own therapy as it develops. The client processes the questions and answers within his or her context, thereby preparing and developing his or her own understanding of the therapy process. The therapist processes the responses within his or her professional context, also preparing and developing his or her understanding of the therapy process. The family and the therapist together process the STIC information within the context of the therapy session. The therapist seems to have a key role in order to choose how to use the opportunities that the feedback procedures offer within the context of the therapy session. These choices play a major role for how a feedback procedure may contribute to the development of user involvement in family therapy.

The STIC procedure is often presented within the framework of Empirical Informed Therapy (Pinsof and Chambers 2009), which implies that the therapist retains control of which data to share with the clients. Seen in this light, the dismissal of the STIC procedure would actually be in line with a user involvement perspective. The STIC procedure may also be viewed within a Client Directed Therapy framework (Duncan et al. 2004), which implies that the control over which data to share is handed over to the client. Within a social constructionist framework, user involvement implies that the data originating from a feedback procedure is given form and perspective through a deliberate and slow-enough movement *together* in the co-creating of meaning. The importance of recognizing the implications of the different theoretical frameworks is at the center of clinical use of feedback procedures. Dealing with this issue should be taken into serious consideration by clinicians especially, as well as by administrators, service owners, and stake holders. The feedback procedure may act to promote or inhibit user involvement, depending on the therapist and the theoretical frame of thought involved.

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Chapter 9
Empirically Informed Therapy Conducted at the Family Unit, Modum Bad

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Introduction

Several studies have confirmed that those seeking couple and family therapy (CFT) typically have a combination of psychiatric and relational problems (Whisman et al. 2009). The Family Unit at Modum Bad welcomes couples and families with this combined distress. Many of our clients claim that their previous treatment was inadequate because this combination was not addressed in lower thresholds services, including family agencies, childcare social services, child and adolescent psychiatry, or adult psychiatry. Each of these services has specialized knowledge, but we find that they rarely see the need to consider individual psychiatric disorders and severe relational distress in an integrated fashion. At the Family Unit, we find it urgent to understand how the dysfunctional relational patterns in the family impact on individual suffering as well as make it difficult for family members to solve their problems. And vice versa, we need to understand how individual psychiatric disorders create or exacerbate relational distress. The combination of psychiatric disorders and relational problems may result in "multiproblem" families in which both parents and children might have psychiatric diagnoses¸ often related to relational traumas caused by abuse and neglect in more than one generation.

We will in this chapter present the Family Unit's 12-week integrative, residential treatment program for severely distressed couples and families, which includes as an integral part an internet-based client feedback system that uses routine outcome monitoring (ROM), the Systemic Therapy Inventory of Change (STIC; Pinsof and Chambers 2009, see Chap. 5 for more information about STIC). This will be followed

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by our theoretical considerations in relation to systems, circularity, and feedback. Finally, we will present how the use of ROM is integrated into our treatments.

The Modum Bad Context

Modum Bad is a national psychiatric hospital for adults in Norway that consists of four inpatient treatment departments, specializing in psychotherapy for clients suffering from depression, anxiety, eating disorders, and severe relational traumas. The fifth department is the Family Unit, which since 1968 has offered residential, intensive treatment for couples and families. Within a stepped care model (Bower and Gilbody 2005), Modum Bad is designed to serve clients at the highest threshold level who do not have psychotic or suicidal features, disruptive or acting out tendencies, or substance abuse as a primary problem. Clients who meet the criteria for admission have failed multiple treatments in their communities.

Because the treatment context of the Family Unit is an inpatient psychiatric hospital for adults, the intake criteria at this unit are that the adults or at least one of the adults in the family need to have substantial individual distress (i.e., have a psychiatric diagnosis) in addition to severe relational problems within the couples or families. Furthermore, one or more of the children might display emotional or conduct disorders. Indeed, most families at the Family Unit could be described as "multi-problem families." The couple/family needs to be motivated to seek residential treatment, which involves intensive treatment for up to 12 weeks. When the clients are hospitalized for treatment, the adults who are in work will be placed on sick leave while in treatment, and the hospital will get reimbursed from public insurance for the costs of the treatment for those adults who have a psychiatric diagnosis. Hence, this treatment is not associated with any economical costs for the clients.

The treatment facility of the Family Unit consists of hospital buildings containing therapy offices and meeting rooms. Each family lives in their own house, forming a village around a community/activity house. Physically, the hospital contains Swiss chalet style-restored buildings with indoor and outdoor embellishment, a sculpture park, and walking trails in the forest that form a quiet and congenial atmosphere for relaxation and reflection/contemplation. This hospital's emphasis on esthetics reflects our core belief that it is important to meet suffering people in a welcoming and caring community environment. A client's initial impression of the treatment environment and staff may well create hope and optimism (see Chap. 10—Vike and Haukelien; Willis and Todorov 2006). Receiving a client within a beautiful context by friendly and caring members of the staff gives—at a symbolic level—the message: "You are a valuable person, deserving the best possible environment and treatment when you are about to deal with the most distressing aspects of your life." Psychologically, this message motivates and strengthens the client's image of self, facilitating growth and helping reach one's potential for life and relationships. Indeed, beautiful natural settings have been shown to be associated with increased well-being (Raanaas et al. 2012; Seresinhe et al. 2015). The concrete way this message is conveyed at Modum Bad is by

encouraging the clients to make use of the surrounding nature, exercise, participate in cultural events, notice the architecture, art and esthetics, and—due to this hospital's diaconal profile—acknowledge their spirituality. This also elicits support and caring from other clients. As suggested in another chapter (Vike and Haukelien, Chap. 10), the clients experience these surroundings as implicit messages of being valued. Thus, we believe that our context facilitates a synergy of mutually enriching forces that is for the benefit of client outcomes.

Treatment length at the Family Unit typically is 12 weeks, and at any time, 9–10 families are in therapy. The clients are admitted to the treatment program on a "slow-open" basis so that at any time there will be a blend of "veterans" and "novices," encouraging peer exchange of experiences and introduction to the program activities. It is a short walk from their houses to the treatment facilities, therapist offices, and a community house for social activities and occupational therapy. The Family Unit has its own kindergarten and school, as well as leisure time activities, and these form natural parts of the village for children up to 16 years old. In the spirit of integrative practice (Flaskas 2005, Tilden 2008), relevant experiences and observations from all these arenas are incorporated into treatment.

The treatment is organized around each family with a team consisting two layers of professional roles. The closest layer to the family is the main therapist (could be either a clinical psychologist, physician/psychiatrist, clinical social worker, or a clinical nurse) and one milieu therapist (nurse or pedagogue). The next layer consists of other professionals that the family relates to during the stay, such as the school and kindergarten staff (depending on the children's age), an occupational therapist, and other professionals who are available for counseling, such as a child psychologist, physician, psychiatrist, or pastoral counselor. The majority of the unit staff has additional training in adult psychiatry and/or CFT. The ambition is to be updated on the current literature within CFT by joining and presenting at international conferences and by conducting cutting-edge research (see for instance Tilden 2010). The core staff members have been stable over several years, representing a continuance of tradition and knowledge to be carried forward to new staff members. Regular peer supervision is carried out, encouraging a transparent working milieu characterized by mutual support in a culture of inquiry where both successes and failures are shared. Therapy sessions with the use of one-way mirror and reflective team are used to increase transparency and to invite other perspectives than what is so far discovered and shared.

Couples therapy is the main approach of the treatment program. This is based on the experience that working with the couple to improve the quality of the relationship impacts positively each family member and the family as a whole. However, the treatment focus and the sequence of treatment interventions might vary. Each week, the treatment program includes two couple therapy sessions with the therapist and the milieu therapist. In addition, family sessions can be conducted by using a one-way mirror. For instance, children sit in a neighbor room, watching and listening to their parents talking with their therapists about the family problems through the one-way mirror in one part of the session, followed by a part where the family members switch roles so that the parents can watch their children talk and reflect with the therapists about what they observe (or vice versa or several other

combinations). We experience that this type of contextual shift enables the participants to discover new aspects of their family interaction. Other types of family sessions may include tasks to be solved (e.g., decision-making) or playful activities (e.g., encouraging joy and laughter), where therapists partly observe, partly participate and intervene. The treatment program also includes two weekly educational sessions: one focusing on adult individual and relational topics, and the other focusing on the developmental needs of children. We seek to create a community, as similar as possible, to the families' regular domestic, work, school, and social home environment. And we experience that this context creates several situations similar to their domestic experiences reflecting their problems and challenges. For instance, clients suffering from social anxiety, who rarely participate in social activities at school with their children, will be challenged and supported to expose themselves to such situations within a safe context during treatment. This is in accordance with the recommendations about optimal treatment conditions, labeled "safe uncertainty" (Mason 1993), implying that in order to make new experiences that promote desired change, one needs to expose oneself to "trial-and-error" or risk-taking (uncertainty). But as a prerequisite to dare doing so without risking dramatic consequences, there needs to be a safety net contextually and professionally around the person. Another example is that clients with personality problems will engage with peers in ways that may evoke reactions from other clients. When this is observed or reported, this can be addressed as part of therapy, inviting the clients to investigate whether this constitutes part of the problems they as family seek help for. If so, the next step is to encourage the clients to make use of the same arena to try out and practice more adaptive behaviors. A third example is when a whole family struggles with a common topic, e.g., lack of appropriate boundaries, that is observed by staff members within several of the family member's treatment contexts at the Family Unit (e.g., kindergarten, school, leisure activities, behavior and topics in the couple, and family therapy). Through an open communication and conceptualization among the staff, we can join forces to intervene on the same arenas simultaneously, enabling a synergy effect.

Theoretical and Empirical Background

Systems theory and cybernetics form the basis for CFT at the Family Unit, implying that a system exceeds the sum of its parts, that systems interact in circular ways, and that systems are self-regulating due to exchange and feedback (Johnsen and Torsteinsson 2012; Rohrbaugh 2014). The notion of systems stands in contrast to the medical model's emphasis on understanding problems from a linear and reductionist cause–effect approach, with an emphasis on deficits in the individual. Hence, in the development of CFT, systems thinking, including circularity and feedback, was initiated as a way to take into account the complexity of an individual imbedded within relational and contextual environments (Johnsen and Torsteinsson 2012; Rohrbaugh 2014). Thus, this broader view considers multiple factors and relationships that mutually influence each other, e.g., between the members within the couple or family,

as well as contextual factors. The systems perspective provides a means to understand presenting problems and design and implement interventions.

Research evidence for circularity exists from a number of different areas. Several studies have found that psychiatric problems and relational difficulties often coexist, and in particular this is the case for depressive symptoms and relational discord within couples and families (Whisman et al. 2009). In their review, Whisman et al. found that persons with individual depressive symptoms very often lived in distressed couple and family relationships. And the opposite way around, there was a 10-fold risk of experiencing depressive symptoms for couples in conflict (Atkins et al. 2009). Several studies confirm that when a depressed partner seeks negative feedback or withdraws to avoid conflict, characteristics of interaction with a depressed person, it has a negative effect on the well-being of the partner and creates relational distress (Whisman et al. 2009). Other studies have shown that relational stress (e.g., a critical and hostile relational climate) leads to depressive symptoms of the participants (Henriksen and Thuen 2012; Johnson and Bradley 2009; Whisman et al. 2009). One way to interpret this association is that relational stress (e.g., anger from one spouse) can be perceived by the other spouse as a threat against attachment, belonging, support, and trust in their intimate relationship. Most likely, every couple and family seeking treatment experiences this bidirectional influence of individual psychopathology and relational distress. For example, a depressed partner is demanding and nagging the partner for more attention and intimacy, which is perceived as distressing to the other partner, who then withdraws. The withdrawal is experienced by the first partner as a threat against attachment, something that fuels the depression, which in turn leads to increased relational demands. This illustrates the "demand-withdraw" pattern, one type of complex interplay between individual distress and relational discord that enforces a maladaptive pattern where the partners get into a vulnerability cycle interplay (Fishbane 2015). This pattern is circular as there is no compelling evidence to suggest that one of the factors, say relational distress, is the cause of the other, say psychiatric symptoms; rather they work together to exacerbate both problems. In addition, each of the partners may well have characteristics that make the situation even worse, such as personality disorders (Whisman et al. 2009). The interaction of psychopathology and relational problems, with one influencing the other and vice versa, supports CFT therapists' emphasis on systems theory, including circularity.

The CFT Treatment Approach

Based on the foregoing, the notion of systems and circularity are important in CFT treatment approaches. Even though particular treatments exist for particular disorders in CFT, as they do in individual therapy, the complex relationship between psychopathology and relational issues has led CFT practitioners to search for broader treatment approaches. One additional reason for this is that compared to individual therapy, each member of the couple or family may have their own view

of the problems and their own goals for the treatment. It is estimated that at least 30% of couples seeking marriage counseling have such mixed agendas; for example, one spouse wishing to save the marriage, and the other moving toward divorce (Doherty 2011). Our main premise is therefore that in CFT, we need to apply different therapeutic approaches toward different family members at different phases during the course of therapy for the same couple or family. Further, we need to be aware how these different approaches interact within a systemic and circularity perspective. Hence, the following view from Wampold and Imel (2015) should be relevant in CFT as well as in other treatment modalities:

> Patients within disorders are heterogeneous with regard to the causal factors creating the disorder and, therefore, different specific ingredients are needed to address specific deficits, regardless of diagnosis. (p. 229.)

Hence, the therapist qualified in one theoretical approach only will not likely succeed with all of the families or all of the members of a particular family. The complexity of CFT and the inappropriateness of adopting a single theoretical approach has therefore lead to an integrative movement in our field (Lebow 2013), resulting in a greater blend of the previous "schools" in CFT (Heatherington et al. 2015). For instance, Flaskas (2005) presented "integrative practice" as a necessary pragmatism in CFT:

> Integrative practice, which is the creative (and usually sophisticated) practice of experienced practitioners, is produced in the environment of day-to-day, family-to-family therapy. The controversy about mixing theory and crossing boundaries loses its heat in practice, where integration is achieved in the specificity of the way in which therapeutic ideas are being used to 'meet' and facilitate a (particular) family's process of change. (p. 133.)

At the Family Unit, we have adopted the Integrative Problem-Centered Metaframework Model (IPCM; Breulin et al. 2011; Pinsof et al. 2011; Russel et al. 2016). The premise for this model is that one specific approach will not fit all clients, and that one needs to be flexible depending on which system (e.g., individual, couple, and family) one is addressing with which intervention and at which point during therapy. This model acknowledges that all "bona-fide" therapy approaches may represent significant contributions to understanding parts of the whole system and may prescribe relevant interventions to be used at some point in therapy. It is, however, crucial to know the indications of which therapy approach to choose in a given situation and when to use it so that the chosen interventions fit into an understanding and appreciation of a complex system. In the guidelines for the use of the IPCM model, it is recommended to start every new therapy by exploring the problem in relation to the context in which it appears and to know what has been tried to overcome the problems previously. In particular, systems and circularity are very well illustrated by mapping the "web of constraints," which refers to how different factors interact so that they in turn hinder the client in achieving the desired change. IPCM recommends starting the changing process primarily by encouraging behavior change in the interpersonal relations in the "here and now." If this is not sufficient in order to obtain desired change, therapy can proceed to make use of more emotional and cognitive interventions, as well as

medications, if needed. The notion of system and circularity is further included in this model due to the need of making use of ROM, something that will be addressed in the following section.

The Use of ROM at the Family Unit

The professional development at the Family Unit has to a great extent emphasized ensuring that our services were effective. We also wanted to give voice to the family member's perspectives on progress, and we wanted to understand the members' perspective on family dynamics and each other. As part of this endeavor, we conducted an effectiveness study at the Family Unit (Tilden 2010) that—among other acknowledged questionnaires—also made use of a simple feedback questionnaire to clients and therapists on a weekly basis. Because we experienced this to be very meaningful, clinically as well for research purpose, a decision was made to look for a tested and validated ROM system suitable for our context. According to our criteria for a comprehensive feedback system for clinical as well as for research purposes that needed to capture different systems (individual, couple, family) as well as the assessment of several domains (symptoms, relationship, outcome, alliance), we chose to try out and implement the Systemic Therapy Inventory of Change System (STIC; Pinsof and Chambers 2009; Pinsof et al. 2016—see Chap. 5 for more details). We collaborated with the founders of the system, professor Pinsof and colleagues, to translate and test the system in a Norwegian setting. And after a pilot period, the system was successfully implemented at the Family Unit, as well as at two other CFT units in Norway (see Chaps. 5, 8, 11, and 12) for more thorough descriptions of the experiences in the use of the STIC system).

The STIC was developed by Pinsof and colleagues for the purpose of regularly asking the clients to complete questionnaires to inform the therapist how well clients are progressing and to help the therapist monitor and adjust therapy in real time according to the client's needs and preferences. The STIC contains six system scales addressing individual problems and strengths, family of origin, relationship with partner, family household, child problems and strengths, and relationship with child (Pinsof et al. 2015). The first time the client completes the STIC (STIC Initial), he or she also gives information on background demographics and motivation for treatment. Before every subsequent therapy session, the client completes a shorter version of STIC (STIC Intersession), which also contains alliance measures. The client completes the questionnaires electronically. Once the client has pushed the "send" button, the data are processed together with previous data of this client and are compared to normative data. In few seconds, a report is made available for the therapist that shows graphs and numbers, including information about (a) the risk items (e.g., suicide or homicide threat, violence, abuse), (b) which problems are most troubling (i.e., are in the clinical range), (c) which changes have occurred since the previous or first session (i.e., an assessment of whether the clients are progressing), (d) whether the therapist and clients have a good enough

alliance, and (e) whether the therapy has reached its goals, indicating planning for treatment termination. This way, the clinical use of STIC should enhance the therapist's understanding of client progress and as a basis for intervention planning. Further, the therapist invites the clients to explore, interpret, and evaluate the STIC information in the therapy session. This kind of user involvement enhances collaboration, which influences positively on the therapeutic alliance. Once the therapist is informed by the feedback, he or she has the possibility to address and evaluate such concerns together with the client during the course of therapy, allowing therapy to be responsive to the client's needs (Boswell et al. 2015; Lambert and Shimokawa 2011; Pinsof et al. 2015).

The systematic and frequent collection of information by the use of STIC that informs the process of therapy is called "empirically informed therapy" by Pinsof et al. (2016). As well, STIC data are ideally suited for research purposes, due to the frequency of data collection, and has potential to investigate the relationship between process and outcome, and in particular to learn more about change mechanisms in CFT. So far, data from a pilot project and a RCT project comparing feedback to treatment as usual (i.e., with no feedback) are about to be analyzed.

STIC is a very systematic way to collect client feedback. This adds to several other approaches at the Family Unit that also promote user involvement and collaboration toward a joint therapeutic goal. In the following, we will share some clinical experiences on how STIC in combination with other ingredients of the integrative residential treatment program is useful for treatment planning and evaluation as well as for creating a powerful therapeutic tool in working with multiproblem families.

Treatment-Planning and Building Alliances

The adults in many of our multiproblem families may have a combination of psychological and somatic disorders as well as social dysfunctions that have impaired their life functioning in all major life areas, including their working capacity. Their communication and emotional regulation skills are often limited, which increases the likelihood that the couple is unable to address life challenges in an adaptive way. The spouses might enter our treatment program with quite different understanding of their problems and what they think needs to be changed. Other couples may have talked about problem areas, but have not really connected emotionally with regard to the content of what was shared in their conversation. In both cases, we find that using the graphs from the first STIC data (STIC Initial at admission) is very helpful in order to create a common ground from where the treatment process can start (see Fig. 9.1). This is because the STIC report gives the therapists an instant and rich picture of the problems and what may constitute treatment barriers. Hence, STIC is experienced to be a very concrete form of user involvement, strengthening the possibility for the voice of the client to be heard as part of the therapy. As such, it also implies a respectful and humble attitude towards

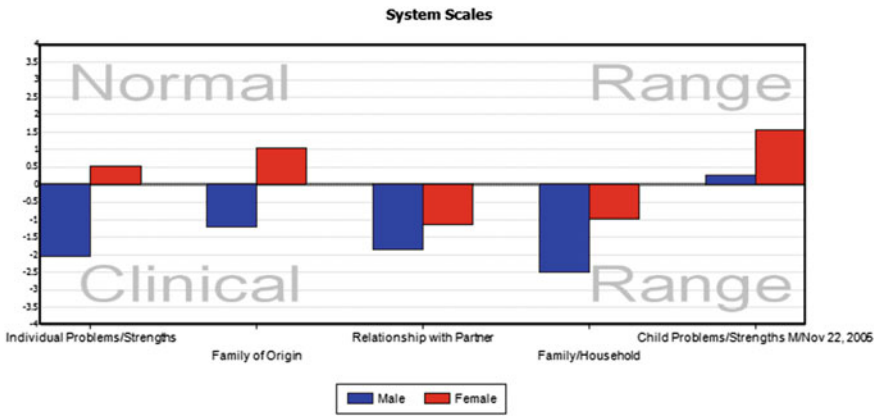

Fig. 9.1 STIC Initial main categories for a couple (male is *blue*, female is *red*)

the client, acknowledging his or her experiences and theory of change as central components in the CFT therapist–client relationship (Johnsen and Torsteinsson 2012). Because the STIC data display variables within one graph for all family members, the therapist and the clients are able to discover connections between different factors. For example, relational traumas in the family of origin may impact on the functioning of one of the partners and the relationship and daily living in the household. It seems like looking at the graphs together with the couple while reflecting upon the shared experience powerfully links emotion with cognition and behavior from early stages of therapy. This makes it easier to agree upon the treatment goals and makes a plan to achieve these goals that is easily accessible for weekly evaluation. The visual feedback given by the STIC graphs can have powerful emotional impact on the clients also because it sometimes reveals issues that have not yet been consciously integrated and shared by the clients. Even when it is known, seeing a graph or numbers may sometimes have greater emotional impact than talking about the same issue. Furthermore, what appears as a minor change in the verbal communication can sometimes be shown to have greater impact on the graphs than expected. Hence, the STIC is not only an assessment tool, but a powerful therapeutic intervention as well. This collaborative approach seems to strengthen the alliance (agreement of goals and tasks, as well creating an emotional bond) within the couple, as well as between each of the clients and the therapist.

Collaborative Approach to Therapy Enhances Change

After having identified problem areas and treatment goals, the treatment program is adjusted according to the family's needs. All parents participate in psychoeducation seminars, including the Prevention and Relationship Enhancement Program (PREP;

Markman et al. 2010) and Circle of Security (a relationship-based parenting program; Powell et al. 2013). This is combined with therapists visiting clients in their house to observe and intervene in their daily life situations, most often in combination with some sessions of video supervision. This provides for different kinds of systematic collection of information and feedback from the client that can be shared, investigated, and reflected upon as they put new interpersonal skills into practice. Answering the same questions every week on STIC seem to increase the client's awareness of how they feel, think, and act and how that may influence their relationships. When a client asks, "When I'm asked to answer this question every week, does that mean it is important?" implies that STIC addresses vital objectives that we believe are crucial for them to be aware and reflect upon to as part of their individual and relational processes. Further, when such observations, reflections, and feelings are put into words that are shared with the spouse, this may strengthen the attachment within the couple. And in turn, this could result in enhanced confidence in addressing conflicts and negotiating needs within the relationship. We experience that such processes strengthen the parental functioning and cooperation. Hence, STIC poses a tool suitable to enhance or develop self-reflective functioning. With those clients suffering from low self-reflective functioning, consultation from the therapists may be needed initially in order for them to understand the STIC questions and how to answer. Interaction between the therapist and clients is also needed in order to understand the clinical relevance of the clients' feedback to clarify how the questions and their answers are understood by the clients. By this investigation, the therapist also makes sure whether some of the client's responses are due to under- or overscoring. We experience that when the client is invited to collaborate on exploring and interpreting his or her own data, the clients become more active and interested in their own therapy process and progress. And for some, the use of data constitutes something "concrete" that increases their abilities to talk about the abstractions of feelings, perceptions, and relationships. We also find that many clients do not have skills in assessing their own, their partners', or their children's well-being and social functioning. However, by the use of the STIC, such skills can eventually be established. The client's capacity to differentiate between self and other may also be addressed through the use of the STIC.

Addressing Lack of Changes and Alliance Ruptures

The weekly STIC assessment of individual domains as well as the relationship with family members increases the likelihood of detecting lack of change in one problem area (e.g., lack of commitment to the partner; see Fig. 9.2). Seeing this lack of change visually on the graphs often has an emotional impact on the clients and invites further exploration and reflections. This may lead to important conversations about what needs to be addressed in order to promote changes in the couple and family. Likewise, ruptures of alliances can be detected, with the immediate chances of repairing the emotional bond, as well as renegotiating the therapeutic goals and

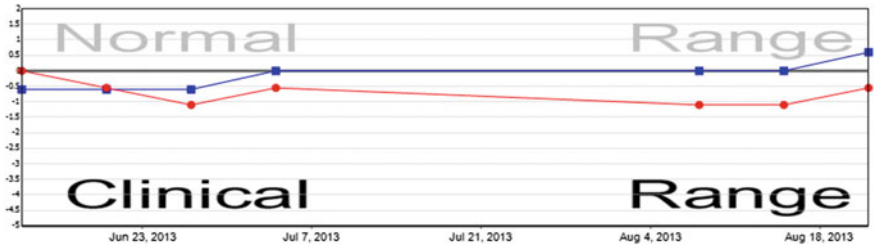

Fig. 9.2 Commitment from session to session (male is *blue*, female is *red*)

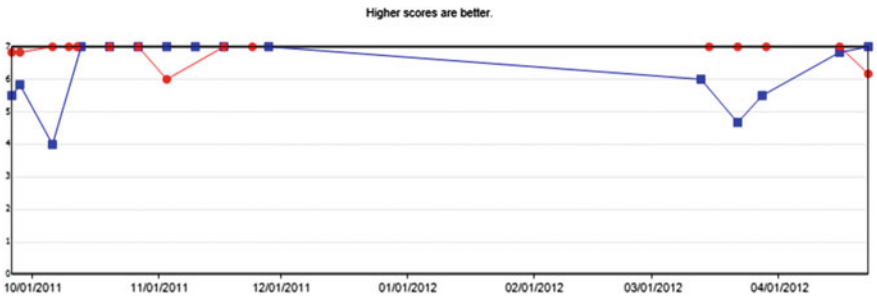

Fig. 9.3 Alliance between each client and the therapist (male is *blue*, female is *red*)

interventions (see Fig. 9.3). The alliance scale gives crucial information about the clients' alliance to the therapist, as well as the alliance between the spouses. The alliance scales also address how the therapy and changes are perceived by other members of the family, hence making it possible to identify and work with factors that might contribute to or constrain change. An important experience is that it is much easier to address important alliance topics in therapy when referring to the STIC reports.

This collaborative dance between practicing new skills, observing self and others and being observed, and sharing and reflecting together seems to ignite enthusiasm and hope in troubled families. We find that this experience of being able to detect and address problem areas successfully in itself is an important skill that enhances the family's self-regulating capacity and ability to adjust and grow with normal life challenges.

Clinical Judgement

The STIC reports do not replace the therapist, and the STIC by itself does not create therapeutic processes and changes. Successful use of STIC, like with any other therapeutic method, is depending upon a qualified therapist and a good therapeutic

alliance. Clinical expertise and experience are needed to assess which of the STIC data have most relevance for the treatment focus, and to interpret and make use of this information for a therapeutic purpose. For instance, it is crucial to time when during the therapy process, different aspects in the STIC report should be addressed in order to derive the full benefit of this information. In order to obtain clinical expertise, we experience that making use of STIC data in therapist peer supervision has a great potential as long as such examination and exploration happens within a climate of curiosity. When successful, this is in line with the concept of "deliberate practice" (Miller et al. 2015), aiming to learn from our mistakes, training on challenging situations, and stimulating a collective responsibility and pride of improving the quality of treatment.

When the therapists have gained experience in the use of the STIC system, it seems to increase the therapists' awareness of how they select and use information from all the available sources in the course of therapy. This relates in particular to what kind of information is considered to be clinically relevant and how it should be addressed in therapy. For instance, it is of importance to sort out information that seemingly is contradictory, e.g., if a client reports higher functioning in activities of daily living than is observed by partner or staff. We experience that this may also strengthen the therapists' own reflections on how they relate to the complexity and uncertainty as the therapy unfolds and how their choices influence the therapeutic process.

Closing Remarks

In the Family Unit, the implementation of STIC was successful (see Chap. 12), however, with many of the same challenges as experienced in other contexts when a new way of clinical practice takes place. Contrary to the other units that have also implemented STIC, the leadership at the Family Unit decided that the use of STIC was mandatory. Even though we experienced some resistance here as well, loyalty to the decision was expected so that the experience with the use of STIC over time could be evaluated before a final decision was taken. Hence, we believe that consistency in this decision has contributed to overcoming the implementation obstacles. Further, regular supervision that also open to frustration and lack of motivation was helpful. And finally, each therapist's growth in how STIC information can be applied in therapy seems to have convinced those who were reluctant. As part of this process, we have also faced one commonly presented objection to the use of standardized assessment tools (ROM) in CFT, and that is the risk of therapists losing their autonomy (Tilden et al. 2015). Our experiences show, however, the opposite pattern: Even though the use of ROM involves a change in clinical practice, therapists adapted the use of STIC information to their individual way of conducting therapy. It is our experience that STIC informs the therapy process and progress with the voice of the clients, and hence this makes user involvement very concrete in the daily clinical practice. The use of STIC in the

Family Unit has provided a unique opportunity to explore clients' capacity to observe and reflect upon their own functioning and relationships and to relate to how this is revealed in daily life situations. In particular, we have experienced STIC to be a particular useful clinical tool when working with multiproblem and low-functioning families. These families most often require an integrative therapeutic approach, as described in the IPCM model. As part of this model, STIC information captures to a great deal the complexity that exists within close relationships. Due to STIC's comprehensive information on several levels of systems and dimensions, the therapist and clients are made aware of the complexity and circularity of interrelated factors embedded in the Web of constraints hindering desired change to take place. This systematic and frequent feedback system informs the clinical practice so that understanding, assessments, and clinical judgements can be made from client-based knowledge. STIC information is crucial to discovering when clients are not improving or deteriorating or there are alliance ruptures, so that therapy can be adjusted to serve the clients more effectively. In addition, we find that STIC in itself can be used as a powerful therapeutic intervention that facilitates good conversations between clients and therapists. Because the same information constitutes research data enabling us to learn more about what works in therapy and why this works, the gap between clinical practice and research is narrowed.

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Chapter 10
Family Therapy and Holistic Complexity—An Ethnographic Approach to Therapeutic Practice in a Norwegian Psychiatric Clinic

Halvard Vike and Heidi Haukelien

Introduction

Family therapy emerges from an intellectual trajectory that, in the aftermath of World War II, generated a particular psychotherapeutic ambition to deal not only with individual pathology, but also with relational systems and the way they failed to adapt adequately to a changing environment. We find this ambition highly fascinating, as it seems to have produced a particular inspiration toward experimentation and intellectual, existential reflection. In particular, the interest in how individual psychological problems relate to social relations in the family and beyond has led researchers and therapists to develop methods that favor "sociological" perspectives of the self. One illustrative example of the intellectual trajectory of family therapy is the influence of Gregory Bateson's ideas of paradoxical communication, especially his famous theory of the double bind (Bateson 1972). "Double bind" denotes communicative situations that produce inescapable role dilemmas, typically represented by a parent who sends contradictory messages to the child. The messages belong to different levels of abstraction, so that a literal one is supplemented by a meta-message (irony, metaphor, body language, etc.). A typical example may be the incongruence between verbal and bodily communication, for example, when a mother says to her child: "Come to me, dear little one" while simultaneously turning her body away signaling disgust. In psychotherapeutic settings, family problems of this kind represent a particular challenge because "the patient" is not an individual but a constellation of social relations (as well as a "team" of involved actors), identities, roles, perspectives and relations. The interpretative work necessary to make sense of potentially pathology-generating patterns often needs to include an acute ability to discern and communicate complex sociological processes, none of which may be reducible to

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any given "core problem." Consequently, such work needs to draw on a wide variety of therapeutic genres and must seek to achieve some kind of integration beyond narrow testing of what "works" in the encounter between a diagnosis and a specialized therapeutic approach. In a family therapy setting, what the actors themselves try to understand may include complex social patterns and even emergent properties of social interaction such as "culture." In order to change the social system that they themselves construct and need to change, patients are likely to be in need of a combination of sociological understanding, strong motivation, as well as an environment safe enough to allow for reflection and experimentation. Clearly, this seems closely related to the fact that as an intellectual tradition, family therapy to some extent seems to have escaped some of the orthodoxy-generating factors that have made parts of psychotherapy into a "one diagnosis-one answer-one approach" type of business.

Our Ethnographic Approach

Our own interest in this phenomenon was stimulated by the possibility to conduct anthropological fieldwork in a psychotherapeutic context—Modum Bad Psychiatric Clinic ("Modum Bad" hereafter), Norway, in 2014. As part of that endeavor, we participated in family treatment and followed the work in the unit for a number of months. As social anthropologists interested in health, institutions, the welfare state, and, more particularly, the sociocultural contexts in which psychotherapeutic develop and are practiced, we enthusiastically seized the opportunity when the clinic opened its doors for us. During fieldwork, we got to know the psychotherapeutic teams, many of the patients, and followed the work as it took place in a variety of contexts—mainly therapy, psychoeducational sessions, coordinating activities, and some more informal settings. Our ambition, as anthropologists, was to try to understand how patients experienced the processes they went through during their stay at the clinic; that is, how and why they attributed meaning to the contexts they became involved in, and how they related to the affordances provided by such contexts to better understand and deal with their psychological and relational challenges. We were given access to most relevant arenas and were allowed—much like the patients themselves—to migrate between many different social contexts and to experience these contexts from within, in the making. As we will return to in more detail below, we gained much valuable ethnographic experience from moving in and out of therapeutic contexts and from observing how patients and therapists made them into vehicles for reflection, experimentation, and change. We emphasize "contexts" here because the patients very actively tried to use the many different arenas available to them as means for reflection and experimentation. Clearly, they appreciated the social experience of moving in and out of contexts.

Thus, an important part of our task, as we came to see it, was to try to understand the therapeutic effects of contextual shifts, as the particular experience of social complexity it generated seemed very meaningful and helpful for them. One

important aspect of this was that such experience seemed very productive for their ability to understand the contingency of their own view of themselves and their significant others, and to explain the patterns in which they sometimes felt trapped. Because the patients tended to see these contextual shifts not primarily as a movement between specialized, more or less unrelated arenas, but as a part of an encompassing whole, we choose to call the phenomenon explored here as "holistic complexity" (Barth 1993; Otto and Bubandt 2010; Vike 2002). By "holism," we refer to patients' sense of consistency and continuity regarding the roles, messages, relationships, and other qualities pertaining to each context existing *between* contexts. Our second, but closely related ambition in this chapter is to explore how family therapy is a part of a wider cultural context. When trying to find ways to understand and develop mental health-promoting patterns of social interaction, therapists and patients draw on a repertoire of meanings embedded in cultural history. In the Norwegian context, individual autonomy and egalitarianism constitute important parts of this repertoire (Sørensen and Stråth 1997).

Dilemmas of Symmetrical Reciprocity

In "*The Pathological Family: Postwar America and the Rise of Family Therapy*," Deborah Weinstein (2013) presents a fascinating account of the intellectual history of a very diverse psychotherapeutic tradition. One essential feature seems to be the combination of a certain intellectual openness and the complexity of its subject matter. Moreover, because of the symbolic significance of the nuclear family in the postwar and late modern Western context, particularly its role as a key arena for the reproduction of democratic values and the like, family therapy deals with much larger issues than those reducible to individual health. In the Norwegian and Nordic context, such issues tend to touch upon gender equality, the role of autonomy within the context of the dyadic partnership, and perhaps especially on the art of stimulating children's sense of security through experimenting with autonomy. Thus, in most of the therapeutic and educational sessions, we took part in during our fieldwork we encountered reflections and discussions circling around dilemmas related to balancing social and emotional obligations with individual boundaries and autonomy. Very often the key term that was introduced to mediate the tensions that grew out of this dilemma was "attachment"—indicating that there may be a way to attain some harmony, or balanced reciprocity, between the exclusive bonds of the family and the freedom of its individual members.

As they appeared to us in this therapeutic context, dilemmas of this kind clearly reflected tensions of a more structural type. As Antony Giddens and others have pointed out, in historical and sociological terms, late modernity presents us with some unique challenges as to how to achieve and cultivate intimacy (Beck and Beck-Gernsheim 2002; Berger et al. 1974; Giddens 1991). According to Giddens, love and intimacy are no longer compatible with "traditional" obligations because our tolerance for personal dependence is so radically reduced. In order to be

emotionally rewarding enough, intimacy can hardly survive if it is not anchored in what he calls "pure relationships." Although of course an ideal conceptual type, "pure relationships" come close to what many people seem to value highly; they leave no other strings attached than the bonds of love themselves and keep intimacy alive by being exclusive and conditional upon nothing but itself and whatever other emotional qualities that nourishes it. Clearly, this conceptualization of intimacy and love is simplifying, but for our purpose in this chapter—attempting to contextualize family therapy in the Norwegian cultural context—it does seem to have some comparative value. In Norway and Scandinavia at large, individual autonomy carries particular salience beyond the world of middle-class men. For a number of historical reasons, but not least as a result of the social and cultural effects of the welfare state, individual dependency has become a widely shared and celebrated value. The relative success of Scandinavian feminism is a major aspect of this; the institutionalization of the historical demands for economic security and freedom from dependence on care-taking obligations is a reality for the majority. The universal nature of public services (childcare and elderly care in particular) and economic compensation for unemployment, etc., has not only served to "naturalize" autonomy as a more or less "self-evident" cultural value shared by men and women alike; it has also become *partly* independent of class. Although empirically such a statement (regarding social class) is not at all in complete accord with the realities, we want to point out that in a context such as Modum Bad, the discursive effects of the cultural ideas of the middle classes can hardly be exaggerated. Here, as in many other public contexts in Norwegian society, social class constitutes a "silent" category which, even though evident to most as systems of distinction available for decoding, is normally not a legitimate topic to be made relevant in social interaction. As many ethnographic account of Norwegian society has demonstrated, this has some profound effects. One of them is that alternatives to the middle-class worlds' view tend to become muted and seen mainly as a temporary stage, as but one step on the ladder to "normality." Another effect is that the eagerness by which many seem to grasp the possibility to adjust to middle-class norms is considerable, and to some extent realistic—considerably more so than in societies where economic security and social status depend solely on wage labor or inheritance. The institutions of the welfare state have surely not abolished socioeconomic inequality, but they have gone a very long way to universalize the access to an attractive (mainly "middle-class") life style. Regardless of its many problems, there is little doubt the welfare state can be seen as an extraordinary successful achievement in sociocultural integration.

Autonomy and Boundaries

Couples and families who come to Modum Bad to seek therapy look for ways to change relationships and emotional states. As it appeared to us during our fieldwork, they most often sought alternatives to asymmetric reciprocity. In other words,

they did not seem to desire complementarity vis-à-vis their partners beyond the emotional reward of love; asymmetry was tolerable only to the extent that it could be regarded as "accidental" outcomes of different and shifting preferences between equals. What they looked for was in a sense a version of themselves in their partners. We do not want to create a caricature of egalitarian partnerships of love, but we regard it necessary to emphasize that the normative and emotional prioritization of autonomy was fundamental among most patients we met at Modum Bad. In the cultural context of Norway and the Nordic countries, which we have tried to describe in somewhat superficial terms above, this may not be very surprising. In psychoeducational settings where the participants (partners and some single mothers) discussed norms and ideals related to emotionally rewarding relationships of love, there seemed to be full agreement that the breadwinner-based family model involving the female partner as a specialist provider of love, care-taking, and "quality time" is hopelessly out of date. Also with reference to socializing children, the conversations we took part in cultivated the egalitarian idea that enlightened parents do not, or should not base their authority on some particular function in the family; this would potentially undermine the autonomy of each partner as well as distort their children's idea of what real equality is about. The main problem arising from these norms and insights seemed to be that "the content" of symmetrical reciprocity turned out to be quite hard to identify; it may be difficult to find out what kind of gift to provide when in principle any gift may undermine your partner's paramount value, his or her autonomy. However, the dilemma was only rarely formulated in such terms, only hinted at, and in most contexts the problem was mainly one of abstraction. The therapists' main message was that dilemmas of egalitarian reciprocity are related to the art of recognizing one's partner regardless of his or her specific achievements. The participants acknowledged this insight and worked with it in several ways, but the challenge of bringing this message down to the level of daily interaction remained difficult for many, as we understood it.

The problem of egalitarian reciprocity as an emergent property of recognition was closely related to another key topic in family therapy at Modum Bad: that of "personal boundaries." "Personal boundaries" was a much discussed theme during sessions, and the way it was made relevant always seemed to underscore its importance as a basic prerequisite for mental health and healthy relations in the family. As a therapeutic category, it proved very useful, as most patients could use it to conceptualize aspects of themselves and their family relations and at the same time acknowledge it as a widely shared normative standard. Its scope of applicability was broad; we first encountered it in the form of a therapeutic warning to the patients as a group. They were reminded that they should tell their personal stories to others with some care, taking into consideration that being given more information about the problems of others may cause distress rather than enabling listeners as partners in productive conversations. Later we learned about it in the form of a theory of self-empowerment, which was frequently communicated on psychoeducative settings. The basic idea was that the ability to receive the acknowledgment of others and use it for strengthening one's self-esteem depends on not being in a state of "leaking." Low self-esteem tends to generate a hunger for

recognition, but the recognition offered cannot do the job of building self-esteem because it always "leaks out" in greater quantities than any "refill" can match. A third important version of the personal boundary theme was about not being able to care sufficiently about one's own needs and instead become too concerned with the needs of others. Not being able to say "no" was one typical formulation of this problem. The challenge of building and guarding personal boundaries typically became a red thread in the couple therapy sessions we observed during our fieldwork and—perhaps needless to say—at a much higher level of complexity. The typical case would be difficult communicative situations in which the therapist(s) and one of the key actors together would try to communicate to the other actor that he or she is about to break the boundaries of integrity in some specific way. Such attempts would, as we experienced them, often fail and would need to be repeated if necessary in later sessions—in combination with other strategies through which the same point could be brought forth and may be across. Such attempts seemed to us as "moments of truth" in the sense that further progress depended upon "the object" becoming visible and made into a problem of reflection as something "outside" the actors' identities. The contrast between partner egalitarianism as an "ideological" model in educative contexts and real therapy could indeed stand out as striking. In the ideal model, a main "theoretical" problem would be, for example, how to walk the line between giving one's partner too little or too much, while in the real therapies we observed the struggle turned out to be one of sharing interpretations of observed events (to the extent, of course, that the actors were capable of "observing" themselves).

Personal boundaries were highly relevant to the parent–children relationship too, particularly in the form of the concept of "attachment." "Attachment theory" has gained much attention across various fields in Norway over the last decade and is in part inspired by various strands of psychotherapy, social work, and pedagogy in the USA (Fitton 2012). In the Family Unit at Modum Bad, its presence is primarily through a socialization program called "COS"—the Circle of Security intervention (Powell and Zeanah 2014). This program, which is presented for the patients at the Family Therapy Unit in many forms, both as a series of short educational videos, as a topic of discussion and reflection in larger groups, in the kindergarten and school, and in therapy, focuses on how children achieve autonomy through their own initiatives. The main point, as we understood it, is that such initiatives can only be taken as long as children feel secure. They gain this security from loving and encouraging parents who let their children explore their immediate environment, and who then are there to receive them as the children again seek the safety of the parents' embracing bodies. The circle of security gets larger as the children grow, but the basic logic stays the same. Clearly, this philosophy made much sense to most parents we met as it grasped in quite common sense terms key ideals concerning non-intrusive and non-authoritarian parenthood. "Attachment" appeared to them as a "natural" model of the ideal relationship and socialization process, a model that cultivates a sensitivity of the child's emerging integrity as it grows out of natural curiosity and a sense of being recognized and subject of continuous interest. The egalitarian ethos seemed to appear as highly self-evident, as we never witnessed any

attempt to formulate alternative models of authority. As such, it illustrates our discussion of class above; although several patients were not used to this approach in their own socialization, or may not have applied it themselves as parents, they were clearly attracted to it and viewed it very positively. In more practical terms, dilemmas appeared here too, as the attachment theory did not imply inspiring children to ignore boundaries nor, it seemed, to lecture them explicitly about their precise nature. Rather, the message that was brought forth was one of implicit, compassionate guidance, stimulating the child to gain experience from experimentation and to generalize from advice relating to that experimentation. It should come as no surprise that this lesson was hard to bring across as it was brought to bear on the practical daily life situations. Therefore, it was interesting to explore in more detail how the therapeutic team in the Family Unit and its allies (the school teachers and kindergarten teachers especially) worked together to "objectify" it as a social reality in the institutional context. Also, we became deeply fascinated by what we saw as a consistent struggle on the part of the therapeutic teams and their allies to communicate to, and with the patients what they saw as important to bring across. To their disposal was a multitude of arenas, genres, idioms, and contexts that could be used to reach them and their challenges. As we experienced it, patients became "enrolled" in an institutional world in which all, or at least most aspects of their lives were turned into dialogical terms—much, in fact, as the Circle of Security program they tried to apply in the context of their own family.

A Therapeutic Agora

Before discussing the family therapy approach at Modum Bad in more detail, we would like to dwell on some aspects of the intellectual tradition of which it is a part. In the USA at least, family therapy became an integral part of the major breakthroughs in sociology and anthropology. In the field of psychology, family therapy became the only field which embraced insights that emerged from the study of the wider contexts of the American society. The attempt to understand the family as "social system" strives toward understanding the family as a part of a wider system of class and race relations and, not least, the intellectual challenge of seeing family relations as a part of human adaption in more general terms (and communication, as was Bateson's take). It is not possible to explore this aspect of family therapy in full detail here, but some of its aspects are definitely worth discussing. The most important of these, as we see it, is the concept of culture. It seems that family therapy arrived at the concept of culture in part via systems theory, which, in the first phase, inspired an interest in internal balance subsumed in the idea of homeostasis. As a part of the interest in more complex systems that followed, the ecological metaphor was introduced and opened up a whole range of new questions, including the larger environment and politics. In anthropology, culture and ecology had of course been intimately connected, and in sociology—the Chicago

school in particular—had brought the idea of culture "home" and used in studies of class and race in urban spaces (Abbott 1999, Bulmer 1984).

At Modum Bad, family therapy is not an extension of the US version, but the kinship is in several ways striking. Compared to the other hospital units (offering individual and group-oriented therapy directed at patients with eating disorders, depression, trauma, and anxiety, respectively), the Family Unit has a stronger intellectual foothold in the humanities and in the social sciences, and is less based on manualized therapy, and its approach is more diverse. Clearly, the influence of systems theory has been strong, as has the idea of culture. The significance of culture has two or three different strands at the clinic. One analytical strand is related to the anthropological concept of culture, denoting both how knowledge and values vary between groups of people (and even between individuals, therapists sometimes say) and are influenced by social conditions. Another strand represents culture as activity, civilization, or even high culture, and stands out as an important aspect of the clinic's "trademark." The clinic is known for its emphasis on architecture, art, and cultural history. Most patients insist that these dimensions are vital for their sense of belonging and the quality and richness of the context through which therapy is experienced. Another aspect of this version of culture concerns "holism," which reflects a deep-seated ambition to make the different parts of the institution connect meaningfully to each other—in esthetic, organizational, and practical/social terms, in order to create synergy. This is made very clearly in the institutional incorporation of new families. Families who come for treatment most often stay for a prolonged period, most often around three months. They are settled in individual houses in the outskirts of the hospital area, in short distance from the school, kindergarten, and the communal house belonging to the unit. The Family Unit offers not only therapy and therapy-related activities, but also day-care, primary schooling, and guided leisure-time activities—as well as extended observation of the family and guidance in their "homes" during the hospital stay.[1] In addition, patients are encouraged to take part in cultural activities together with the other patients at the hospital. Each new family is introduced to a "settled community" with a distinct "culture," or so it tends to seem as they arrive.

As Deborah Weinstein (2013) points out in her account of family therapy in the USA, the Family Unit at Modum Bad has inspired a strong culture of observation—presumably for the same general reasons that made US therapists experiment with ways of observing social patterns. From that point of departure, what we call the culture of observation at the clinic has been extended in many interesting ways. During our fieldwork, we took part in a range of contexts in which therapists and patients maximized reflexive distance to their objects by shifting roles and modes of expression in ways which seem reminiscent of what became called "family choreography" and "family cybernetics" in the 1960s (Weinstein 2013). In the therapist–patient relation, the presence of one-way mirror illustrates both some of the possibilities and limitations of the observational culture. In the Family Unit at

[1]We refer here to the individual family's house, which is assigned to each family upon arrival.

Modum Bad, the mirror was used as a breakable boundary, as the therapists exploited the possibility to feed back to patients (typically the couple) the experience they gained from their particular observational positions. In some cases, observer behind the mirror would come into the room and discuss what she had observed with those she observed. For us, as participant observers of both patients and therapists, this complexity of cybernetics put into practice was very fascinating and had some striking effects. Many of the contexts experienced in the Family Unit appeared to us as "public spaces" almost in the ideal-typical sense of the concept, more so than what was the case in other units. Why this was the case puzzled us, but gradually we found it reasonable to assume that it was precisely the relative systemic application of the "theatrical" approach that made the "public culture" merge. For the observing anthropologists, it is often a challenge to get access to the backstage and to find the front-stage interesting; here however, the front stage was the main stage and an intriguing place to be. The patients, as "public" women and men, often acted as though the unit was an agora where a certain expressivity was expected, where strangers could be embraced and where issues of common concern could be quite freely discussed. One of courses we attended—"PREP" (The Prevention and Relationship Enhancement Program—Renick et al. 1992), which is aimed at helping coupes deal with relational problems through alternative communicative techniques and strategies—elaborated this "public" aspect of therapeutic practice through theatrical measures. Each main component in the course was illustrated by the two therapists in charge of the course through role play. In deeply ironical and highly playful ways, they played out schismogenetic communication (Bateson 1958) and offered some possible alternatives, and made them available for discussion. Although their performances conveyed portraits that hit many of us "in the stomach" in ways that felt painful, the context made us all into observers of virtual realities that appeared very good to think with and discuss in public. On one occasion, the discussion became particularly engaged and after a while took off as a debate on the nature of freedom in modern society.

The "agora" aspect of the Family Unit was illuminated for us with particular clarity in the form of a "public" therapy, which was arranged during a seminar and which involved a couple from a nearby town (who were not regular patients at the clinic). Until this happening occurred, we had never heard about such a thing and were taken by surprise simply because we did not expect it, and if we had heard about it, we would most probably have thought that the idea would be out of context. The therapy session was observed by some 50 people. For us, it became the primary manifestation of how we, during fieldwork, had our ideas of the relationship between the public and the private rearranged. Institutional psychiatry is normally not associated with public culture. "Public" in the form we observed it in this (and other) contexts is not to be seen as another version of "openness"; it denotes qualities applying to broadly discursive arenas rather than to a mechanism allowing for previously hidden truths to become openly expressed. Serious mental health problems tend to belong to, and kept within spheres that are either private or modeled upon the private realm, and strict measures are often taken to secure integrity to be protected.

Another event that we now, in hindsight, see as an example of how the particular institutionalized manifestation of family therapy as an intellectual tradition has generated productive, public arenas at the clinic was a particular seminar on the theory and practice. The purpose of the seminar was, among a few other things, to discuss the empirical foundation of therapeutic ideas and practice. We were keen to understand more of this because we had learned that in family therapy in Norway this has been a controversial issue where humanist orientations and evidence-based therapy in part have been seen as radically different alternatives. The seminar was attended by a number of therapists from other parts of the country, in addition to the majority of the Modum Bad Family Unit staff, and included presentations of therapists' experiences with patients' own documentation of the therapeutic experience. The method that made this possible ("STIC"—Systemic Therapy Inventory of Change, Pinsof et al. 2012, see Chap. 5 for a presentation) consisted of a battery of questions to be answered by the patients at frequent intervals before every therapy session, questions relating to his/her own experience of his/her own health and emotional state and to the therapy itself (Breunlin et al. 2011). When processed, outcomes could be presented in a wide variety of ways according to need and could be read and analyzed by the patient and therapist together as means for correcting and improving the process. The method was not bound up with any specific therapeutic model, but was meant to be a heuristic tool to make any model work better—as a model. The theoretical underpinnings of the methodological approach were discussed in detail in the seminar, and became the focus of much interest—and less controversy than we expected. A basic, widely shared, and clearly formulated assumption was that successful treatment does not seem to depend on one specific set of factors, but on the quality of (potentially many different) combinations of specific and general factors. In the discussion that followed, the participants sought to look for analytical perspectives that could be used for making sense of what actually happens in therapy as the patients experience it—"making sense of the data," as was the expression. Objectifying patients' experience as an exercise in interpreting data became yet another way of making the therapeutic process "public," accessible, and—we may add—potentially less hierarchical. The analytical perspectives discussed for the purpose of facilitating this interpretative process were presented in the form of a system of systems (natural, social, cultural, etc.) to be used according to the nature of the empirical data and the therapeutic tasks at hand.

Perspectivism

Our ethnographic fieldwork at Modum Bad made us attuned to some of the particular epistemological challenges in psychotherapy. Like anthropology, psychotherapy seeks insight into "the mind" through language, behavior, and social processes, and in family therapy, it seems that "naturalist" approach to this is preferred, that is, to say observation and description of what people do and say.

Added to this, of course, is the particular challenge of transforming insights into practice. In this endeavor, a number of external factors enter psychotherapeutic epistemology, such as social hierarchies, budgets, institutional factors, health policy, and more. For example, recent changes in health policy involving a stronger emphasis on effective treatment have led to a drive toward standardization. Clearly, such developments may have unintended consequences, for example, a narrowing down of experiments of the kind described above, as the search for efficacy may delimit the intellectual motivation needed to confront therapeutic packages with really existing empirical variation. Family therapy seems to be characterized by a much greater variety than individually oriented therapies designed to treat patients who fit well with specific diagnoses and who can be selected on that basis. During our fieldwork, we observed some radical differences in this regard, particularly that between the inpatient units on the one hand and the outpatient clinic (located at the Modum Bad site) on the other. The outpatient clinic is organized very differently from the former. Patients could not be selected on the basis of clearly delineated diagnoses, mainly because there were too many who need help and are formally entitled to treatment. Consequently, the outpatient unit experienced a considerable capacity problem and the therapists there found it difficult and undesirable to offer standardized therapy. Clearly, the intellectual atmosphere was affected by this institutional feature, and debates took a very different form than in most of the inpatient units. The professional autonomy of the individual therapist was more strongly emphasized, and the debate about what should count as evidence was broader and more critical. On this background, we found it interesting that the Family Unit seems to stand out as an intellectual context in which the full complexity of the therapeutic challenge was embraced. While in general the specialization of science and therapy tends to increase the tendency to delimit contexts and privilege an analytical gaze that remove potentially relevant factors from them and classify them as "out of context," the practices and discussions we encountered in the Family Unit were different. Here, they looked for ways to secure analytical rigor but at the same time embrace complexity and utilize the "perspectivism" that has been generated by the general interest in insights deriving from shifting contexts and socially positioned experiences. "Getting to the data" (i.e. STIC) and using them as a source for mutual reflection for patients and therapists seemed to be practical operationalization of this intellectual horizon.

Contextual Complexity in Therapy

As noted above, the one-way mirror was used more systematically as a breakable boundary than was the case in the other units we observed during our fieldwork at Modum Bad. The observing therapists quite consistently took their observations back to the patients (and the other therapists in charge of the sessions). On one occasion, this was done according to a format known as "reflective team." The couple and the therapist had taken issue with certain relational challenges that had

emerged during the previous session and assisted by the therapist initiated a discussion about what they really had in common that could justify the marriage. Behind the mirror, we were accompanied by two other therapists who followed the discussion, made notes and comments, and even initiated their own discussion of what they observed, even involving the two anthropologists. From our point of view, the excitement and emotional involvement on the part of the observing therapists reflected our own. And reflecting on our own emotional experiences as the drama took place felt necessary, enlightening and even as an act of sympathetic involvement with the actors in front of the mirror. The two therapists then moved into the therapy room and sat down with the couple and their therapist and started talking together about what they had seen, letting the couple observe them as they discussed their observations and interpreted the communicative process. In this particular situation, they chose to emphasize that they were impressed by the couple's courage; that is, to say their ability to face the pain involved in trying to formulate awkward truths when faced so directly with one's partner and being exposed to the therapist's questions concerning potentially painful implications. After that, the couple and the therapist were all invited to comment on their comments, thus generating a specific type of discourse characterized by the acute awareness of socially and discursively positioned points of view and messages that had emerged during the session. Our impression was that the experience influenced the actors' ability to take the role of the other as they spoke; when they summed up what they had just taken part in, it struck us that the very complex communicative situation that had developed during the session did not leave them behind in the characteristically dyadic position in which they started. If they had failed to embrace and live up to the contextual demands set by the various social roles and perspectives represented by the three therapists, and the effects of these upon their own roles and their relationship, they would certainly have appeared "out of context." In other words, our experience was that something had occurred during the session that was not simply a matter of routine context shifts.

On another occasion, we observed a therapist who, during a couple therapy session, introduced contextual changes during the dialogue and changed the relationships between the actors. From our position behind the mirror, we did not realize what she was doing until after the fact because the changes she introduced seemed spontaneous or as an integral part of the dialogic flow. After having introduced the session with a third party version of some basic experiences from previous sessions, establishing the context and formulated a topic for the dialogue in the form of a challenge, she took the role as a neutral mediator and then moved between the positions as a curious listening partner to each of the spouses. The tension between them increased as one of them identified and formulated what the wife saw as the main problem in their relationship: the husband's inability to listen to her and respect her. The problem had become manifest during the previous weekend (the session was on a Monday), when they had started an argument about dinner preparations. The problem had not been solved, and she was still quite irritated. Her husband said that he could see why she saw this as a problem, but he had not realized that it was so serious and general for her. As they discussed this

problem for a while, the therapist moved between their points of view and contributed with attempts to clarify their messages and secure that they came across and were understood, and that the spouses tried to explore the implications and alternative pathways. The dialogue became increasingly tense as the spouses introduced more problematic events from the past that had caused wounds that had not really healed, and which contributed to make the marital problems at hand much more serious. Increasingly, the dialogue became undermined by frequent interruptions and repetitive messages. The therapist then intervened by getting up from her chair and sat down very close to the husband. She asked the wife to look her in her eyes as she herself spoke on his behalf, emphasizing what she (the therapist) had heard him say to his wife but not been able to get across. Then, after having succeeded to some extent, she asked her to look her husband directly in his eyes and formulated a simple rule to secure non-interruption. The social effect seemed striking, as the dialogical situation changed quite dramatically. The reciprocal exchanges between the spouses changed, and the problem took a somewhat different form. Clearly, the therapist's manipulation of the social context had the effect of separating the interactional style from the problem itself. From our point of view, it looked as though the spouses changed their style because their perspective had changed; they appeared perplexed, not as if they implemented a rule suggested/dictated by the therapist. Our impression was strengthened by what followed immediately after. The therapist went back to her own chair, and the social effect was maintained—accompanied with a new emotional awkwardness of a type we had not previously seen, one which in fact enabled the spouses to conclude the session in a very different relational context. We do not know what came out of this, but we ourselves concluded that we had witnessed a social "ritual" or, more precisely, a set of contextual shifts which generated some very powerful cognitive–emotional effects. In our eyes, during the session their relationship went through transformations that made it possible to see it in very different ways from different angles.

Summing Up

"This place is not hospital-like" is a common expression among patients at Modum Bad. The expression sums up a variety of experiences, but the key denotation is a specific combination of esthetic and social qualities which patients generally tend to see as both unusual, unexpected, interesting, and often rewarding. Families (couples with and without children) become integrated in a web of social relations with some very unique qualities, comprising "village life" in families inhabiting the houses in the Family Unit, the therapeutic "community" in the unit as a whole, and, lastly, the various activities that attract patients from all or most of the other units at the clinic as well. Many tend to talk metaphorically of this web as "a community," while in fact its qualities derive not primarily from an undifferentiated system of multiplex relationships but, on the contrary, from the formal, highly functional and rather strictly regulated qualities of these social relations. Although the relations between

the patients are to some extent informal and developed partly as an aspect of their neighborhood relations, activities in the communal house, etc., they rest most fundamentally on the integration in a formal system regulated by the bureaucratic organization of therapeutic goals and methods. As noted above, patients are often reminded that they should try to be attuned to the development and cultivation of their personal boundaries when taking part in informal activities in the communal house. Somewhat paradoxically, it is precisely this aspect that inspires many patients to explain to us that they feel very well taken care of at Modum Bad. In interviews, the overwhelming majority of the patients point out that "care" is a foundational element, one which makes them feel "safe" and able to concentrate on the hard work of trying to deal with their problems. The kindergarten, the school, the activity specialists at the communal house, the nurses who visit the families in their home and offer guidance in the morning an evenings, and the therapists all observe them, guide them, and offer advice—and coordinate their activities thoroughly. On several occasions, they all take part in "community rituals" together, as when celebrating the children when they leave school and kindergarten or marking seasonal transitions such as Christmas, Easter, and summer holidays.

As a social system, the Family Unit is highly complex in a particular sense: The patients' experience of community is moored on the principle that social roles should be quite strictly delineated. The main symbol if this is "personal boundaries." As a "culture," life in the unit appears as regulated by a complex set of informal rules concerning how to relate to others in specific contexts. Consequently, being "out of context" becomes the key signal triggering therapeutic concern. As we have seen, this in turn is structured by some specific cultural categories pertaining to how to become an autonomous person and ways to deal with relationships in the family (and beyond) such as to promote the autonomy of others, the children in particular. However, our key concern in this chapter has been to try to describe how social complexity is organized and realized in the Family Unit so as to maximize reflection. In this little unit, a large number of highly specialized arenas are developed, and the social experience of shifting context provides the actors with different perspectives and discursive resources. As all actors take part in contextual shifts but grasp the opportunity this provides for assuming different roles, points of view, and ways to talk about problems, they objectify problematic aspects of their own selves and behavioral patterns such as to make them into potentially transparent objects of manipulation (Berger and Luckmann 1967, 1988). The "public" nature of many of these arenas and discourses should be emphasized. The intellectual resources provided by family therapy as an academic and therapeutic tradition have been applied at Modum Bad so as to make mental problems and relational challenges as a more or less common human set of issues to be dealt with in "public spaces" (Alexander 2006; Sennett 1992). In this way, patients and therapists alike are encouraged to deal with them not only as personal pathologies, but as something to be approached like any other challenge relating to the mysterious interface between individuality and culture. The apparent absence of therapeutic orthodoxy seems to represent a vital factor here.

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Chapter 11
An Anthill of Questions that Made Me Prepare for the First Session: A Clinical Vignette of the Usage of STIC Feedback System

Rune Zahl-Olsen and Camilla Jensen Oanes

Introduction

We, Rune and Camilla, have used STIC (Systemic Therapy Inventory of Change—Pinsof and Chambers 2009) in our clinical couple and family therapy (CFT) practice since 2010. The use of STIC in a CFT setting like ours may be seen as a clinical advantage. One example is the opportunity to view all the family members' perspectives of the family function by the graphs provided by the system, addressing topics such as agreements and differences. However, the same features may also be viewed as potentially burdensome for the clients. A topic that becomes visible on the graphs may not be viewed as important for the family, and some family members may find it painful to discover the distress of their fellow family members. A related question is whether the STIC gives directives for the form and content of the therapy. These and other important questions and dilemmas when using STIC together with clients will be discussed in this chapter.

All questions and dilemmas we address are in our experience typical with the clinical use of STIC. Throughout the work with this chapter, we have asked clients to help us illuminate our concerns as well as the advantages in the use of this system.

The heading is made of comments from two of our clients after using the STIC in therapy. The information in this chapter is based on clinical experience as couple and family therapists using the STIC in addition to interviews with clients. The clients who are quoted have approved to it.

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Our Context

We work as couple and family therapists in the family unit at an outpatient child and adolescence psychiatric clinic, organized as a part of a regional hospital in southern Norway. Due to national regulations, at least one family member has to be the referred client (as opposed to referring the whole family as a unit for care). The referred client needs to be a child or an adult with children below the age of 18 living at home. Our clinic accepts clients a wide variety of problems or challenges that a referred family member may have, but we always have a systemic perspective for our treatment. Usually, two therapists meet the couple or family throughout the course of the therapy.

Our Theoretical Platform and the STIC Procedures

Our theoretical platform is broad, and our ways of performing therapy vary from family to family, meaning that there is more than one way for us to reach the desired goals of therapy. We believe that people and their actions have to be understood at least in the context of themselves, their family, and the community. As therapists, we also believe that the ones who are closest to the problems are the ones who know them the best (Andersen 2005). We find that the dialogical framework of therapy as presented by Seikkula and Eliassen (2006), the client-directed approach (Duncan et al. 2004), and narrative therapy (White 2007) to be inspiring for our clinical effort to stay client-centered.

We originally found nothing in our theoretical background that suggested the need for such a *comprehensive* questionnaire like STIC. However, after using STIC for sometime, we do not find that it contradicts the theories within our theoretical platform and indeed may well facilitate our client-centered approach. However, we do not take for granted that we understand the STIC information until it is discussed with the clients. As mentioned elsewhere in this book (see Chap. 5 by W. Pinsof), the STIC procedure involves having the clients' answer a variety of questions prior to the first session (the STIC Initial). Before every following session, clients are asked to complete a shorter version, the STIC Intersession. Subsequent to receiving the STIC information from all participants, the STIC software makes it possible to display all participants' answers simultaneously in the upcoming session. This process allows the therapist and the family to make a joint interpretation and exploration of the clients' answers. Based on the clinical guidelines for STIC (Pinsof et al. 2015) that recommends emphasizing those domains that indicate clinical distress (that is, are in the clinical range), the therapist initiates the selection of topics for the therapy session. If there are other topics that are more important for the family at that particular session, these topics get priority. With these prerequisites, we find that the STIC works well in our practice.

We will in the following present different topics regarding the use of STIC in clinical practice. Since we started using STIC in 2010, we have had continuous conversations with our colleagues about our clinical experiences. We have also interviewed several clients over the years, and some of these client interviews have been videotaped and transcribed. Through several rounds of reading and discussions, we have organized the material under the headings that follow.

Answering Before Meeting the Therapist in Person

In a way it is OK to know that you answer to someone who doesn't know you. (Karl, 45)

The STIC Initial is completed before the first session. This involves having the clients answering quite intimate questions about themselves and their relationship before meeting the therapist. One of the concerns we had before starting using the STIC was whether clients would be uncomfortable with this part of the STIC procedure. A related question was whether these circumstances would affect the way people responded. Would they be honest in such an early phase of the therapy (Oanes et al. 2015)? Our clinical experience is that important, sensitive, and sometimes shameful topics surface only after some sessions. This can be interpreted as a natural development and response after building a safe therapeutic alliance and trust toward us as therapists. For many clients, this process requires time spent within the therapy context.

We asked two client couples with quite different life situations about how they felt about answering many questions and not knowing the specific therapist who would receive their responses. Ola (35) and Monica (35) quickly responded that to them this was not a difficult task. Monica said, "It is an assessment which can be used as a starting point." They both felt that the STIC Initial was part of a therapy package, a procedure that they accepted as any other procedure, and without much consideration. The other client couple, Karl (45) and Susanne (45), had more elaborate answers to this question. Susanne said, "Completing the STIC helps to organize one's own thoughts, to think about what the problems really are. It was a great help in preparing for the first session, because our life is just a huge bunch of challenges really." Susanne's answer confirms our impression of her as a woman who really tries to organize her life and have time for everything. We also got the impression that the process of answering STIC questions lingered with her and continued to organize her thoughts even after completing the questionnaire.

Her husband had a different approach to the question about giving personal information to a therapist he had not yet met, "I never thought of that. I was concerned with the reason why I sought help, so for me the most important thing was to describe our situation as accurately as possible in order to get the help we needed. I never thought that much about the recipient."

These clients had no problem giving STIC answers to a yet unknown therapist, although for different reasons. Monica found this as a way to report her private

thoughts, Ola did not reflect much over it, Susanne found it useful, and Karl was mostly focusing on the task of describing their challenges. We would like to emphasize here that the clients are informed that their answers will be read by the therapist they are going to meet. This therapist may not be seen as a random person, but rather as one with whom the clients have trust and positive expectations. It is possible that the clients have confidence in this professional to provide needed help.

However, some clients we have met have used the option to skip some of the questions on STIC. A father, for example, whose daughter was referred to us due for depression, did not want to answer the questions about substance abuse and violence in his family of origin. He did not find those questions relevant or connected to his understanding of his daughter's problems. Other clients may have other reasons for not answering the STIC questions, including topics connected to opinions on using questionnaires in general. The STIC system will automatically alert the client about questions they have not answered, giving them a second chance to decide whether they wish to answer or not, which means that missing answers most likely are a result of an active choice. We use our clinical intuition concerning whether to address this or not in the upcoming session. According to the clinical guidelines for the use of STIC, the clinician needs to be cautious depending on the content of the questions. For instance, if one spouse has not answered the couple violence questions, and the therapist's intuition is that this is an issue, there are guidelines on how to address this in therapy to avoid an increased risk for violence. Because of the great variety of reasons for not answering, we find that to focus on what they actually report is often a more fruitful path than focusing on the missing answers. However, later in therapy, and especially if there is a pattern in the missing answers, we may address the phenomenon of skipping some questions.

Too Burdensome for a Family in Crisis?

> Should I come here to you without having filled out STIC? No, I couldn't do that! (Ola, 35)

Clients may feel exhausted about their situation and perhaps demoralized about lacking ideas for solving their problems. Within our context of therapy, as in any other therapeutic frames of reference, the therapist is anxious not to add to the family's burden. We have had some discussions with our colleagues about how the STIC procedure might add to the burden for some families or family members, especially for those who are suffering from severe distress. Hence, we may have prejudices about how much one particular client can take in certain situations. This sometimes makes us hesitate to offer STIC as a part of therapy from the start, even if we are aware that we at that time really do not know the families and what they might feel too burdensome. To counterbalance these prejudices, we often ask clients about their experience with filling out STIC in order to learn more, and we have found that clients most of the time manage to protect themselves. If it is too burdensome, our impression is that they simply chose not to answer. Still, we are

intentionally excluding some clients from using the STIC feedback procedure. We want to give two examples. STIC does not ask whether there is a certain event that made a family seek therapeutic help. We have therefore not offered STIC to couples or families that are referred due to a loss of a child or similar acute crisis. In such circumstances, we regard STIC to be not relevant and too burdensome. The other cluster of cases where we do not offer STIC is where a family member does not speak English or Norwegian sufficiently, as the STIC Webpage is currently only available in English and Norwegian. The use of an interpreter is too complex and burdensome, and thus, for now, our conclusion is that STIC is not appropriate in these instances.

We would like to return to Ola. Ola and Monica have marriage problems. Ola has ADHD, bipolar II, and dyslexia to deal with, and Monica is a very quiet and reserved person. They have one-year-old twin boys. We thought that Ola would have trouble filling out the STIC because of his ADHD, bipolar II, and dyslexia diagnosis, conditions that we anticipated would have an impact on his level of concentration. We decided to ask him how it was for him to answer all the STIC questions. Ola said, "It is an anthill of questions, and sometimes my computer hangs, and sometimes my head hangs, but that's how it is for me. Of course it is demanding."

Rune: "What happens to you then? I mean—you carry through with it, obviously?"
Ola: "Of course! Should I come here to you without having filled out STIC? Without putting in any markings?"
Rune: "Well, you could?"
Ola: "No, I couldn't do that!"

Ola was very clear that he wanted to fulfill what in his view was an obligation and a task that belonged to the therapy. His wife Monica commented that after completing the STIC before every session had become a routine, he started to remind her to fill out the STIC even if it already was a routine for her. The fact that Ola asked her about answering STIC was a positive sign to her, because the usual pattern for them was that she would jog his memory about almost everything. Ola explained this change by simply stating, "Now I have a routine, and routines are good for me!"

Karl and Susanne, the previously mentioned couple, had earlier described their life as a huge bunch of challenges. It was often hard for them to know or decide what problem to deal with at any given time. Karl and Susanne are parents in a multi-troubled family of seven. Their children are aged 7–18 years. Karl and Susanne both have psychiatric diagnoses and are worried about how to be good parents to children with different challenges and needs. From previous therapy sessions, we knew that Karl and his wife had different opinions and views of the children as well as of their challenges. By completing the STIC, the parents are asked to complete forms assessing every child's problems and strengths, as well as their relationship to every child. Rune interviewed the couple about whether they found completing the STIC to be too burdensome in a hectic everyday life.

Karl said, "No, it is not too much. It is important to see each child." For him, the filling out of STIC offered a good opportunity to really focus on one child at a time and answering the questions considerately and thoughtfully. His wife nodded to this and said, "Well, this demands time, which I actually don't have. At the same time I think this is a way of making the most out of the time we have here (at the clinic). I liked it when we had filled out STIC before last session and could just start talking about it."

Although Ola, Monica, Karl, and Susanne found completing STIC meaningful, other clients have told us that even the mere thought of opening the STIC e-mail was burdensome for them. Expressions like "It's too much in my life right now" are not unheard of. However, most of the clients we meet find STIC to be a meaningful part of the therapy, which possibly compensate for practical obstacles. Some find it helpful to themselves, while others see that it helps the therapists to lead the therapy toward important areas of their life. One lesson learned here is that in spite of living in a complicated situation, a family may still have the energy to describe their situation through STIC. To concentrate on describing their own and their family's functioning may also represent an opportunity to focus and prepare for a therapy session, as emphasized by Susanne. It also gives the therapist the opportunity to highlight salutogenetic[1] topics that emerge (Antonovsky 1979) and to take a solution-focused point of view (Berg 1994).

To Become Visible

> We might not see the invisible stress that exists in those differences (Susanne, 45)

In our clinical practice, the members of a couple or family meet together in the sessions. We believe that we need to see the broader picture in order to understand the pieces and the meaning for them (Bateson 1972). STIC gives the opportunity to let all family members see each other's views, displayed both as graphics and answers to each specific question. Looking at lines or columns on a screen is different from talking about different opinions. The sharing, viewing, and discussing the family's responses are supplementary modalities that may help the family to better understand what the differences *mean* for each individual and for the family as a whole. However, the visual display is also a powerful intervention (Pinsof et al. 2012) and should be used with care and deliberation. In addition to the discussion in Chap. 8 by Oanes, we will present our clinical experiences here. We experience that even though the clients have been previously informed that information they give online at home could be shared in the sessions, they have not

[1]Salutogenesis is the theory of health promotion, in particular emphasizing resources, resilience, and sense of coherence (Antonovsky 1979).

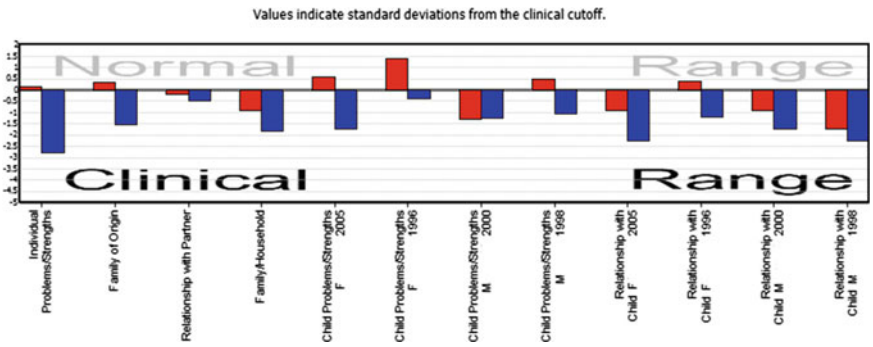

Fig. 11.1 System scales—Initial

always anticipated how this part of the STIC routine would be for them. Furthermore, we experience that even though the clients had this aspect of sharing in mind when they completed the STIC, circumstances may be such, at the time of the session, that they would like not to share their STIC responses. This has led us to establish the routine of always asking for permission to share STIC responses in the first session. According to this routine, we asked the Andersen family, a family of four, if it was OK to share their answers in the session. The parents said it was fine for them, but Sofie, the teenage daughter, wanted to talk with us first. Outside her parents' earshot, she told us she had marked that she was bisexual and that her parents did not know and that she did not want them to know. She was, however, comfortable with sharing her remaining answers with her family.

Our experience is that most people want to share their answers, although quite a few have said they were a bit anxious the first time and even some who report that they were still anxious at the third time.

Figure 11.1 shows all system scales for Karl and Susanne's family at their first session. The blue columns are derived from Karl's answers and the red from Susanne's. Because neither of the children participated in this session, the columns represent the parents' views on their situation and included their individual view on each child below the age of 18. All of Karl's graphs were within the clinical range, meaning that he was experiencing more severe distress than his wife on almost all topics that are covered in STIC. Susanne stressed the willingness to discuss and elaborate on possible differences in family members' responses once they are shared. She said, "It is very interesting to see the differences because it is a part of the package that we interpret things differently, and then we might not see the invisible stress that exists in those differences. But of course you have to be willing to *see* those differences." In our experience, invisible stress becomes visible when we look at graphs together with the family. However, differences in STIC graphics are not obvious in their meaning, and the task of looking into what these differences mean to each family member may be demanding.

Forced to Be Clearer

It's straight forward. Black on white! (Ola, 35)

Another question we had before starting to use STIC was whether STIC would push people to be clearer and to display their meanings and feelings in a way they were uncomfortable with. With the use of STIC, many questions are presented. Moreover, these questions are all asked at once, which also was different from a more tailored, step-by-step approach that many therapists prefer (Oanes et al. 2015). With STIC, the written markings for each question are visualized through the graphics. For many clients, this resembles becoming more visible as a person, both to themselves and to other people.

Helge (48) was referred because of both personal and relational issues. In the first session with him and his wife, we discussed their problems, and after a while, we showed them their initial graphs. We first shortly described what the different graphs represent and the couple confirmed that the graphics displayed how they felt about their situation. The wife turned to me (Rune) and said, "I didn't know he had it that tough. That his upbringing was hard I knew, but that his life now is so much tougher than mine was new to me. I did not know that he had so many depressive thoughts." To look at each other's graphs made them able to see what they had not seen before.

When the Andersen family, as mentioned before, shared their STIC information, it became obvious that the daughter Sofie experienced the family very differently than the rest of the family did (see Fig. 11.2).

Sofie's responses (orange columns) were far into the clinical range (below the clinical cutoff line), some of the fathers' columns (blue) were in the clinical range, while a majority of the mothers' columns (red) were in the normal range. The other sister was too young to fill out STIC, but she verbally told her view of the family

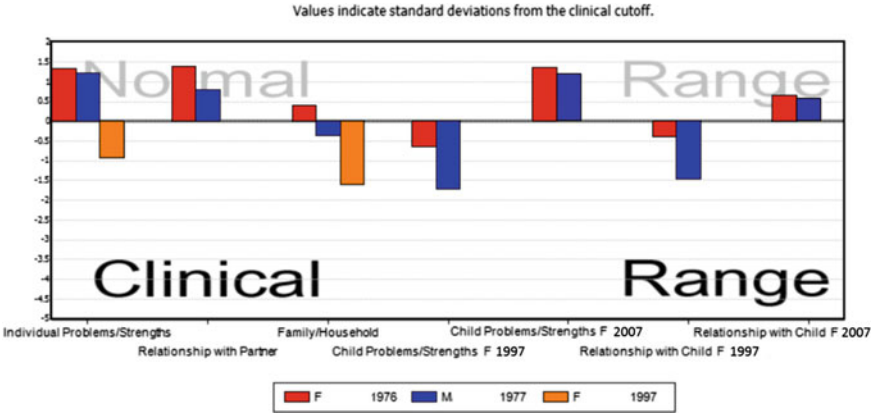

Fig. 11.2 System scales—Feb 5, 2015

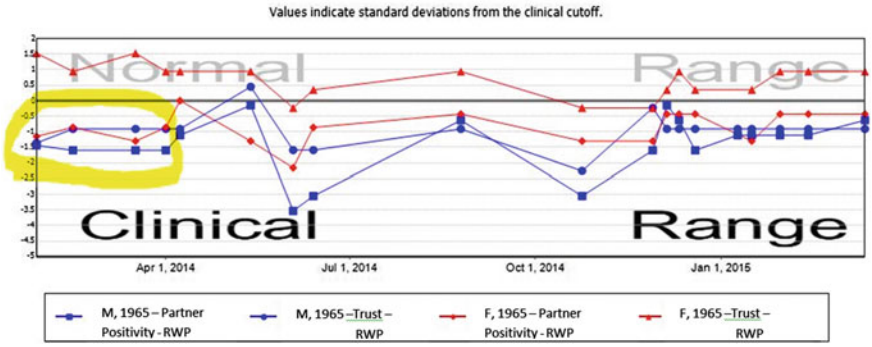

Fig. 11.3 Positive subscales displaying change over time

function. It was no surprise to any of them that Sofie had a hard time in the family. She told us in the session that she really felt as an outsider in the family, and the graphs helped us to talk about what in particular made her feel that way.

Ola told us that he experienced that his wife Monica held her cards close to her chest and did not share much of her own opinions or feelings at home. He said, "I never even get permission to see her examinations. She is afraid of showing me her stuff." He then continued to explain that it was only here in the sessions that he got the opportunity to learn about her view of things in a simple and straight forward way. "It's no nonsense. It can be a good or bad message, but it's straight forward and a wonderful brutality. It's black on white." Monica replied, "It makes the themes visible and concrete."

Johan, who was referred due to OCD and relational issues, had a different approach. STIC has five response options to each item. Johan told us that he never answered any item with a distinct strong opinion, just because this was not his style of communication. Therefore, out of habit, Johan automatically removed each extreme of the scale and ended up with only three options. We talked about this, and he discovered how his developments in therapy became invisible through his response style. He then started to report more nuanced, also including the extreme values (see Fig. 11.3). This made him more vivid in other aspects as well. In the beginning, his way of speech was vague and hard to catch, but later in therapy, he became much more visible to himself, to his wife, as well as to us.

This graph displays the answers from Johan (blue) and his wife Ingrid (red) on two of the STIC subscales (partner positivity and trust) within the area of relationship with partner (RWP) from the first to the last session (Jan 2014 to March 2015). The yellow circle indicates the period when he was answering using only three of the five possible options.

To Be Exposed

We believe that all kinds of therapy have elements of exposure, some more explicit than others. A common intervention is to use verbal communication as an exposure to one's own voice and thoughts as well as to other peoples' reactions to what is being communicated. Another is to get questions from a therapist based on what they have said followed by reflection, clarification, discussion etc. We believe that STIC provides three additional sides of exposure in a therapy session. The first is that the clients get the opportunity to expose their feelings and meanings as their answers are displayed to their spouse or family by graphs. The second is to be exposed to their own answers in this way, and third is to be exposed to the answers of the others in the family.

Does STIC Open Up for Untold Stories?

STIC is a comprehensive feedback system, which implies that some questions might be irrelevant to some families, but at the same time, it might open up areas not otherwise discussed. This theme is further elaborated in Chap. 8 by Oanes, and we will point to two additional aspects of this theme here. Firstly, as most therapists are not asking their clients sufficiently about violence, abuse, drugs, and suicidal thoughts (Reigstad et al. 2006), the STIC provides this information, as the clients are asked to answer these questions frequently, and we as therapists are alerted if the clients report these issues. In our experience, these features of STIC have made us more aware of such topics compared to our practice prior to using STIC. Following is an example on how STIC guided us to help in a better way.

We worked with Linda and Helge, focusing on relational issues. They had been using STIC for six months, when Linda suddenly responded through STIC that she had suicidal thoughts all the time during the last week. We had never thought about asking her questions regarding suicidal thoughts because no previous information on STIC and no themes in therapy indicated that this might be a problem area for her. This came as a surprise to us when we prepared for this particular session. Because we did not know whether this was a mistake in filling out the STIC, or whether she wanted her partner to know about her answer, we decided to not address the topic first thing in the session. As the conversation developed, she did not bring it up, and 30 min into the session, Rune asked her husband to leave the room because he wanted to talk to Linda in private, as we sometimes do. The husband accepted, and Rune asked about the reported suicidal thoughts. It turned out that Linda was thinking about ending her life all the time, even now. We got permission from Linda to address this issue and invited the husband back into the room. Immediately after the session, Linda was referred to the emergency unit.

In the beginning, it may be tempting to draw the misleading conclusion that the STIC captures it all because it is a comprehensive system with a professional design. A Danish study suggested that questionnaires given prior to treatment are

giving the clients an image of what topics this clinic values as important to their therapy (Ejbye-Ernst et al. 2015). The STIC procedure is supposed to be completed before as well as during the treatment, which may imply that the signals about what topics our clinic values may be even stronger. Clients as well as the therapist can be misled by believing that almost everything worth questioning in therapy is in the comprehensive STIC questionnaire and that a topic is of less importance if it has not been covered in the STIC. On the other hand, we have experienced that through the use of STIC, clients have become aware of important aspects of their own and their families' lives.

Changes Displayed and not Displayed on the STIC Graphs

Change? I don't really know (Karl, 45)

Sometimes, it is difficult to detect changes or believe that something has changed for the better. Here is an example of how STIC may be used to recognize even small changes and make them a topic for dialogue. For Karl, there was a change for the better on three areas from the first to the second session on his answers on STIC (less negative affect, disinhibition, and substance abuse) (see Fig. 11.4).

This graph displays change for three of the subscales in the area of Individual Problems and Strengths (IPS) for Karl from the first to the last session. At the time of the mentioned session, we only had data from the first session and the second session (marked in yellow). It might be of importance to notice that on this graph, the clinical range is on the upper level as opposed to the previous graphs.

In the second session, we showed the graph and asked how we could understand the change. Karl replied, "Change? I don't really know but things that happen in life sometimes give you good times and sometimes not so good times. I feel it is on its way up now. I don't know how much, but at least a little bit of a change. It is

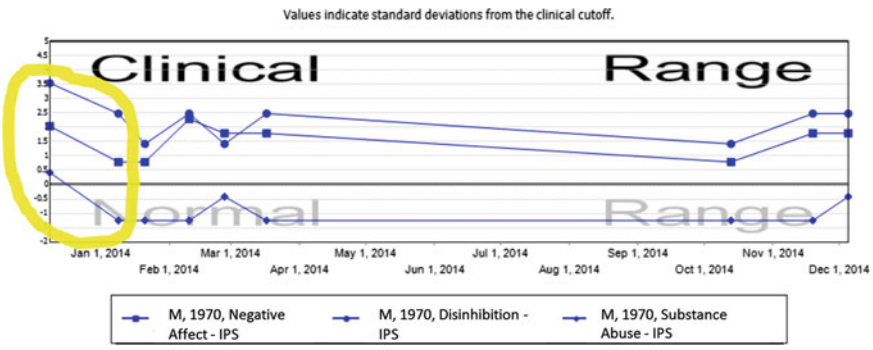

Fig. 11.4 Negative subscales displaying change over time

connected with how I manage to handle situations in an ordinary day, and also how I look at what happens, and how my wife responds to that, and so on."

Rune: "Can you give an example to help me understand?"
Karl (thinking for a while before answering): "For example at school [he is a teacher]. We have this very challenging student. None of the other teachers manage to handle him, but lately I have been able to do that. That has now led to him applying for my class for the next semester. He is very hard to manage so I don't really want him in my class, and I don't think his fellow students want him there either. To me that is a recognition from this student that he experiences me as a good teacher, and also that my colleagues recognize it. It tells me that I can do what none of the others managed to do."

Karl was reluctant to see a change at all in the beginning. He suffered from a depression, and most of his attention was on what he did not manage to do well in his life. This was reflected in his way of talking as well. In the sessions, his speech was monotone and sometimes hard to understand. This story of success would probably not have emerged if we had not investigated the positive change shown on his STIC responses. In this case, STIC became a starting point for a meaningful dialogue, and this falls in line with what Sundet writes (Sundet and Johansen 2012) about feedback instruments as conversational tools. So even though not directly questioned in the STIC, this demonstrates how the use of STIC invites the client to be aware of and communicate broader personal experiences and reflections.

On the other hand, we sometimes experience that the graphs do not change even though the clients are telling us the most amazing stories about how they have dealt differently with difficult issues since the previous session. According to narrative theory, such alternative stories often go unrecognized and invalidated in peoples' lives (Freedman and Combs 1996; White and Morgan 2006). We find that the use of STIC illustrates this phenomenon in some cases. Karl addressed this, "It is challenging though, to differentiate between last week[2] and the general condition. It's hard to think only about last week. Often, the situation is unchanged from week to week. In addition, particular situations often colour the answers." By pointing at the discrepancies between the unchanged graphics and the stories about the exceptions that are told in the session, Karl became more aware of his more generalized way of thinking. In this case, the backdrop was narrative theory. We find, however, that this way of using STIC is an effective way of addressing change independently of therapy model. Described by using the theories of Tom Andersen, this opens up the possibility to bring in something unusual and unexpected—in Karl's case something that gave him a possibility to move to another position. This new position eliminates some descriptions and adds other descriptions to what Karl had prior to the intervention (Andersen 2005).

[2]STIC intersession asks the client to report experiences during the last week prior to the next session.

STIC Works Outside the Therapy Room

I turned to my son and asked (Susanne, 45)

It is well known to all therapists that some clients almost forget therapy while they are outside sessions, while others are fervent in doing their homework and discuss and think about therapy often in-between sessions. In our experience, sometimes, a couple or some family members sit in the same room at home answering the STIC and ask each other what they feel or think about some of the items. It happens that this leads them into conversations that they have never had before. Susanne was eager to tell us about one incident at one of the sessions: "Yesterday, as I was answering STIC, my son was in the room. As I was to answer the questions about him I thought 'I might just ask him.' So I turned to my son and asked him if he would say that he had close friends, and we had a talk about it." Frequently, couples tell us that they have been talking about their STIC answers in the car on their way to therapy. We do not think it is unusual for couples to talk about therapy on their way to therapy, but it seems as if STIC is providing them with topics that they find interesting to discuss. Sometimes, they bring those conversations into the therapy room. Not all families do that, and we do not know whether STIC is the ignition for that kind of conversations. However, in Susanne's case, STIC provided a gateway for an important chat between mother and son. It might be that the persons talking together about STIC answers are the ones who would have talked to each other about therapy topics anyway if STIC was not present in their therapy. However, what is asked in any questionnaire guides the clients' attention; hence, it is highly probable that STIC has an influence.

Youth, Truth, and STIC

It is much harder to answer face to face (Siv, 15)

In the family of Karl and Susanne, four of the five children are teenagers and they are all answering the STIC. Prior to the first session together with their kids, the parents told us that they were very interested in getting to know the answers from their teenagers: "It probably is easier for young people to give their expressions on something on the internet, than directly to their parents in a session." Rune had an interview with the fifteen-year-old daughter Siv, who was referred due to depressive thoughts and self-harming activities. He had met her sometimes alone and sometimes together with her mother in therapy. Siv told us that for her it was "all right to respond to questions on the internet." Rune asked whether and how she found it different compared to answer directly to him in a session: "It is much harder to answer face to face. It is better on the internet because then you are more honest. You do not have to be afraid of the response." If that is true or not for all youth, we do not know, but our impression is that most people, young and old, answer as

truthfully as they can. As described earlier, the teenager Sofie reported her bisexual preferences through the STIC, but was not willing to share this information with her parents, which is consistent with the suggestions of Andersen and Svensson (2013). These authors suggest that youth more easily open up into the private on Web sites rather than in personal meetings with professionals. Our impression is that some clients are answering personal questions with more ease on the STIC online than face-to-face in the therapy room.

Is STIC in the Way?

> What is frightening to me is when you write on a notebook with pen and paper (Ola, 35)

We have had many discussions with colleagues about the influence a system like STIC may have, or actually has, on therapy. One theme has been that STIC could have a decisive impact on which topics are to be addressed in the session. The STIC clinical guidelines recommend starting the dialogue with the clients based on the dimension(s) that are reported furthest into the clinical range. It has been suggested that this procedure opens the doors to conversations about problematic issues that might be overwhelming or even discouraging. We have experienced that to keep focus on what is healthy while talking about problems helps to boost hope during therapy. Because STIC also identifies areas that are working well (resources and resilience), these aspects become visible even though the clients are overwhelmed by hopelessness. These topics are discussed more thoroughly by Oanes et al. (in press, 2015).

Another theme connected with the STIC is the technicalities and administration of STIC. To use STIC, you need a tablet, laptop, or computer in the therapy room or alternatively print the graphs beforehand. In our colleague group, we discussed how having to deal with technical equipment that one is not familiar or comfortable with in the context of therapy impacts the therapy processes as well as influences the therapists. In some ways, a computer or a questionnaire resembles an uninvited guest in the room. This guest demands attention, which may diminish the capacity to stay focused and present with the clients (Oanes et al. 2015).

We wanted the client's opinion on this theme: Did the clients find it disturbing when we sometimes look down at the tablet to log in and navigate to the right graph during therapy? Ola told us, "For me it is not disturbing at all. I'm used to being logged out of my computer, forgetting the password and so on, so it is not disturbing to me when you do that." He further told us, "What is frightening to me is when you write on a notebook with pen and paper. That frightens me, but an IPad on the table makes me feel at home."

Concerning the question that STIC might take too much of our attention in therapy, Monica said, "The way you do it, that you have read the results before we meet and therefore are prepared to give us feedback is really good. It seems as if you notice the important changes and then bring them back to us in the session."

Ola fills in, "You seem well prepared and that gives us confidence." Our experience is that the clients will use STIC and find it useful if the therapists do it. If the therapist makes an effort to prepare the session by investigating the STIC reports and addresses this in the session, we assume that we signal (or may be explicit on this) appreciation to the clients' contribution—which is an ethical imperative—constituting a very concrete way of user involvement.

A third theme is related to the notion that knowledge is power and furthermore that professional knowledge often is given more attention than experience-based knowledge (Borg et al. 2009). The first time the client looks at the STIC graphs in a session, the graphs might not tell much. However, from the experienced eye of a therapist—who knows what items that lay behind each of the scales—the graphics give a lot of information. This may add to the already unbalanced relationship between the therapist and the client, where the therapist is the expert professional helper and the client is the one seeking help. At the same time, it is only the client who knows the processes of thoughts and choices that came prior to all his or her answers that finally ended up as a graph. We find it important to balance the relationship between the therapist's professional knowledge and the client's experience-based knowledge, and it should be the therapist's responsibility to make sure that this balance is kept (see Oanes et al. in press for a more in-depth discussion of this theme). When STIC is included in therapy, we experience the necessity of constantly having in mind that STIC is a therapeutic tool that is not self-explanatory. It is important to communicate that the information that is brought to the table through the STIC is a joint venture between therapist and clients. Experience with the STIC is necessary to avoid the seductive potential embedded in the comprehensiveness and the professional looks of the STIC graphics. By constantly asking what the clients have meant by their responses and how they related the question to their context, the power of knowledge may be shared meaningfully.

In our experience, it is often interesting to check out the clients' answers to particular questions and explore these more thoroughly. The graphs are built up by more than one question, and the statistics may play a trick on the therapist by presenting a dimension more or less severe than the client feels is right. As Karl puts it, "I'm not so interested in the statistics and graphs, but more in the details like looking at each question and their subsequent answer. Statistics can show anything and if there is an increase on one item and a decrease on another, they equal each other out so that it seems as there is no change." It is again an invitation to remember that STIC does not capture it all and the logic of STIC does not always match the logic of particular clients.

The fourth theme we would like to address is something we already knew from clinical experience, but it becomes very obvious by using STIC. It is the phenomenon that as clients are entering a therapeutic process, symptoms sometimes emerge or become more powerful in people's lives. These changes are displayed on STIC, as on other instruments, as deterioration. These results must be interpreted in light of clinical experience and process, in conversation with the clients.

One Size Fits All?

One of the epistemological pillars of client-centered therapy theory is that one size does not fit all. Everyone has their own perspective and system of meanings, and they should be met accordingly (Anderson 2005). STIC as a self-report questionnaire represents a standardized measure and viewed as such it contradicts the essence of systemic therapy theory that emphasizes that all people and families are different and therefore need different approaches. However, the way a standardized measure is used in therapeutic practices may differ from family to family, and from therapist to therapist (Oanes et al., in press). The experiences with STIC as a part of the therapy are therefore multifaceted and compatible with a systemic practice.

We asked some of the clients about certain episodes in their therapy that might illustrate this variety. The most frequent illustrations of the "one size that does not fit all" are those incidents where the couple has divergent answers to the same item. These differences may be due to different understanding of a particular item, which of course may give rise to divergent answers. When preparing for a session with Lena and Ulf, we found that they had seemingly very different views on their 6-year-old daughter and her food intake. The item in STIC is "I am concerned about my child's weight." Possible answers to this item range on a five-level Likert scale from "not at all/never to all of the time." Lena answered "often," and her husband answered "not at all/never."

We inquired into this difference in the session and found that the daughter was being tube fed at that time. Lena told us she had a lot of worries about the girl's situation now and for the future, filled of sad thoughts about how difficult the situation had become. These thoughts had occupied her quite a bit for the last week; therefore, she found that "often" was a suitable answer. Ulf compared the daughter's situation now and before the tube feeding started. He found that now that the situation was taken care of by professionals, he might relax a bit. Because his mind was not particularly occupied with the food issue over the last several days, he marked "not at all/never."

For Lena and Ulf, the different answers mirrored different views on the same situation, as well as different understanding of the item. Ulf understood the item as a description of the concrete situation, while Lena used this particular item to express her experience and thoughts about the development of the situation as a whole.

A conversation with Monica and Ola illustrates that different answers to the same item may actually reflect consensus about the situation. These quotations are from the eleventh therapy session with Ola and Monica:

Rune: "There is a difference in how the two of you answer the item: *After we hurt each other's feelings, we are good at making up*, and I wonder how to understand that. Ola answers "Often" to that item and I don't know how you (looking at Monica) think about this, because your answer is "Never"."
Monica: "I have been thinking about last week, and we have not had any bad arguments during that time, so my answer is no, not at all."

Rune: "I was afraid you meant that you had a lot of arguments but you were not able to talk about it?"
Monica: "No not at all. If there were an argument we would have been able to talk about it."
Rune: "Ok, so you two really mean the same thing?"
Monica: "Yes" (Ola nodding)
Monica: "We have even been able to talk about things that we have never been able to talk about before, like economy and paying bills. That has been something we have not been able to discuss before. He has just gone crazy about that. Any questionnaire or internet bank system was too much for him. Now we can talk about it without problem."

This small part of a conversation illustrates the importance of inquiring into the meaning each person has placed on the question/item and answer. The focus on STIC answers as not being self-evident is perhaps even more important and relevant to the questions about alliance that we will discuss later in this chapter.

In other cases, STIC seems to be too comprehensive or unsuited for the presenting problem. This is typical for some families where one of the children is the referred client. Some parents find parts of STIC irrelevant, such as Ragnhild and Tore. Tore commented, "I thought we came here due to the problems of our daughter, but the STIC asked me about so many things about me and us and even my childhood. How can that be relevant?"

Such situations offer a unique possibility to address systemic topics, such as how childhood experiences may influence present adult family life as well as issues including attachment, parent conflict, and cooperation and how that might be related to the presenting problem. However, sometimes, we as therapists also agree that some of the STIC questions are really irrelevant to the presenting problem. Through training and feedback from the clients, the therapist gains experience to rapidly distinguish relevant from irrelevant information.

This became clear through another conversation with Lena and Ulf. This couple had many issues to address in therapy, and we have seen them over several periods in therapy for the past six years. This particular time we wondered how we could be of any help, because according to STIC most things in their life seemed to be working fine.

Lena explained this in a very straightforward way. The reason for seeking help this time was connected to two of their older children who did not live at home. The son had refused to come to therapy with his parents and therefore had not responded on STIC. The daughter lived in another city and could not attend the session. The parents had given answers about their impression of the girl (child's problems and strengths), but as she now was coping much better with her other difficulties, problems did not present themselves strongly through STIC. For this particular situation, STIC was not compatible to the presenting problem. Lena commented, "There are many questions, too many actually, and still they do not cover the areas we are struggling with. There is a chance that you are missing the other parts that we are not able to respond to in the STIC." It is very important to make the

therapists aware of those limitations, so they do not rely on STIC too much: In our experience, STIC is like a fishing net. When you throw it out in the ocean, it will catch some fish, while some slip through and others swim elsewhere in the ocean close or far from the net. It would be a mistake to think that what's in the net is all there is in the ocean. The same with STIC, it is not just what is caught with the STIC that might be important. STIC should never be the only source to inform us about people and families.

What we have learned from this is that in order for the therapist to understand the STIC, the answers should be the topics to discuss in sessions. This offers an opportunity for each client to present the context from which they had added meaning to both question and answer. Likewise, the therapist may offer professional knowledge about topics such as emotional development and relational functioning that could help people to find STIC relevant to their situation, but STIC most certainly will not match every situation and every family that comes to our clinical practice.

Alliance

I don't understand my relationship anymore, so how could you? (Ola, 35)

From the second session on—as a part of the STIC Intersession—the clients answer questions about the therapeutic alliance, which are also displayed as graphs. The alliance items in STIC build on Bordin's classical theory of the therapeutic working alliance (Bordin and Kovacs 1979) as comprised of agreement between client and therapist on the goal for the therapy, agreement of the tasks and methods performed in and between the sessions, and the emotional bond between the client and the therapist.

In addition to goals, tasks, and bonds, the client is also asked to assess two other topics (Pinsof and Catherall 1986; Pinsof et al. 2008). The first is whether the therapist understands and cares about "the relationship" between the couple or within the family. The second topic is whether the client feels that the therapist possesses the skills and ability to help.

To capture the complexity of multiple alliances that are set in motion when there is more than one client and one therapist present, each client is asked to express their opinions on the alliances three ways. Firstly, they are asked to answer questions from their own perspective, for example, "I trust the therapist." Secondly, the clients are asked to take the perspective of the therapist, for example, "The therapist cares about my family." Thirdly, the client takes the perspective of their partner or other family members: "My partner feels accepted by the therapist."

We find that the alliance section gives the opportunity to talk about nuances and different aspects of alliance with the clients. In our experience, the alliance questions in STIC may be a gateway for expressing a variety of topics related to the

therapy process. One example was in the case of Ola and Monica. Rune tells this story from one session when he met the couple alone:

> I believed I really had understood Ola and addressed an issue that was very important to him in the previous session. To my surprise I read on his subsequent STIC report concerning the alliance that he did not feel that I understood neither his goals for therapy nor his relationship with his wife at all. I asked him what he meant by those answers and he replied, 'I don't understand myself anymore. I don't understand my relationship either. So since I don't understand myself or our relationship, how could you?'

A further exploration revealed that Ola had not lost his faith in Rune as a helper or his ability to understand Ola and his relationship with Monica in the future. One may say that Ola's response perhaps revealed his lack of ability to see Rune as different from himself. However, within the context of alliance, one may also say that Ola gave Rune the message, "This relationship is very complex and difficult for everyone to understand, including me and you." Seen this way, the drop in the alliance graphs did not communicate a rupture (Goldsmith 2012). In order to understand the significance of the drop, it was necessary to talk about it in the session. Real ruptures in the alliance happened several times with Hege (age 52), who has strong relational wounds from childhood maltreatment and domestic violence. She easily views others as hostile, including us as therapists. She says things such as, "I think you hate me for this" and "I am afraid of answering those questions now." Before one of the last sessions, she did not want to answer the STIC at all because she thought we did not care about her anymore as we were planning to end the therapy. We experience that alliance ruptures in therapy with vulnerable persons like Hege, who suffer from basic deficit conditions such as lacking attachment, safety, and trust, the alliance repair may be the most central healing potential in therapy.

Our clinical experience is that we as therapists have become more focused on alliance as a result of using STIC. In addition to giving an opportunity to address the alliance as such, STIC also represents permission to do so without the risk of being accused of "fishing for likes." It is also our impression that the alliance items provide the clients with the opportunity to describe their multiple alliances more precisely than was the case without STIC.

Conclusion

In our experience, the use of STIC as a part of couple and family therapy has many advantages. Furthermore, most clients report to us that they find STIC useful. However, it is important to use STIC in a flexible way in order to find the best possible fit for each family and couple. STIC used in a systemic family therapy context also requires that the STIC answers need to be brought back into the dialogue and the relationships in order to be meaningful. In the context of systemic practices, STIC may work as a powerful point of departure for dialogues that will make a difference.

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Chapter 12
Lessons Learned from the Implementation of a Feedback System in Couple and Family Therapy

Åshild Tellefsen Håland and Terje Tilden

Introduction

In this chapter, we share our implementation experiences from a combined clinical- and research-based project where we explored the use of a routine outcome monitoring (ROM) within three couple—and family units in Norway. Monitoring the clients' process and outcome frequently throughout the course of treatment was successful at one clinic but represented a considerable change of the clinical practice for the other two units. One of these units withdrew from the project as the implementation challenges grew too large. The third clinic experienced considerable challenges and was about to withdraw from the project, yet they managed to turn the situation around and ultimately succeeded. This latter unit will be the focus of this chapter as reflecting on this unit's process was a learning experience on implementation and project leadership. Our major take-home message is that implementing ROM in a clinical unit is doable, but the challenges may be considerable and time-consuming. Some of the challenges in our project could have been avoided if we had more knowledge about implementation in general, and implementation of feedback systems in particular, when we began the project. The aim in this chapter was to convey our experiences and the lessons learned so that hopefully others can avoid the same pitfalls.

Adapted from Tilden et al. (2015).

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Background

As professionals within the systemic field we have ideas based on values and theories that emphasize user involvement, humility, and respect for the clients' own experiences and their personal theories of change (Johnsen and Torsteinsson 2012). Based on systems theory and cybernetics, a core assumption in the couple and family therapy (CFT) field is that feedback about the system—to the system—will regulate how this system works, either to maintain balance or to adjust to new environmental and relational conditions. In therapy, this theory has been put into practice by several ways for the clinician to relate to the clients so that the clients get information about themselves, for instance how a couple's interaction is perceived from another person's perspective. When such information is shared, there is a strong theoretically and philosophically based belief that this couple—as a system—has the capacity to adjust in an adaptable way. Thus, their own problem-solving abilities are strengthened by minimal external expertise interventions. This way, most CFT clinicians make use of feedback as an ingrained and implicit part of their practice. We therefore believed that establishing a systematic way to make feedback explicit as a regular part of CFT would be consistent with the systemic approach that is the basis of CFT. This belief was strengthened after experiencing successful use of a systematic and frequent feedback tool at one of the participating units (Tilden 2010). And this notion was also supported by research showing that the use of feedback from the client improves therapy (Lambert 2007). As well, feedback seems to be important as a means to predict early in therapy whether there is risk of treatment failure (no-change or deterioration), enabling the therapist and client to evaluate and adjust the therapy to improve the outcome (Lambert and Shimokawa 2011). Research has also shown that therapists are not precise in judging the success of their own treatment and, in particular, are not able to predict when therapy is not progressing adequately (Walfish et al. 2012). For these reasons, a more reliable and systematic monitoring of therapy process and progress assessed by the clients and fed back to the therapists is recommended (Boswell et al. 2015).

In Norway, CFT is organized on three levels. The level that offers the easiest access for clients is the local family counseling services (see Chap. 6). Then, there is a mid-threshold regional service primarily offering CFT when the children in the family are referred to child and adolescence psychiatry (see Chap. 11). The third level is the family unit at the national psychiatric hospital Modum Bad, which is organized within adult psychiatry (see Chap. 9). We wished to include these three levels in a project implementing a feedback system; hence, we established the following CFT consortium: the Family Unit at Modum Bad; Department of Child and Adolescent Mental Health (ABUP) at Sørlandet Hospital, Kristiansand; and the family counseling office in Ålesund (Tilden et al. 2010). Based on our search for an existing feedback system developed for CFT that could be appropriate clinically and for research, we chose the Systemic Therapy Inventory of Change (STIC; Pinsof and Chambers 2009). Compared to other feedback systems we assessed, the STIC was the most comprehensive and produced clinical as well as research

information that was tailored for CFT. In particular, this system provides information on several family *systems* (individual problems and strengths, family of origin, relation to partner, family climate, children's problems and strengths, and relationship to children), and *dimensions* (in contrast to diagnostic categories), displaying information for all the family members on the same graph (see Chap. 5 for a more thorough presentation of the STIC). The initial completion of STIC gives background demographics as well as a snapshot into every family member's problems and resources, something that enables a rapid overview of what might constitute the problems to be addressed in therapy. Before every subsequent session, the clients complete a shorter version of STIC (intersession) that also includes alliance scores as well graphics showing the progress of therapy over the course of treatment. Completion of the STIC is accomplished electronically, and client data are processed in comparison with previous scores as well as against a normative sample.

After choosing the feedback system and making an agreement with the founders of STIC, we started a pilot project to try out this system within our consortium lasting from 2010 to 2013. The first step was to translate and test the system, followed by a randomized controlled trial (RCT) comparing feedback with the STIC to treatment as usual (TAU, which is treatment without feedback) that ended the data collection Sept. 2016. STIC can be completed by clients from the age of 12 and above, although in our settings the instrument was completed mainly by adults. Implementation involved the therapists, who were mainly social workers and psychologists, and managers as well as administrative staff persons.

Implementation

Implementation is defined as the act of carrying out an idea, a plan, or a strategy in practice (The Free Dictionary) and involves specific activities required to do so (Fixsen et al. 2005). Because implementation is so important and so complex, it has become a field of study, one which emphasizes research-based knowledge about what it takes to succeed with implementation (Flottorp and Aakhus 2013). Lack of implementation knowledge can be one of the reasons why it often takes a long time before new knowledge is made applicable (Brownson et al. 2006). For example, it took 70 years from the first research findings demonstrated that hospitalized children benefited from the presence of their parents, until it was enacted by law that children in Norway have the right to be accompanied by their parents (Havik 2011). The field of psychotherapy has begun to recognize the importance of implementation, as evidenced by a special issue of *Psychotherapy Research* that was devoted to implementation, with emphasis on how to build collaboration between clinicians and researchers using feedback (Castonguay and Muran 2015).

In a review article on implementation quality, Sørlie et al. (2010) defined key concepts and processes, as follows:

(a) *Implementation context* refers to management support, including the needed decisions, at the organizational level. The management then uses their authority to give priority to implementation to provide the necessary conditions and resources so that actions are enabled and completed. This may include training, supervision, facilitation of work, and identifying and overcoming obstacles and challenges.
(b) *Program qualities* refer to the quality of what is being implemented and how easily it fits into existing practices. The new program should be easy to use, be tested and evaluated locally, have earned a positive reputation, and should not come into competition with other tasks.
(c) *Organizational and human factors* point to the connection between the planned action and the organization's self-understanding, values, goals and needs, in order to achieve broad consensus and commitment within the staff group for introducing such new practices. Sufficient staff, a "local champion" who is eager to advocate the new practice, sufficient time, money, physical arrangements, and technical-practical support are key factors. The local champion should be surrounded by an implementation team. There should be a professional climate of cooperation without major personnel conflicts. Suitable personnel must be selected and given training, supervision, and constructive evaluation throughout the implementation process. This factor was rated as the most important for successful implementation in a summary of the various applications of evidence-based psychological treatment (McHugh and Barlow 2010).
(d) *Implementer qualifications* refer to the qualification of the person in charge of the implementation. This person must be able to share information, influence others, and be in direct contact with users (Sørlie et al. 2010). To ensure adequate support, this person must have credibility and legitimacy to achieve alliance with opinion leaders who in turn affect other employees positively, which can ensure adequate support.

Studies on ROM Implementation

Even though several studies suggest that the use of ROM is beneficial in therapy (Krägeloh et al. 2015; Lambert and Shimokawa 2011), there are few studies investigating the implementation of ROM in ordinary clinical settings. However, parallel to our study, similar ROM implementation has been conducted in other clinical settings, as reviewed by Boswell et al. (2015) and by Miller et al. (2015). Even though the majority of experiences seem be similar across different clinical contexts, we have discovered only a few studies reporting ROM implementation experiences from the CFT field (Boswell et al. 2015; Christensen and Dalgaard 2013; De Jong et al. 2012; Tilden et al. 2015).

In a study of implementation of feedback tools, De Jong et al. (2012) found that only when therapists experienced and recognized client feedback information as helpful in their clinical work was the use of feedback associated with good outcomes. Boswell et al. (2015) emphasized the need for close collaboration between clinicians and researchers and that the ROM system needs to be user-friendly. Further, the ROM training programs need to be led by local champions who have the confidence of colleagues as well with leaders. Christensen and Dalgaard (2013) concluded that the following factors were important for successful implementation of KOR[1] at a municipal family center in Denmark: (1) Focus on therapeutic relevance, (2) trust between management and employees, (3) trust among employees, (4) sufficient time for practicing the new tool, (5) follow-up of decisions taken, (6) involvement of the employees from the start, and (7) completion of questionnaires must be made electronically rather than on paper. Factors found to strengthen the implementation of KOR in Norway was its clinical relevance and facilitation of user involvement (Anker et al. 2009; Sundet 2012; Tuseth et al. 2006—see also Chaps. 6 and 7).

Lessons Learned from Our Project

We wish to evaluate retrospectively the implementation experiences of the therapists, managers, and the administrative staff members in our project. This was motivated by our experience that our project was more complicated to carry out than we had expected. Hence, we conducted an evaluation with a short self-report questionnaire that was filled out anonymously, which asked therapists, managers, and administrative staff about their experiences (Tilden et al. 2015). Parallel to this, a qualitative study was conducted (see Chap. 8). The main finding in this evaluation was that two of the units, Ålesund and Kristiansand, experienced considerable challenges and problems, while the use of STIC was more successfully implemented at Modum. Due to these problems, Ålesund chose to withdraw from the project. For these reasons, the discussion in the following mainly relates to the Kristiansand unit, which experienced many ups and downs. We believe that evaluating unsuccessful experiences, followed by new trials that work better, which occurred in Kristiansand, may constitute the optimal learning conditions that we wish to convey in this chapter.

The Kristiansand unit is organized within child and adolescence psychiatry, offering couple and family therapy. The unit consists of 16 therapists, but during the

[1]KOR is a Norwegian acronym for Klient—og resultatstyrt praksis, also called Feedback Informed Therapy, using the ORS (Outcome Rating Scale) and the SRS (Session Rating Scale)—(Duncan et al. 2010).

project period the unit was reorganized twice, resulting in new leadership that did not have ownership of the STIC project. The decision to join this project was therefore revisited several times during this period, varying from an initial decision that every therapist was to participate, to opening up for voluntary participation.

In the following section, we will discuss implementation in our project in Kristiansand through five phases.

The Honeymoon Phase

At the beginning of the project we, as project leaders, had a good experience promoting the project to the clinical staff. The idea about conducting research on our own clinical practice with the use of a feedback tool created general interest and enthusiasm. A few staff members expressed skepticism, but they were eventually convinced to join. Further, there was a general agreement that one needed to document the effectiveness of therapy and that the STIC tool was suitable for gathering such data. It was therefore decided that all the therapists in the unit would be included in the project. This agreement was not initiated by the top management, but rather established as a "bottom-up" movement by a local champion who managed to convince her colleagues to participate. The unit management also gave their approval, but they were not involved in the project details. We had workshops with the founder of the system Professor Pinsof that created much enthusiasm for the STIC. Pinsof's involvement was primarily training in the use of the system, and he was not involved in the implementation. One characteristic in this phase was that there was much discussion about the advantages of the system; however, there were few invitations to discuss the possible disadvantages. In the hindsight, we realize that it was a mistake at this stage not to identify which risks, obstacles, and disadvantages as well as advantages, allowing skepticism and objections to be aired. As part of this, we should have arranged for at least one full-day workshop to discuss implementation, addressing the commitment and feasibility for the unit to carry through such a project. As we later experienced, several problems occurred, but as project leaders we were either not sufficiently aware of these, or we actively ignored them, hoping that by not addressing these, people would not become aware of them, which we thought could jeopardize the project. Through this way of putting our "heads in the sand," we hoped that the wave of enthusiasm would remain so that the project would be successfully carried through. As such, we realize that our *implementer qualifications* were lacking at that time, in particular not paying enough attention to the *organizational and human factors* as important implementation factors (Sørlie et al. 2010). We learned, however, that positivity alone is not a sufficient condition for successful implementation. We believe that some colleagues were skeptical and had objections even from the start of the project, but in a staff climate of enthusiasm they may have found it difficult to

object, not wanting to be the one who sounded negative. Unfortunately, negative opinions were shared informally in smaller groups which may have created latent conflict and splitting.

From Initial to Action Phase

In this phase, we went from agreement to use STIC to actually putting it into action. At this stage we experienced several problems with the electronic system, we discovered translation errors, and many therapists expressed that they were overwhelmed by information from STIC that they had not asked for. Many therapists felt that clients should only provide information about themselves and their therapy when they were ready to do so and that inquiring about functioning in many areas was intrusive and disrespectful. In retrospect, we underestimated the importance of therapists' professional rationales for why they work as they do. The study of Oanes et al. (2015) points out that many of the therapists perceived STIC as belonging to a tradition in which the therapist's role is characterized by being more of an expert than they themselves preferred to be. Many perceived STIC as detached from the client context because all clients were given the same questions regardless of what they sought help for. In addition, some of the therapists were concerned about whether the use of STIC could adversely affect alliances (Oanes et al. 2015). One such example is that the therapist via the STIC information would gain knowledge of clients' problems without the client having been personally invited to give such information through a face to face meeting. This was experienced by many therapists as not in agreement with what they considered to be good clinical practice.

When these challenges occurred, we experienced that there were considerable variation in the degree of commitment by therapists to follow up what had been decided regarding the use of STIC. Of all the factors that might explain the poor compliance, we think the most important one was that some of the therapists did not experience STIC as useful in clinical practice. The main reason for this may have been poor training and insufficient support in practical terms (e.g., time, lower case load). As a comprehensive ROM instrument, STIC provides large amounts of data that requires training and supervision in order to be perceived as a useful tool. Initially, we wanted the therapists to become comfortable with the use of STIC in clinical practice without strict guidelines. However, many therapists did not have a sufficient volume of STIC cases. So even though the therapists received weekly supervision, many of them were not able to utilize this optimally because they had too few STIC cases. The reason for this was that the use of STIC was not mandatory and the management assessed whether a case would be a "STIC-case" or not. Conversely, we found that therapists who did receive sufficient training on a number of cases experienced STIC as a useful clinical tool. Many therapists never progressed pass the initial education phase, and hence, they did not achieve mastery

of using STIC. A lack of mastery weakened motivation and lead to the conclusion that the STIC was not useful. In retrospect, we initially should have trained a few supervisors who could become experts before the entire group of therapists was required to use STIC. Therapists should have gone through a training program with a sufficient number of STIC clients over a period of time, with supervision and training, and an expectation that they achieve some criterion level of competence in the use of STIC (McHugh and Barlow 2010).

Another factor that may explain poor compliance is that the use of the system was more comprehensive and work demanding than expected. Most therapists did not employ any form of systematic survey or questionnaire before the project started, and there were few who had previously called for such an instrument. Several therapists therefore had to learn to use an instrument they experienced as unnecessarily complex in relation to their expectations. It was also raised questions regarding how suitable the instrument was with children as the identified patient, in particular since STIC was not designed to be completed by children under the age of 12. Sørlie et al. (2010) point out that it is much harder to implement complex tools with recipients who have not seen a need for such tools.

It should also be added that by the time the implementation started, the STIC system was not fully developed and tested, something that reduced the odds for successful implementation. For instance, it is a demotivating experience every time the electronic system shows "Error" and "System is down." Hence, we should have tested out the system within a smaller group of dedicated "test pilots" so that errors could be corrected before the system was launched for the larger group of therapists.

Another challenge was that implementation of the STIC changed the daily routines of therapists. At this unit, relatively large structural changes were necessary for the therapists to have enough time before each session to prepare for the use of STIC. The larger the structural change, the larger the risk it is for the unit management to fail in preparing adequately for implementation (Sørlie et al. 2010). For instance, the management did not provide the therapists with the necessary extra time for them to call new clients in advance of the first session to inform about the STIC, asking for their consent to participate in the project. Eventually, some of these extra tasks were accomplished by administrative staff rather than therapists, something that worked better.

In this implementation phase, a major reorganization occurred at this unit with several management changes at different levels and this created problems in relation to the ownership of the project. We think that several of the new managers felt they inherited the STIC project and they were not invested in it. All these factors together were not favorable for the STIC project. However, despite a motivational decrease and poor adherence to follow the decisions and guidelines about the use of this system with some of the therapists at this phase, all therapists were using the STIC, something that changed in the next phase.

The Downturn Phase

In this phase, the attitudes toward the STIC among several of the therapists became negative and led the unit management to decide to make use of the STIC voluntary. As a result, many of the therapists withdrew. This represented a remarkable change in the staff, e.g., simply talking about the STIC project created tension in staff meetings. It was also clear that preexisting or latent conflicts among staff were expressed as disagreements about STIC and this exacerbated both the conflict and the resistance to STIC (Friis and Vaglum 1999). We also believe that the resistance within the CFT field to quantification of therapy processes also was a factor that influenced on this process (Solem et al. 2008).

The problems were further exacerbated when we received funding to conduct an RCT to study the effects of feedback. Two of the management leaders had a conversation with each therapist to see whether there was support for joining the research project. Our hope was that the management leaders would encourage each therapist to join the RCT but this did not happen. As a result, the number of participating therapists dropped from 16 to 1! Consequently, it was decided that this level of participation was not sufficient for the unit to remain as a partner in the project. However, negotiations with the project leadership and the unit management opened up a possibility to continue being part of the project with only one participating therapist, yielding a future possibility of recruiting some others. Due to all this "noise," the project leadership chose to keep a low profile for a while, waiting for a climate change that could enable new therapist recruitment.

This experience raises questions about advantages and disadvantages of voluntary versus mandatory participation. Making participating voluntary increases the intrinsic motivation of those who are participating. Yet, making it voluntary substantiates the number of therapists who participate to decrease and this may be low because generally there is reluctance to change and to take on more work. Still, some therapists, if they have good experiences, may become willing and eager to join. On the other hand, if the management makes participation mandatory, then this will likely provoke resistance, and therapists perceive that management is interfering with their professional judgement and autonomy. We assume that this represents a unit management dilemma, which is particularly evident when introducing research on and within clinical practice. Further, this addresses an ongoing debate related to power and professional influence on own practice and discourses that prevail in our field at our time (Utvåg et al. 2014). These authors highlight the nuances of this debate, where they point out that professional autonomy needs not necessarily be threatened as a result of new management tools. We have no clear answer to this dilemma related to our project. However, if the management had insisted that everyone had to participate, then the therapists may have experienced that getting training in the use of STIC on a sufficient number of clients would have given them a feeling of mastery regarding the clinical usefulness of this tool. The negative reactions in this phase—that perhaps mainly were based on therapists' expectations to the use of STIC and not experience—could then have changed or

ceased. Alternatively, starting using the STIC among the most motivated therapists only, new therapists could have been recruited through collaboration with a trained STIC therapist.

The Upturn Phase

Our hope in recruiting new therapists to the project was fulfilled eventually. In a "bottom-up" dissemination process, the therapists who worked closely with the remaining STIC therapist observed that the STIC was useful in clinical practice. These therapists then became eager to learn more about the clinical use of STIC in their own cases that they conducted together with the STIC therapist. Parallel, a "top-down" process took place that included a growing awareness at the unit management about the need for documentation and quality assurance. This took place as part of a growing culture at this hospital of valuing research, exemplified by about 15 researchers becoming affiliated to the unit. Hence, research has increasingly been put on the agenda not only as a way to ensure documentation and quality assurance, but also as a means for earning more clinical relevant knowledge. As a consequence, questions were asked about which system and instruments could be feasible in collecting such data at the unit. Because STIC already was in use, a renewed interest in this system was ignited. We also experience that there was a parallel reduced ideological resistance against using quantitative approaches in general. This may be explained by therapists learning to know the persons promoting the STIC system, as well experiencing how the STIC information may contribute to conducting better therapy. These factors influenced the climate to change from a single STIC therapist and a taboo about talking about STIC to a situation where therapists on their own started talking about STIC as something desirable. As we write, the number of STIC therapists has grown to include all in the unit except two. As discouraged project leadership, we did not dare hope for this to happen. The end of this phase was characterized by eager participation of most therapists and support from the management.

The Consolidation Phase

We will call the final phase as the consolidation phase, characterized by a smooth operation where the STIC system is fully integrated into the functioning of the unit. The administrative staff member attends to all the practical logistics, such as calling patients and reminding them to fill out STIC. We also have a local champion who is an expert on STIC and who has been given time to assist the other therapists with their use of STIC. This experience supports the implementation literature that emphasizes a local champion who is present in the daily activities and takes an active part in the implementation as a prerequisite for successful implementation. In

our project, the local coordinator at each unit was also supposed to be the champion. This did not work because this person was responsible for her own separate project that needed her attention, resulting in too little time to be present in the daily clinical activities to make sure STIC was implemented. To reduce the vulnerability of a project, we learned that the roles as champion and local coordinator do not need to be with the same person, but can successfully be shared by more than one person. The local coordinator has a role as a bridge between therapists and the unit management. If there are difficulties, it is important that there is a dialogue between the unit management, the coordinator, and the therapist group so that necessary actions can be taken.

A metaphor of the implementation of STIC at this unit may be the resilient child, who has managed against all odds. One of the important resilience factors is this unit's culture, which became to be characterized by an innovative work environment where research plays a key role. The STIC project was aided by a growing awareness among therapists that research in clinical practice is important and desirable. Despite some obvious lack of implementation and project leadership knowledge to begin with, we as project leaders have also earned the necessary confidence along the way. Gradually, the ownership to the use of STIC is within the local unit, and the advantages of the use of the system seem to be obviously greater than the disadvantages. Once it is learned as beneficial for the treatment, becoming an implicit part of the clinician's toolbox, it is no longer reflected upon as something new and strange, but appears as an integrated part of the clinician's everyday practice.

Implications

In conclusion, based on our findings, we would like to provide some recommendations on how to increase the likelihood of successful implementation.

1. Not all ideas should be implemented. One should discuss with all stakeholders involved, where everyone is able to express whether the suggested changes are meaningful or useful, and how the new program could be integrated into the established practices and what structural changes are needed.
2. At the start of the project, knowledge about implementation and project management is needed (Andersen 2006). All participants, and especially the unit managers, should envision for themselves what possibly could go wrong in the implementation in relation to their knowledge of their own organization. One should actively invite skepticism and objections. Local conditions and consequences of success would also be useful to survey.
3. A general positive attitude or promise of support from the unit management is not sufficient. Implementation requires commitment. Therefore, it should initially be established a steering group of relevant staff members within each unit, including unit managers, coordinators and local champion(s) who has frequent

meetings involving clarification of specific agreements, such as who does what, at what time, and who reports to whom.
4. Some selected enthusiastic therapists would need training to become either coordinators or local champions for the new system. Two champions at each unit would be ideal.
5. If system development is the primary purpose of the project, it must be made clear that this is time limited and that the participants agree to be "test pilots."
6. The project management must be clear about the different phases of the project, so that everyone is confident when testing and implementation ends, and when research begins and how long each phase is anticipated to last.
7. It is crucial that therapists quickly achieve mastery through training of a sufficient number of cases in the new system within a period of time. Training should end with certification, which rewards competence and can be a motivating factor.
8. It should be determined which tasks could be done by administrative staff (research secretary/research assistant) to relieve the therapists of the extra work load. For instance, such tasks may include ensuring logistics and procedures, and assisting therapists to follow up their work related to the project.

Conclusion

Feedback systems are recommended as useful tools for different purposes; clinically, for user involvement, systematic evaluation, documentation, and research, as well as to reduce the distance between clinical practice and research (Boswell et al. 2015; Pinsof and Chambers 2009; Pinsof et al. 2012; Sexton et al. 2013). We have in this chapter argued that implementation knowledge and project theory serves as an important basis for the implementation of new practices—such as feedback systems—and should be feasible in clinical operations. We have emphasized that "lessons learned" originate mainly from the least successful experiences from our implementation efforts. Despite these difficulties, we were able to proceed into the main RCT project that currently (September 2016) has ended the data collection, and we have just started the data analyses. Hence, the most important "take-home-message" is that implementation may succeed as long as the therapists experience the new program or tasks as useful for themselves and for patients. However, in retrospect, if we were to start a new implementation project, we would have benefitted from our lessons learned, hence adhering to our above mentioned recommendations.

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Part IV
Reflections from Abroad on Couple and Family Therapy in Norway

Chapter 13
How, When, and Why Do People Change Through Psychological Interventions?—Patient-Focused Psychotherapy Research

Julian A. Rubel and Wolfgang Lutz

Introduction

A new clinical idea proposed by a clinical researcher or practicing clinician is—traditionally—the starting point for the development of a new treatment concept. Based on this idea, a new treatment package, comprising a number of interventions, is developed and eventually tested. If these efforts result in preliminary evidence suggesting that this new intervention is effective, the new package and the proposed clinical mechanisms of change are then often disseminated to interested clinicians. However, the evidence base, especially with regard to the actual moderators and mediators of change for psychological interventions, is somewhat limited (Kazdin 2014). The research that actually tests the clinical idea often lags behind and is hardly taken notice of by practicing clinicians. The consequence for the field of psychotherapy is the existence of ubiquitous gap between research and practice. The present chapter deals with an alternative paradigm of treatment development and research, which provides a way to consider the scientist–practitioner gap from both the scientist's as well as the practitioner's perspective (Castonguay et al. 2013). This paradigm is called *patient-focused research*[1] (PFR; Howard et al. 1996; Lutz et al. 2015). While efficacy and effectiveness research are traditionally concerned with the average treatment effect of an established or new treatment approach, PFR is concerned with monitoring actual progress over the course of treatment and providing "real-time" feedback of this information to clinicians (Howard et al. 1996; Lambert 2007; Lambert et al. 2001; Lutz 2002). As such, the pivotal goal of PFR is the use

[1]Patient-focused research (PFR) should be seen synonymous to the expression "patient-oriented research (POR)" used elsewhere in this book, e.g., in Chaps. 1 and 16.

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and implementation of research into the actual treatment process, thereby turning psychotherapy in clinical practice into a truly research-supported intervention. From this point of view, it is not enough that efficacy and effectiveness trials have shown a treatment to be effective on average. Instead, *research support* should be an integral part of each individual's ongoing treatment.

The foregoing chapters have already provided examples of how the ideas of patient-focused research can be implemented in a family therapy context. The present chapter complements these examples with some more empirical and theoretical background. It is important to note that the models discussed in this chapter are not based on a particular approach to psychotherapy. Psychotherapies are considered a class of treatments, defined by overlapping techniques and proposed outcomes. Outcomes are measured by aggregating item scores related to many disorders and complaints. Instead of adapting the treatment only at the beginning by selecting a specific manualized treatment for a respective diagnoses, patient-focused research focuses more on the (real-time) improvement shown in treatment as implemented and the ongoing dynamic adaptation of the treatment based on the progress and the specific needs (dosage and clinical strategies) of the patient (Lutz 2002; Lutz et al. 2015). Therefore, this approach supports a research perspective more focused on outcomes and the improvement of actual clinical practice and less based on a debate about therapeutic schools (e.g., Goldfried 1984; Grawe 1997). Accordingly, the core of this approach requires research to be conducted for individual patients on the course of patient change, in order to learn about differences in patient change as well as subgroups of patients with specific patterns of change.

The chapter is organized into three sections: First, a short overview of dose–response and phase models presents the history and theoretical foundations of patient-focused research. Second, different methods for the generation of decision support tools are described and discussed. Finally, recent research on moderators and mediators of the effects of psychometric feedback are presented, which helps to understand how and for which patients and therapists feedback tools can enhance the effectiveness of psychotherapeutic interventions.

Dose–Response and Phase Models of Therapeutic Change

The theoretical origins of patient-focused psychotherapy research are rooted in the dosage and phase models of psychotherapy. The dosage model of psychotherapeutic effectiveness proposes a negatively accelerating relationship between the number of treatment sessions (dose) and the probability of patient improvement (effect). As such, an increasing number of sessions is associated with diminishing returns in terms of improvement (Howard et al. 1986). In subsequent work, these findings were interpreted as representing rapid improvement early in treatment, while, in later phases, increasing numbers of sessions were necessary to reach a higher percentage of changed patients (Howard et al. 1993; Kadera 1996). Integrating data from 15 studies, Howard et al. (1986) found that after 2 sessions,

30% of the 2431 patients had shown positive results. This percentage increased to 41% after 4 sessions, 53% after 8 sessions, and 75% after 26 sessions. In an extended analysis, Lambert et al. (2001), using more rigorous clinically significant change criteria, showed that these improvement rates were overestimates and were dependent on patients' pretreatment impairment. Using their approach, 50% of patients who were in the dysfunctional range before treatment required 21 sessions to meet clinically significant change criteria. However, for 70% of these patients, more than 35 sessions were necessary to achieve this result. Further research has shown differential change rates for different diagnostic groups and symptom impairment levels (Barkham et al. 1996; Kopta et al. 1994; Maling et al. 1995). Patients who start treatments more severely impaired tend to have more change from pre- to post-treatment but have a lower probability of achieving clinical significant change (Ogles 2013). Also, recent research suggests that change is more rapid in short, time-limited controlled settings than in longer treatments without a predefined end point (Lutz et al. 2015). Lutz et al. (2015) showed that the effects of naturalistic CBT for depression are equal to those reported in the CBT arm of the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH TDCRP; Elkin et al. 1989), if the samples are matched. In the matching variables, several patient intake characteristics were used (symptom severity, dysfunctional attitudes, sex, age, education, and employment status). However, to reach the same BDI outcome scores, CBT in controlled settings needed only about 17 sessions, while, in naturalistic settings, about 35 sessions were provided. Further research using longitudinal assessments is required to reveal how much change in the naturalistic sample had already taken place up until, and how much after, the 17th session.

The question of how much therapy is needed is still an active area of research. An extension and, to some degree, alternative model to the dose–effect model is the good-enough level (GEL; Barkham et al. 1996) of change concept. The GEL model suggests that the diminishing strength of successive sessions (i.e., negatively accelerated/log-linear) is an artifact of aggregating patients with varying treatment lengths. Following the GEL model, patients in routine care stay in treatment until they have reached a level of change that they personally perceive as *good enough*. The path to this individual level might rather be linear than log-linear (Barkham et al. 2006). To test this conjecture, Stulz et al. (2013) separately modeled latent growth curves for patient groups with the same number of treatment sessions. Irrespective of the total amount of treatment sessions, a log-linear model consistently outperformed a linear model supporting the notion of a negatively accelerating change trajectory. Moreover, the dose–effect model is often interpreted as assuming a universal association between the number of sessions and their effects. The GEL model, on the other hand, suggests that the rate of change differs depending on the overall number of sessions attended. That is, patients with shorter treatments should have higher change rates than patients with longer treatments. Meanwhile, this assumption of the GEL model has been supported by several findings (Baldwin et al. 2009; Falkenström et al. 2016; Owen et al. 2016; Reese et al. 2011).

A clinical explanation of the dose–effect relations described above is provided by the phase model. The phase model formulates hypotheses regarding which specific dimensions of outcome change and in which temporal sequence (Howard et al. 1993). Three sequential and progressive phases of the therapeutic recovery process are proposed: (1) remoralization—the enhancement of well-being; (2) remediation—the achievement of symptomatic relief; and (3) rehabilitation—the reduction in maladaptive behaviors, cognitions, and interpersonal problems that interfere with current life functioning. In accordance with the phase model, the decelerating curve of improvement proposed by the dose–effect model can be related to the increasing difficulty of achieving treatment goals in these different domains. This means that well-being is more quickly achieved than symptom change, which, in turn, is achieved more quickly than rehabilitation of life functioning. Moreover, a probabilistic causal relationship between changes in these dimensions is proposed in the phase model. That is, improvement in well-being is assumed to be necessary, but not sufficient, for a reduction in symptom impairment, which, in turn, is assumed to be necessary, but not sufficient for the subsequent amelioration of life functioning. In a study testing the phase model hypothesis, Stulz et al. (2007) identified three patient subgroups on the basis of their development in the respective dimensions (well-being, symptoms, life functioning) over the course of treatment. In each subgroup, well-being increased most rapidly, followed by a reduction in symptoms, while improvements in life functioning were slowest. This finding supports the proposed differential change sensitivity of the three dimensions. Furthermore, about two-thirds of the cases developed in accordance with the predicted temporal sequence of phases (i.e., well-being → symptoms → functioning). However, one-third violated at least one of the two predicted sequences (e.g., moved directly from increased well-being to increased life functioning without a phase of symptom improvement). In addition, results suggested that for more severely distressed patients, the phase model seems to provide a less accurate description of treatment progress. Joyce et al. (2002) reported a similar finding. In light of the earlier findings, further refinement focusing on differential change sequences between individuals is important.

Decision Support Rules

The dosage and phase models conceptualize the process of recovery for an average psychotherapy patient. However, individuals' patterns of improvement can differ significantly from the general trend (Krause et al. 1998). Thus, to take this individuality into account, models are needed that allow the estimation of expected recovery curves for individual patients, based on their progress-relevant pretreatment characteristics. Indeed, this idea was the starting point of patient-focused psychotherapy research (Howard et al. 1996). Patient-focused research asks how well a particular treatment works for the actual treated patient (i.e., whether the

patient is benefiting from the treatment they are currently engaged in). The evaluation of treatment progress depends on the idiosyncratic characteristics and developments of the patient with respect to their expected treatment response. For example, minimal progress by session 8 might be insufficient for most patients to consider their treatment a success. However, for a severely impaired patient with a comorbid personality disorder, such moderate progress might be an indicator of a successful intervention (Lutz et al. 2009). As a result, feedback systems designed to support clinical decision-making in psychotherapy should include decision rules allowing the evaluation of treatment progress based on the individual patient's status (e.g., Lambert 2007).

Decision rules can be categorized into two classes (cf. Lambert et al. 2002; Lutz et al. 2006b, 2014b): One approach comprises *rationally derived methods*, which are based on a priori expert judgments about progress in mental health functioning over sessions of psychotherapy. The other approach comprises *empirically derived methods*, which, in contrast, are based on empirically derived expected treatment response (ETR) curves, based on large available data sets of already treated patients.

Rationally Derived Methods

Rationally derived methods make use of psychometric information based on standardized measures for an a priori definition of how much change is necessary to consider a patient improved or recovered. The concept of reliable and clinically significant change is a classic example of rationally derived methods (Jacobson and Truax 1991). This concept comprises two criteria: The first criterion focuses on the actual amount of change achieved by the patient, which must be larger than what would be expected if measurement error were solely responsible for the difference in scores. The measurement error of an instrument depends on its reliability, hence the term reliable change (which comprises both, reliable improvement and also reliable deterioration). The second criterion is fulfilled if a client who was more likely to belong to a patient population before treatment is, at the final assessment, more likely to belong to a non-clinical population (e.g., a community sample). A patient who meets both of these criteria (i.e., improved reliably and crossed the cutoff that separating a clinical from a non-clinical population) is considered clinically significantly improved.

Empirically Derived Methods

Empirically derived methods are based on expected treatment recovery curves generated using data from already treated patients showing similar intake characteristics as the index patient. Additionally, confidence or prediction intervals can be

calculated around the predicted change courses. Using this method, it is possible to provide therapists with an estimate of how much their patient's current progress diverges from the expected response curve. Lutz et al. (1999) developed ETR models on the basis of 890 psychotherapy outpatients and identified a set of seven intake variables that significantly predict individual change (e.g., initial impairment, chronicity, previous treatment, patient's expectation of improvement). In an extended study, Lutz et al. (2006a) explored this empirical decision system, varying the size of the prediction interval around each patient's predicted course from 67 to 99.5%. Using this schema, it was shown that the more often a patient's current scores lie outside a confidence interval and the higher the interval, the higher the predictive validity of the current score for ultimate treatment outcome. For instance, as the number of observed values falling below this failure boundary increases (for example between sessions 2 and 8), the probability of treatment failure increases. Vice versa, increasing numbers of observed values above this failure boundary are also associated with a higher probability of treatment success. Thus, the higher the number of positive deviations and the more extreme they are, the higher the probability of treatment success. Similarly, the more frequent and extreme any negative deviations occur (e.g., early in treatment), the higher the probability of treatment failure (Lutz et al. 2006a). These resulting failure/success probabilities can be provided to therapists as a decision support tool. Using this additional information, practitioners can make more empirically informed decisions about whether and how to evaluate and potentially adapt their treatment strategy to enhance the individual patient's outcome. For example, a deviation from the ETR profile in a specific session might result in a "warning" signal to the therapist (and potentially supervisors) or other clinicians involved in the case (e.g., Finch et al. 2001; Lambert et al. 2002; Lueger et al. 2001; Lutz 2002). Different approaches to ETR models have been developed that provide information to help understand individual patient progress. For example, ETR models have been specified for different diagnostic groups or symptom patterns as well as been applied to the study of therapist effects. Furthermore, information about patients' early change has been included to improve these models (e.g., Lutz et al. 2002a, b). Two further extensions are presented in the following: The first concerns a method for the identification of patient subgroups, which helps to generate even more individualized ETR curves. The second concerns adjusting ETRs to different shapes or patterns of patient change.

Nearest Neighbors Techniques

To refine the generation of ETR curves, Lutz et al. (2005) introduced an extended growth curve methodology that applies nearest neighbors (NN) techniques. This approach is based on prediction research from fields other than psychotherapy. In

one application, NN are used for the prediction of avalanches (e.g., Brabec and Meister 2001). In this area, large databases with daily-recorded data on potentially relevant parameters (e.g., temperature and barometric pressure) are used to make predictions of avalanche risks on a new day. For this purpose, the 50 (or more) most similar days are selected with respect to the relevant parameters and it is calculated on how many of these similar days an avalanche occurred. This methodology was adapted for the prediction of treatment response by Lutz et al. (2005) in a sample of 203 psychotherapy outpatients seen in the United Kingdom. In accordance with avalanche prediction models, the response curves of the most similar already treated patients (as pendent to the most similar days) are used to derive a prediction for a newly incoming patient. Similarity among patients was defined in terms of Euclidean distances between the relevant predictor variables. Using a sample of 4365 outpatients in the United States, Lutz et al. (2006a) further demonstrated the NN technique to be superior to a rationally derived decision rule with respect to the prediction of the probability of treatment success, failure, and treatment duration using the Outcome Questionnaire (OQ-45; e.g., Lambert 2007). Moreover, Lutz et al. (2006b) tested the predictive validity and clinical utility of the NN approach for differential treatment selection. The authors generated individual predictions for different treatment protocols (cognitive-behavioral therapy [CBT] versus an integrative CBT and interpersonal treatment [IPT] protocol) and compared whether one of these treatments was predicted to be more or less beneficial for a specific patient. Although, on average, no significant difference between the two protocols was found, with the NN method, it was possible to obtain clinically meaningful differential predictions for about one-third of the patients. For the other two-thirds, the predicted change curves did not differ between the two protocols. However, being able to improve treatment selection for one-third of all patients could considerably improve the effectiveness of mental health services and reduce expenses resulting from failed treatments.

Recently, a similar method has been introduced, which aims at treatment selection based on empirical data, namely the Personalized Advantage Index (PAI; DeRubeis et al. 2014; Huibers et al. 2015). Using multiple regression methods that weigh the predictive value of different patient intake characteristics, the PAI is a measure of the potential advantage of a Treatment A over a Treatment B. The use of the PAI has been shown in two applications: In the first demonstration, DeRubeis et al. (2014) used the PAI to predict which patients would profit more from CBT than an antidepressive medication (ADM) and vice versa. In the second study, Huibers et al. (2015) demonstrated the PAI's potential for the selection between cognitive therapy (CT) and IPT. With regard to personalized treatment selection, the ideas behind the NN approach and the PAI are the same. Yet, methodological comparison studies are needed to learn more about their differences and commonalities. A recent extension of both prediction methods could be the integration of data collection during patients' everyday life before the beginning of the treatment (e.g., Fisher 2015; Trull et al. 2012).

Detecting Typical Patterns of Patient Change

By studying different types of psychopathology, psychotherapy research helped to accumulate a large amount of knowledge in terms of specific treatments for particular diagnostic groups (e.g., Barlow 2007). However, considerably less is known about typical patterns of patient change. This situation is stunning given that over the past three decades, outcome research has demonstrated that patient variability is the main source of differences in outcomes (e.g., Lambert 2013; Wampold and Imel 2015). Accordingly, careful examinations of how and when patients improve, or fail to do so, may both increase our understanding of psychotherapy and provide us with tools to improve its effectiveness.

In the last couple of years, this topic emerged in the field of psychotherapy research (e.g., Stulz et al. 2007). Different methodologies that have the potential to reveal meaningful change patterns have been discussed (e.g., Stulz et al. 2007; Tang and DeRubeis 1999). One possibility to extract this kind of information from a collection of individual response curves is pattern recognition procedures such as Growth Mixture Modeling (GMM; e.g., Muthén 2006). GMM clusters patients into subgroups with similar change trajectories on the basis of a latent categorical variable. Thus, it is a form of group-based trajectory modeling that extracts groups of change curves, which develop similarly over time. These kinds of clustering methods already stimulated much research in clinical psychology (cf. Nagin and Odgers 2010). With regard to psychotherapy, GMMs have been used to analyze data from naturalistic settings (Lutz et al. 2007; Rubel et al. 2014, 2015; Stulz and Lutz 2007; Stulz et al. 2007) and from randomized controlled trials (Lutz et al. 2009, 2014a). The most consistently found pattern in the early treatment phase was a subgroup of patients who started severely impaired and improved rapidly (e.g., Rubel et al. 2015). This subgroup of patients is referred to as “early responder”. It has been repeatedly shown that this subgroup of patients has very successful treatments in both naturalistic and controlled settings. The association between early response and treatment duration seems to be dependent on the current setting. While, in naturalistic studies, early response is connected to shorter treatments, in RCTs, it is connected to a higher probability that the patient will complete the number of sessions scheduled in the treatment protocol, i.e., longer treatments (Lutz et al. 2015).

Rationally or Empirically Derived Decision Rules

Several studies investigated the advantages and disadvantages of rationally derived and empirical approaches and yielded mixed results. For example, Lambert et al. (2002) compared a rationally derived method to predict treatment failure with a statistical growth curve technique. The results showed that both methods were relatively equal in their predictions with the empirical approach being somewhat

more accurate. Other research also indicates that the empirically derived methods may be slightly superior (e.g., Lutz et al. 2006a; Spielmanns et al. 2006). A recent study compared GMM with clinical significant change criteria to identify early positively responding patients (Rubel et al. 2014). Patients identified in the first three sessions as early responders by means of the GMM method were compared to patients who reliably or clinically significantly improved during the same time period. Generally, GMM categorized many fewer patients as "early positive responders" than the rational methods. Although all of the patients identified via GMM were also identified via the reliable change method and most of the patients were also identified via the clinically significant change method (64%), the group of GMM early positive response patients were shown to be highly specific but insensitive for the prediction of treatment outcome. Consequently, a stepwise approach could use rational clinically significant change criteria as a sensitive screening tool in the first step and, if these criteria are met, the information provided by GMM to increase the specificity of outcome prediction in the second step (Rubel et al. 2015).

Irrespective of the chosen approach (rationally derived or empirical), more research on typical change patterns for subgroups of patients is needed to be able to relate these empirical findings to clinical theories. These theories could be further enhanced by considering related mediators and moderators, which cause different patterns of change and could be used to guide or support clinical decisions (Kazdin 2014). Research on patterns of change is still in its infancy. More studies are necessary to validate and replicate previous findings. However, this research also importantly has the potential to support therapists in their decision-making for each individual patient. For which therapists and patients this information could be especially valuable is discussed in the following section.

Mediators and Moderators of Psychometric Feedback Effects

A large body of research suggests that psychometric feedback and decision rules, such as those described above, are effective for the prevention of treatment failure (e.g., Lambert and Shimokawa 2011). When feedback was additionally complemented with clinical support tools (CST's; Whipple et al. 2003), these effects were even larger. CSTs comprise a special questionnaire for cases that do not develop as positively as expected. Those patients are referred to as "signal clients" as therapists are provided with a red signal so that they are alerted to the increased risk of these patients to have not benefitted at the end of the treatment. This additional questionnaire, the assessment of signal clients (ASC; Lambert et al. 2007), hints at potential problem areas (motivation, alliance, social support, life events, and medication) of this specific patient and accordingly suggests therapists how to tailor their interventions to the needs of these patients.

While most of the early feedback studies were conducted within settings in which relatively short treatments were provided to moderately impaired patients (e.g., college counseling centers; Newnham and Page 2010; Poston and Hansen 2010; Shimokawa et al. 2010), recent studies have investigated feedback effects with more disturbed outpatients (De Jong et al. 2012; Simon et al. 2012), with inpatients (Amble et al. 2015; Byrne et al. 2012; Probst et al. 2013), with patients with eating disorders (Simon et al. 2013), and with patients receiving long-term treatments (>= 35 weeks; De Jong et al. 2014). These more recent investigations generally showed less pronounced feedback effects. Different explanations have been discussed for this reduced effect (Riemer and Bickman 2011; Simon et al. 2012).

Therapist and Patient Differences

A closer look has revealed that feedback is not uniformly effective for every patient and therapist. In a study by Simon et al. (2012), only 50% of the therapists were actually able to use the feedback to substantially improve their clients' outcomes. For the other half of therapists, it made no difference whether or not they received feedback about their patients' progress. Likewise, De Jong et al. (2012) found substantial differences among therapists in the degree to which they profited from a feedback intervention. Female therapists and those with a higher commitment to use the feedback information showed a higher probability of actually using the feedback. The use of feedback, in turn, was associated with being more effective for patients who made less progress than expected (not on-track; NOT). Furthermore, a higher commitment to use the feedback at the beginning of the study was related to more rapidly progressing patients. As a result, therapists seem to have a differential ability of using feedback information for the good of their patients. Underlining another potential factor explaining therapist differences in the context of psychometric feedback, Lutz et al. (2015) found that therapists' as well as patients' attitudes toward and the use of the feedback system were significantly associated with treatment outcome. Especially those therapists who were satisfied with the provided feedback reports and who used the feedback for one specific modification per patient were successful. In another recent study, De Jong and De Goede (2015) investigated factors that influence the attitude formation of therapists toward routine outcome monitoring and feedback. The authors found that a positive attitude toward feedback was associated with a strong prevention focus (i.e., a high motivation to prevent failures) in therapists. This finding suggests that those therapists who are especially eager to receive psychometric progress feedback have a high level of motivation to prevent failures generally. Therefore, efforts with the goal of improving therapists' attitudes toward feedback should especially be designed for those therapists who are motivated by a promotion focus (i.e., high motivation to achieve success).

These therapist differences might in part explain general differences in therapists' ability to successfully provide psychological interventions (e.g., Baldwin and Imel 2013; Lutz and Barkham 2015). Research suggests that about 5–8% of the variability in outcomes is due to therapist differences, depending in part on differences in study design and the impairment of the patient sample (Baldwin and Imel 2013; Saxon and Barkham 2012; Wampold and Brown 2005). It seems that therapist effects are greater for more severely impaired patients and is larger in naturalistic compared to controlled samples (Lutz et al. 2007; Saxon and Barkham 2012). An under-investigated area of research is the question of the impact of therapist effects on treatment length. So far, only one study provides evidence for the existence of substantial differences between therapists with regard to the average length of their treatment (Lutz et al. 2015). In this study, the authors found that about 9% of the differences in treatment length were due to therapists. In an additional analysis, there were also significant therapist differences for patient dropout. However, there was no correlation between the average effectiveness of therapists, the average length of their treatments, and their average dropout rates. That means being an effective therapist with respect to outcome does not mean being effective in terms of dropout or treatment duration. Nevertheless, a comprehensive analysis of therapist effects could help mental health services identify those therapists who might benefit from additional training or supervision. For example, a therapist with a high average effect size but also a high dropout rate might be someone who treats only patients (on purpose or without) for which they are effective and other patients do not stay for some reason with this therapist for very long and drop out.

How Does Feedback Work?

Relatively little evidence is available regarding the question of how feedback works. Investigators in feedback research have devoted considerable energy into predicting treatment non-response (e.g., Lambert et al. 2002; Lutz et al. 2006a; Spielmans et al. 2006) and concluded that the essential value of feedback systems is to help clinicians become aware of pending treatment failure, something that they could not achieve well by means of clinical intuition (e.g., Hannan et al. 2005). In this context, the alarm function is the proposed mechanism by means of which feedback works for NOT cases. That is, feedback hints at negative developments, which therapists might have missed without receiving feedback. However, the findings with regard to therapist differences presented above suggest that it is not this alarm function alone that makes feedback effective. Rather, it seems to be important how therapists use the provided information. In their contextual feedback theory, Sapyta et al. (2005) propose two options if therapists are confronted with negative developments in their patients. In the first option, therapists reduce their commitment to reaching the goal of helping that patient. This is possible by externalizing the reasons for the negative developments to uncontrollable aspects of the patient or context. In this case, the therapist would not change his or her

behavior and feedback would not help to improve treatment for the respective patient. If, however, the therapist sticks to his commitment to reach a positive treatment outcome for the patient and believes that they have at least some control over factors that might be associated with failure, then feedback could lead to a behavior change in the therapist. In that case, there is the chance that feedback may help to improve treatment for an individual patient (Sapyta et al. 2005). However, to date, this theory has not been empirically tested.

Another variable that has been proposed as a potential mediator of feedback effects is treatment length. Early feedback studies found that patients with negative feedback (NOT) stayed in treatment longer, while patients with positive feedback (on track; OT) had fewer sessions in comparison with therapies where no feedback was provided (Lambert et al. 2003). This finding suggests that the effects of feedback on treatment outcome might, in part, be mediated by treatment duration. That is, feedback may be effective for NOT patients by informing therapists that these patients need a higher dose of treatment. In turn, this higher dose may lead to better treatment outcomes. However, in more recent studies, the effect of feedback on number of sessions has not been consistently found (Hawkins et al. 2004; Knaup et al. 2009). To date, no study has explicitly tested treatment length as a mediator of feedback effects.

In summary, research on the moderators and mediators of psychometric feedback effects is in a very preliminary stage and most theories hypothesizing how feedback works need more empirical support (Wampold 2015; Amble et al. 2015). Feedback also needs some further development and testing in a variety of settings and environments (e.g., Pinsof et al. 2015). Moreover, more research is needed that investigates and further elaborates CSTs that help clinicians to directly translate psychometric feedback into clinical actions.

Summary

The present chapter provides an overview of patient-focused research, which is the youngest of the three main research paradigms in psychotherapy outcome research. While efficacy and effectiveness research both have a long tradition, PFR was only introduced about 15 years ago. Compared to the traditional paradigms, which focus on the average effects of a treatment, PFR is concerned with the prediction, monitoring, and decision support of individual patients' treatments. Thus, PFR provides individualized empirical support that is designed to inform therapists in the treatment of each of their patients. Technological developments will likely facilitate the implementation of feedback and new adaptive clinical problem-solving tools in the future. These developments might also have an impact on clinical training and supervision (e.g., Castonguay et al. 2013; Emmelkamp et al. 2014; Lambert 2015; Lutz et al. 2015). The more technology develops, the easier it is to implement these feedback and adaptive clinical tools into daily routine and into clinical training. Given that twenty years ago psychotherapy research was limited to a few patients

treated in a university setting and assessed in a pre–post design, this new line of research allows us to study psychotherapy in practice, based on large databases, and to immediately integrate this information into the field, while further promoting the integration of science and practice. Thus, the implementation of feedback in the training and supervision of future therapists helps them to build a clinical attitude, which includes psychotherapy research as an integral part of treatment and the clinical identity.

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Chapter 14
How to Use Research to Become More Effective Therapists

Bruce E. Wampold

Therapists work in an unusual environment. We see our clients in a private room, and our conversations are confidential. In ordinary practice, no one observes what we do or assesses how effective we are at what we do. We believe we are good at what we do, we attend to various workshops and seminars to keep up on the latest developments, we want the best for the clients we treat, and we believe that we are working diligently in the client's best interest. Yet there are some very troubling issues to consider. One issue is that most therapists believe they are above average, therapists do not recognize when their clients are deteriorating, and on average do not improve with experience (Goldberg et al. 2016; Tracey et al. 2014; Walfish et al. 2012).

To address these issues, the field of psychotherapy has begun to embrace the notion of measuring the progress of clients over the course of therapy, which has been called routine outcome monitoring (ROM). It appears that providing the information obtained from ROM to therapists and clients improves outcomes, primarily by preventing deteriorating cases (Lambert and Shimokawa 2011; Shimokawa et al. 2010). Nevertheless, it also appears that providing such feedback in routine practice, without any other assistance, does lead to therapist improvement. Goldberg et al. (2016) found in a sample of 170 therapists (6591 patients) at an agency that routinely used ROM, over a period of 17 years (average time at the agency for the therapists was approximately five years), therapists did not improve—in fact, over time (and number of cases treated), the outcomes of these therapists decreased, although to a small degree. However, some of these therapists improved, and there are agencies that seem to encourage their therapists to improve and actually do so (Goldberg et al. 2016). A related problem is that there is variability in the outcome of therapists within therapeutic orientations (Baldwin and Imel 2013)—that is, some therapists delivering Treatment A consistently achieve

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better outcomes than other therapists delivering the very same treatment. This seems to be true in clinical trials as well as in practice and is unrelated to the degree to which the therapist adheres to the treatment protocol (Wampold and Imel 2015).

If therapists are to improve, what is needed is a model that explains how psychotherapy works—that is, what are the key components of effective practice that have been identified by research evidence? In this chapter, I present a model for psychotherapy that is based on evidence related to (a) what is known about how psychotherapy works and (b) what is known about effective therapists. This model, called the contextual model, is a meta-model because it is not an alternative to specific treatment models, such as cognitive–behavioral therapy or emotion-focused therapy, but rather is a model that explains how all psychotherapies produce their benefits. This model was developed based on social science theory and the research evidence from randomized clinical trials of psychotherapy as well psychotherapy process research (Wampold and Imel 2015). This model indicates a set of specific skills that need to be practiced in order to improve outcomes.

The Contextual Model

The contextual model (Wampold and Budge 2012, Wampold and Imel 2015) is a meta-model of how psychotherapy works. Psychotherapy is a complex process that unfolds over time, and thus, it is difficult to stipulate what makes psychotherapy work, yet there is theory and compelling evidence that psychotherapy exerts its effects through multiple pathways. The contextual model is not a model of how a particular therapy works, but rather is a model of how *all* psychotherapies work. Thus, this model serves the purpose of this volume sufficiently well in that it identifies the skills that therapists need to master to increase their effectiveness. The model certainly is not the only one that could be adopted (see, e.g., Frank and Frank 1991; Orlinsky and Howard 1986).

The contextual model is presented in Fig. 14.1. The model contains three pathways through which flows the power of psychotherapy. Some treatments emphasize one pathway over another, but to be optimally effective, any psychotherapy must utilize all three pathways. In this chapter, various indicators of the

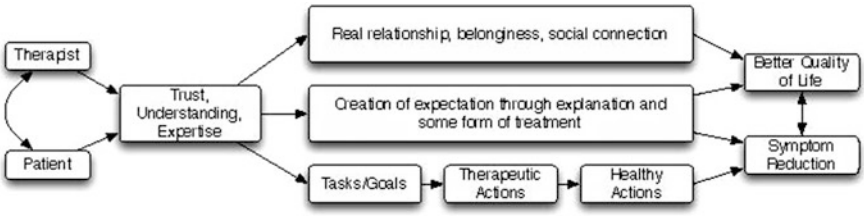

Fig. 14.1 The contextual model

quality of a therapy in each pathway are discussed. In the following section, therapist skills that are needed to enact each pathway effectively are discussed. However, before discussing the three pathways, the therapist must develop an initial therapeutic bond.

Initial Therapeutic Bond

The patients come to therapy with distress—they are having difficulties in life and are discouraged about finding solutions to their problems. They feel demoralized, in Jerome Frank's term (Frank and Frank 1991). The patient also comes to therapy with a personality, a racial/ethnic background and identify, a social network (or lack of), economic (or lack of) resources, occupation/vocation/work history and situation, a history, and current life events (e.g., recent death). The therapist also comes to the initial meeting with a personality, a racial/ethnic background and identity, a history, and current life events. It is a meeting of strangers, imbedded in a professional context.

The patient is seeking immediate answers to some questions: Can this therapist understand me and my problems? Can I trust the therapist? Does the therapist have the capacity and expertise to help me? Bordin (1979), who developed the concept of the therapeutic alliance as a pantheoretical concept, noted that the initial bond was necessary before beginning therapeutic work: "Some basic level of trust surely marks all varieties of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed" (p. 254).

The formation of the initial bond is a combination of top-down and bottom-up processing. The top-down processing involves the belief that therapy will be effective and is based on what the patient knows about therapy, past experience, stories from friends or family members, and so forth. Indeed, patients seem to experience significant benefit from the time they make the initial appointment to the time they present for the initial meeting with the therapist (Frank and Frank 1991), as they are remoralized because they believe their involvement in the impending psychotherapy will be helpful. Expectations about the particular therapist may be present as well due to the fact, for example, that this therapist had been recommended by a friend who had benefitted from therapy. Bottom-up processing involves the human propensity to make rapid appraisals of the trustworthiness of strangers (Willis and Todorov 2006). Of course, the patient is also making judgments about psychotherapy from the context—for example, the warmth and efficiency of the clinic staff, the attractiveness and comfort of the waiting room, the therapy room itself, including diplomas and pictures hung on the wall, and so forth. It is clear that the initial interaction and patient engagement early in therapy is critical to the success of therapy, if for no other reason than most patients who drop out of therapy prematurely, do so after the first session, the second most after the second session, and so forth (Connell et al. 2006; Simon and Ludman 2010).

The Real Relationship

The patient and the therapist have distinct roles in therapy—the patient has a problem, complaint, or disorder that he or she wants resolved and the therapist is a professional, providing something of value to the patient, based on his or her training and experience. However, despite these roles, psychotherapy involves a deep and intimate interpersonal relationship between two human beings. This relationship can be described psychodynamically as the transference-free genuine relationship based on realistic perceptions (Gelso 2009), where genuineness was defined by Gelso and Carter (1994) as "the ability and willingness to be what one truly is in the relationship—to be authentic, open and honest" (p. 297) and *realistic perceptions* as "those perceptions that are uncontained by transference distortions and other defenses … [the therapist and patient] see each other in an accurate, realistic way" (p. 297). In therapy, the real relationship involves a therapist who is warm, caring, and empathic with a contract that this relationship will continue regardless of the material discussed.[1]

The real relationship would appear to be fundamental to humanistic approaches, important for dynamic therapies, but generally not emphasized, if not ignored, by behavioral and cognitive therapies. However, there is a compelling case to be made that the real relationship is critical to the benefits of psychotherapy of all types. Humans evolved as social animals and attachment is fundamental to the survival of humans, as discussed by many prominent theorists (Baumeister 2005; Bowlby 1980; Cacioppo and Cacioppo 2012; Lieberman 2013; Wilson 2012). Indeed, there is compelling evidence that perceived loneliness places an individual at as great or greater risk for mortality than smoking, obesity, environmental pollutants, and lack of exercise (for general population or those at risk of cardiac events) (Holt-Lunstad et al. 2010, 2015; Luo et al. 2012). Holding the hand of a beloved one, or even having a beloved person in the room, increases tolerance of pain, with the expected concomitant neural processes (Benedetti 2011), suggesting that individuals in higher quality relations benefit from greater regulatory effects on the neural system involved in negative emotions, e.g., the affective components of pain (Benedetti 2011, p. 149).

The healing power of an empathic relationship should not be underestimated. The evidence is strong that an empathic, caring, and understanding relationship will be beneficial and will augment the effectiveness of treatments, medical as well as psychic health. The impact of empathy on healing in medicine has been discussed extensively (e.g., Decety and Fotopoulou 2015). Research on the real relationship indicates that it is predictive of psychotherapy outcome (Gelso 2014).

Some patients will benefit more from the real relationship than others. Those patients who present with attachment difficulties, insecure attachments styles, poor social support, impoverished social networks, chaotic interpersonal relations, and

[1]There are limitations to the continuity of therapy, as would be the case of danger to self or others, for example.

features of borderline personality disorder but find a relatively stable real relationship with their therapist will benefit more from the real relationship than patients with relatively supportive interpersonal relationships. For patients with poor attachment characteristics, it takes time to establish a secure relationship with the therapist, the value of the real relationship accrues slowly, and the benefits of this aspect of therapy might well be demonstrated rather gradually (Budge and Wampold 2015).

Creation of Expectation Through Explanation and Treatment

Patients come to therapy with a maladaptive conception of their distress. These maladaptive explanations, sometimes called "folk" psychology (Boyer and Barrett 2005; Thomas 2001), are culturally influenced and are often acquired from family, friends, and influential others, as well as from the larger society (e.g., in advertisements for psychotropic medications). These explanations are not labeled as "maladaptive" because they are unscientific, although surely many are, but because they fail to lead the patient to find solutions to what is distressing (Budge and Wampold 2015; Wampold et al. 2006). An important aspect of healing practices, including Western medicine, is that the patient is provided an explanation for their distress. Indeed, patients presenting to a physician would be quite disoriented if no explanation were provide—is the pain in my gut due to indigestion, an ulcer, or cancer? The explanation provides the patient hope that there exist some treatment actions that will lead to improvement—in that way, the therapist is substituting an adaptive explanation for a maladaptive explanation. Notice that we are not saying that the adaptive explanation is more scientific than the maladaptive explanation—what makes the explanation adaptive is that it allows for ameliorative actions (see next section). Cognitive–behavioral therapists, interpersonal therapists, emotionally focused therapists, EMDR therapists, and dynamic therapists will offer their patients very different explanations of their distress and plans for getting better. What is critical is that the patient accepts the explanation and believes that it will lead, through the therapy process, to a reduction in distress. That is, the patient believes that participating in and successfully completing the therapeutic tasks will be helpful in coping with his or her problems, which then further creates the expectation that the patient has "control" over his or her problems. These expectations and beliefs are central to theories of how individuals change and behave, including theories involving mastery (Frank and Frank 1991; Liberman 1978), self-efficacy (Bandura 1999), and response expectancies (Kirsch 1985, 1999).

It is well known, scientifically as well as in our own experience, that expectations have a large impact on what is experienced. Compelling evidence for the power of expectations is found most convincingly in the placebo literature. Although there are several theories of how placebos produce effects, expectations

are central to understanding why placebos are so powerful (see Benedetti 2014; Kirsch 1985; Price et al. 2008). It is well beyond the scope of this chapter to review the placebo research, but a few examples are sufficient to make the point. Placebos have been studied extensively for pain, including chronic pain, medically induced acute pain (e.g., postsurgical pain, and dental procedures), and experimentally induced pain (e.g., the cold pressor test) (see Benedetti 2009, 2014, Price et al. 2008 for a comprehensive review). It is well established that taking a placebo analgesic with the expectation that the substance or procedure will reduce pain reduces the experience of pain. Furthermore, it is also well established that taking the placebo results in the release of endogenous opioids into the brain, indicating that the placebo effect is not simply a subjective response but is mediated by a physiological process. Moreover, in an "open-hidden" paradigm, giving a postsurgical patient a given dose of morphine administered surreptitiously to the patient (the hidden condition, e.g., by an intravenous infusion from a machine out of the awareness of the patient) is less effective (viz., the patient reported more pain and requested more additional doses of analgesics) than when the patient is aware that the drug was being administered (open condition, e.g., a clinician indicated to the patient that the drug was being delivered). Moreover, giving dental patients a placebo in an open condition was equivalent to giving a patient 6–8 mg of morphine in a hidden condition for molar extraction. What is clear from these studies (and hundreds of other studies) is that the patient's expectation for pain relief results in pain relief and that their expectations are created by what is said to the patient—that is, in a verbal interaction with the therapist.

Demonstrable placebo effects are not limited to pain. Parkinson patients benefit from placebos both in terms of symptoms (viz., motoric activity) but also levels of dopamine in the brain (see Benedetti 2014). Cardiac and diabetes patients have lower mortality rates if they adhere to protocols of beneficial drugs (i.e., take the medication as instructed), but patients who are more adherent to the placebos in these trials also have lower mortality than those who are not adherent (Simpson et al. 2006). Adherence to a protocol is a sign that the patient believes the treatment will be effective and in this instance adhering to the placebo protocol (i.e., ingesting nothing medically active) can reduce death. In another interesting study, female hotel room attendants were told that their everyday work was good exercise. Compared to hotel workers who were not provided any information, the informed workers reported that they got more exercise and they had better health indicators (lower weight, lower blood pressure, and less body fat), *even though they did not do more exercise* (Crum and Langer 2007). Over 90% of the effect of antidepressants is due to the placebo effect (Kirsch 2010). Psychotherapy patients who attribute their therapeutic gains to their own efforts rather than a medication they had taken, which was actually a placebo, were significantly less likely to relapse (Liberman 1978; Powers et al. 2008).

Simply creating expectations through providing the patient an explanation for the patient's distress and describing the treatment is not sufficient. The patient must

actually enact the therapeutic rituals—explaining that a pill will decrease pain must be accompanied by taking the pill. The explanation and ritual work together and the patient must believe that therapeutic progress is a result of the patient's own efforts, providing a sense of control over one's distress. There is evidence that humans evolved to heal in a social context (Benedetti 2011; Wampold and Imel 2015) and the importance of expectations in psychotherapy have been well established (Constantino et al. 2011).

Critical to the acceptance of the explanation and to the creation of expectations is agreement about the tasks and goals of therapy, central aspects of the therapeutic alliance. The alliance is defined as a pantheoretical construct that reflects collaborative and purposeful work and is composed of three components, including the bond as well as agreement about goals and tasks (Bordin 1979; Hatcher and Barends 2006; Horvath 2006; Horvath and Luborsky 1993). The alliance is the most researched construct in psychotherapy process research, and nearly 200 studies have investigated the correlation of alliance with outcome and found meta-analytically that there is a strong association of the alliance, measured early in psychotherapy, and the final outcome, across all forms of psychotherapy (Flückiger et al. 2012; Horvath et al. 2011).

Enacting Health Promoting Actions

The power of therapeutic rituals is not limited to the expectations that are created. The third pathway indicates an indirect effect of the relationship on outcome. A collaborative working relationship involving agreement about the goals of therapy and tasks needed to achieve those goals will lead to the likelihood that the patient will engage in therapeutic tasks. Apart from the relationship, the actual tasks may well have therapeutic benefit.

An important point to keep in mind is that different treatments will utilize very different therapeutic actions. Cognitive–behavioral therapists ask patients to think more adaptively and to change maladaptive cognitive schemas, behavioral therapists have patients approach previously avoided situations or people, interpersonal therapists have patients work to improve the quality of relationships, and dynamic therapists encourage the expression of avoided emotions. For many disorders, a variety of treatments, utilizing very different treatment actions, have been found to be effective (Wampold and Imel 2015).

The effects of lifestyle changes have large but underestimated effect on mental health (Walsh 2011). Improved mood and well-being suggest to the patient that the treatment is working and augments the belief that the therapeutic components are efficacious. Again, the patient believes that his or her own hard work (i.e., engaging in the activities inherent in the treatment) is responsible for the benefits of therapy. What all effective treatments have in common is that the patient is persuaded to do something that promotes health and well-being.

The Three Pathways in Summary

The contextual model involves three pathways, which were presented sequentially, but they play out in therapy as interacting influences. For example, the presence of a real relationship will facilitate a collaborative working relationship (i.e., the alliance), creating positive expectations and increasingly the likelihood that the patient will enact healthy actions. For example, it has been found that empathy, central to the real relationship, augments the effects of expectations created by placebos and is vital to the efficacy of medical practices (Decety and Fotopoulou 2015; Kaptchuk et al. 2008).

Now that the pathways through which psychotherapy exerts its influence to benefit patients, I turn to how therapists use these pathways to be effective.

Actions of Effective Therapists

In 2004, Beutler and colleagues noted that there has been little research on characteristics or actions of effective therapists in the two decades preceding publication of this chapter, and moreover, surprisingly, little was known about who are effective therapists and what they do differently from less effective therapists. Fortunately, in the last decade, much has been learned about what effective therapists do and how therapists can improve their effectiveness, as discussed briefly in the remainder of this chapter.

Alliance

As discussed previously, the working alliance is a central construct in the contextual model. The alliance is a vehicle used to create expectations and is necessary for the patient to enact the rituals of psychotherapy, which lead to the enactment of health promoting actions. Moreover, the bond in the alliance is quite similar to the real relationship. That is to say, the alliance seems to be central to therapeutic change, an observation strongly supported by the research evidence.

As strong as the research is relative to alliance, it is not clear that it is what the therapist does in therapy that makes the alliance therapeutic. Some patients come to therapy with strong social support, secure attachment style, interpersonal skills, and motivation to change. Such a patient will form a relatively strong alliance with most therapists and has relatively good outcomes, and thus, it might well be that it is the patient's contribution to the alliance that is important. However, just the opposite has been found. Baldwin et al. (2007) disentangled the therapist and patient's contribution to the alliance and found that *only* the therapist's contribution to the alliance predicted outcome, a result confirmed meta-analytically (Del Re et al. 2012).

It is what the therapist offers the patient in terms of forming the alliance that produces better outcomes. The conclusion from this research is unequivocal: *Effective therapists form strong alliances across a range of patients.*

Facilitative Interpersonal Skills

Anderson and colleagues (2009, 2016) have used an interesting method to identify the characteristics and actions of effective therapists. Instead of using material from therapy sessions or asking therapists to provide information, they presented a video of a challenging patient (i.e., a stimulus that was constant across therapists) to 25 therapists at a college counseling center, and the therapists recorded their responses to the patient at various instances. The responses were then coded for what the authors called *facilitative interpersonal skills* (FIS), which included verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus.

FIS components are endemic to the contextual model. *Empathy* is critical to the real relationship but as well, as discussed earlier, augments the effect of expectations and increases the likelihood that patients will form a collaborative working relationship and engage in therapy. Many believe that most therapists are empathic most of the time, but there is variation between and within therapists in empathic responding, particularly in response to interpersonally aggressive and difficult patients.

Verbal fluency is critical for providing a believable, succinct, and adaptive explanation and a cogent rationale for the therapeutic actions. Psychotherapy is above all else "talk therapy." That is, the delivery of psychotherapy is via verbal means, and thus, an effective therapist must be able to communicate clearly and succinctly. Of course, some therapies emphasize particular components that are expressed verbally, such as interpretations in dynamic therapy or psychoeducation in CBT.

Emotion is central to the success of therapy. Again, some therapies are explicitly focused on emotion (e.g., emotion-focused therapy or affect phobia therapy), but emotion is central to all therapies, including cognitive and behavioral therapies (see, e.g., Thoma and McKay 2015). The effective therapist is able to *modulate and express emotion*. Often, therapists need to activate avoided emotions such as sadness or anger and will have to be able to appropriately model and express these emotions for the patient. In other instances, the therapist will assist to reduce or inhibit emotions, such as fear, guilt, and shame. For example, a behavior therapist conducting a panic induction with an extremely fearful patient will have to express calmness, even if the therapist is anxious, as might likely be the case. And of course, therapist will need to mask some of their affective reactions to patients, such as the disgust one might feel toward a patient who does not bathe regularly or anger toward a patient who is insulting of the therapist's skill level.

As discussed earlier, a key component of the contextual model is that the patient accepts the explanation provided by the therapist and believes that the treatment will be beneficial. Not surprisingly, Anderson et al. (2009) found that effective therapists are *persuasive*. Therapists who "mandate" an explanation, because the therapist believes a particular approach is superior, will often meet some resistance, whereas therapists who work collaboratively and adapt therapy to the patient will have more engagement (Wampold and Imel 2015). Moreover, effective therapists make it clear that the patient's progress toward achieving therapeutic goals is paramount—that is, the *focus of the therapeutic encounter is on the patient's problems and their solution*. And of course, effective therapists communicate *hopefulness and optimism* that the patient can reach therapeutic goals, even if the particular patient has made many unsuccessful attempts, within and outside of therapy, to solve their problems, say for a patient who abuses substances and has failed repeatedly to maintain sobriety for significant periods of time.

Delivery of a Cogent Treatment

It is becoming increasingly clear that treatments without structure or a focus on the problems that motivated the patient to seek help are less effective, particularly with focal symptoms, than are treatments than have a problem/solution focus (Wampold and Imel 2015). Unstructured treatments emphasize the real relationship as the change agent but ignore expectations created by an explanation and a plan of action and eliciting health promoting behavior change, the last two pathways of the contextual model. Effective therapists collaboratively develop a cogent treatment so that the patient understands what needs to be enacted in order to achieve his or her goals in therapy. There are many cogent therapies available, and they seem to be about equally effective (Wampold and Imel 2015), so an effective therapist chooses an approach that will be accepted by the patient.

Professional Self-doubt and Deliberate Practice

In a series of studies, Nissen-Lie and colleagues (2010, 2013, 2015) found that therapists' self-reported professional self-doubt (PSD) predicted outcome—that is, therapists who had more doubt about their skill in helping patients (e.g., "lacking confidence that you might have a beneficial effect on a patient" and "unsure about how best to deal effectively with a patient") had better outcomes, particularly if they also had a positive sense of self.

Perhaps therapists who doubted their effectiveness also were motivated to improve. Chow et al. (2015) found the amount of time therapists reported spending time on improving targeted therapeutic skills outside of therapy predicted their outcomes with patients. This practice meets the definition of deliberate practice (Ericsson and Lehmann 1996) and is the focus of this volume.

Characteristics and Actions of Therapists that Are *not* Related to Outcome

It is informative to understand what characteristics and action of therapists are not related to outcome, as spending time and effort in those domains would not lead to improved outcomes. Generally, it has been found that the age of the therapist, the gender of the therapist, and the profession of the therapist (e.g., psychology, psychiatry, social work, professional counselor) do not predict outcome (Wampold and Imel 2015)—of course, these are not variables that can be modified through practice and are of little relevance to the topics discussed in this volume.

Anderson and colleagues (2009), as discussed, used a test where therapists recorded their responses by watching a video of a challenging patient to assess FIS. Schöttke et al. (in press) coded a discussion among trainees following a provoking video and found results similar to those of Anderson et al. In sum, it appears that therapists display important skills in challenging situations. Interestingly, in these studies, self-reported social skills (Anderson et al. 2009) and responses in a structured interview designed to assess clinical skills (Schöttke et al. in press) did *not* predict outcomes. When making decisions about what skills to practice, these studies suggest that therapist self-report of skills is not useful in identifying particular skills that need attention but rather *therapists must be observed in challenging interpersonal situations*.

Consistent with the more general literature on theoretical orientation (Wampold and Imel 2015), the studies examining characteristics and actions of effective therapists have found that theoretical orientation did not predict a therapist's outcomes (Anderson et al. 2009; Chow et al. 2015; Schöttke et al. in press). It is important to note that therapist adherence to treatment protocols also does not predict outcome (Boswell et al. 2013; Webb et al. 2010). That is to say, those therapists who more closely follow a treatment protocol do not achieve better outcomes, and indeed, flexibility in terms of adherence appears to be more important (Owen and Hilsenroth 2014). How a treatment is delivered is more important than the particular treatment that is offered to the patient.

It also appears that the competence of delivering a particular treatment, as rated by experts in clinical trials, does not predict the outcomes of therapy (Boswell et al. 2013; Webb et al. 2010). This is a curious finding because one would think that experts' rating of competence must be related to how well the therapists perform and the outcomes achieved. The key to understanding this finding is to emphasize

that such competence measures are sensitive to *competence in a particular therapy* and not competence in many factors discussed in this chapter, including alliance building, empathy, hopefulness, and persuasiveness. Indeed, training therapists to be more competent in a particular therapy does not seem to improve their outcomes (Branson et al. 2015).

Conclusions

In this chapter, I have presented a meta-model for how psychotherapy works and what effective therapists do. As mentioned at the outset, while feedback to therapists about patient progress improves outcomes, it does not appear to assist therapists to develop greater expertise. However, ROM is critical to therapist development under the right conditions. ROM is absolutely critical to development as it is the metric that reveals whether or not a therapist is improving. Paul Clement, a therapist in private practice, asked the important question, "Are you any good?" (Clement 1994, p. 173). To answer this question, Clement assessed the outcomes of his patients since he began practice, a time that spanned over 26 years (Clement 1994, 1996). Without ROM, we will never know whether we are becoming better therapists, we are remaining stagnant, or whether we are actually deteriorating!

It appears that it takes practice to become a better therapist. But simply doing more therapy, even with feedback, does not appear sufficient. Rather therapists must practice skills in contexts other than the actual delivery of treatment, as might be possible in supervision, group consultation, and other professional activities. And the focus must be on practicing the skills that are important for effective therapists, as discussed in this chapter.

It appears that therapists in agencies whose climate fosters improvement by examining therapist skill and practicing to improve actually do improve (Goldberg et al. 2016; see also Chap. 15). ROM that involves global outcome measures can be used to assess whether or not a therapist is benefiting a particular patient or patients in general. However, additional information is needed to know what an underperforming therapist—and indeed any therapist—needs to do to improve. Various measures of important therapeutic factors, such as the alliance, empathy, verbal fluency, may be helpful, but as discussed, the skills necessary to an effective are make known in challenging therapeutic situations. In agencies that improve, such as the one studied by Goldberg et al. (2016), there is a climate in which therapists can seek assistance of colleagues when they are struggling with a patient, a willingness to display one's own work in such challenging situations, and an opportunity to practice the skills necessary to improve with feedback about those skills from experts and colleagues.

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Chapter 15
How Can Outcome Data Inform Change? Experiences from the Child Mental Health Context in Great Britain, Including Barriers and Facilitators to the Collection and Use of Data

Jenna Jacob, Elisa Napoleone, Victoria Zamperoni, Lily Levy, Matt Barnard and Miranda Wolpert

Introduction

The Child Outcomes Research Consortium (CORC) is a learning collaboration of mental health providers, schools, funders, service user groups, and researchers who function as a practice research network. CORC was formed in 2002 by a small group of practitioners and service managers interested in improving child mental health services through monitoring outcomes. Over a decade later, approximately 65 member services across the UK, Scandinavia, and beyond are committed to using outcome measurement to ensure that young people and their families receive the best help possible. Its members are committed to collecting and using routinely collected outcome data to enhance service provision and improve understanding of how best to help children and young people with mental health and well-being difficulties, and their families. CORC aggregates and reports on outcome data, advises, and trains professionals in how to collect and use data, offers commissioning support, consultants with interested parties, and advises governments.

Members of CORC and others further afield (Bickman et al. 2011; Hubble et al. 1999; Lambert et al. 2005; Mellor-Clark et al. 2016) have been working on models to track outcome information with a view to improving mental health and well-being provision for some time. However, this has received more recent and

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widespread attention in the UK, not least due to a government review into the state of child and adolescent mental health, which found a lack of sufficient funding, linked to inadequate provision (House of Commons Health Committee 2014). The result of this was a commitment from the UK government's Children and Young People's Mental Health and Wellbeing Taskforce to improve how children's services are commissioned, organized, and delivered (Children and Young people's Mental Health and Well-being Taskforce 2015; Department of Health, Department for Education, & NHS England 2015).

CORC aims to support its members to enable them to collect and make the best use of outcomes data in order to improve services at three levels:

1. decision making in relation to individual children and families (clinical);
2. decision making for service development (service evaluation); and
3. research.

This chapter focuses on the first two aims in terms of service change where there might be particular implications for the international context.

Table 15.1 provides a summary of the support CORC provides to its members alongside key aims.

Table 15.1 CORC support for clinical practice, service evaluation, and research

Aspect	Primary aim	How CORC supports each aim
Clinical practice	Aid clinical decision making	• Makes measures freely available
		• Trains clinicians in use and interpretation of measures, UPROMISE[a], and bespoke trainings
		• Advises on how to choose data collection systems
		• Provides access to free data collection systems
Service evaluation	Support performance management	• Provides team and service-level reports that compare service with others using appropriate metric
		• Provides advice on how to consider such data collaboratively using the MINDFUL[b] approach
		• Present reports at service meetings
Research	Contribute to the evidence base	• Analyses collated data to support member enquiries
		• Used data to answer key questions
		• Shares findings with members and publicly as relevant
		• Submits to articles to peer-review journals and publishes findings

Adapted from Fleming et al. (2016, p. 2)

[a]Using patient-reported outcome measures to improve service effectiveness (Edbrooke-Childs et al. 2016)

[b]Multiple voices; interpreting differences; negative outcomes; directed discussion; funnel plots; uncertainty; learning collaboration

Use of Outcome Data in Direct Clinical Work (Decision Making in Relation to Individual Children and Families)

"Without direct feedback on how their clients are progressing, clinicians are essentially wearing a blindfold while shooting at a target." (Sapyta et al. 2005, pp. 152–153).

Routine outcome monitoring (ROM) is a systematic way of collecting information from service users to help healthcare providers gain additional information about therapy progress (Carlier et al. 2012; Worthen and Lambert 2007). Evidence suggests that solely using clinical judgement to assess whether a child is not progressing as expected is less reliable than using psychometrically validated outcome measures (Hannan et al. 2005). For the most part, these outcome measures take the form of questionnaires that can have either a service evaluation or clinical focus.

The benefits of tracking outcomes have been widely demonstrated, particularly in terms of their ability to improve outcomes themselves in a shorter space of time and improve retention (Bickman et al. 2011; de Jong et al. 2012; Hannan et al. 2005; Hawley and Weisz 2005; Lambert 2010; Lambert and Shimokawa 2011; Miller et al. 2006; Shimokawa et al. 2010). However, actually measuring the impact of services is a challenge in itself, not least because mental health is a multi-faceted construct that is reliant upon subjective views with proxy indicators, rather than externally verifiable outcomes such as deaths in surgery (Lowe 2013; Wolpert et al. 2014).

Child mental health has additional complexities in that there are a range of people involved (i.e., the child, parents, carers, teachers, and practitioners), which brings into play a range of perspectives and among whom there are often high levels of disagreement about what the difficulties are and the work to be done (highlighting the need to capture relevant perspectives and discuss any differences of opinion; Yeh and Weisz 2001). There is also the potential challenge of using self-reports from children (e.g., due to a lack of age-appropriate measures for young children). Accordingly, there is a broad spectrum of outcome measures and feedback tools (questionnaires) used in this area and there is not universal agreement about which are most appropriate and accurate to use when.

There is a wide range of types of outcome measures (i.e., change over a specified time period) and feedback tools (e.g., how things are progressing in sessions) available. These range from standardized measures aimed at capturing change in practitioner-defined presenting difficulties, general well-being, and the impact of difficulties on life, which may also include measures for use with specific service user groups (e.g., specific to children with learning disabilities or family therapy), to more idiographic tools (e.g., goal setting) which are unique to the individual (CORC 2015). The diverse way in which these measures have been developed has resulted in a set of measures that reflects particular needs and uses, rather being able to address a broad set of requirements (Deighton et al. 2014; Meltzer et al. 2000).

Standardized measures are particularly useful when exploring outcomes on an aggregated level, to explore service or team information, or to create norms (Meltzer et al. 2000; Wolpert et al. 2015). However, evidence suggests that standardized measures may be less meaningful in informing clinical practice, with the argument being that they cannot appropriately measure the impact of an intervention on a person's life as they do not encapsulate the complexity of the individual's life (Grenville and Lyne 1995; Lowe 2013; Moran et al. 2012; Norman et al. 2013; Ruble et al. 2012).

Idiographic tools on the other hand have been criticized as being vulnerable to subjective interpretation and potential manipulation ("gaming"), particularly if targets are introduced (Bevan and Hood 2006; Law and Jacob 2015; Wolpert et al. 2015). Nevertheless, research has indicated that idiographic tools are more effective in demonstrating appropriate change for individuals than standardized measures (Edbrooke-Childs et al. 2015) and may capture areas not covered by other measures (Jacob et al. 2015).

To counterbalance the tension between measuring outcomes in a standardized way and ensuring the outcomes measured are central to the individual, a new approach to selecting measures has been suggested based on findings from the CORC dataset. Within this approach, standardized measures are chosen in collaboration with the young person/family based on the goals they set at the outset of the intervention. This ensures that both standardized and idiographic outcomes are reflected in the use of measures and represents a move away from a more medical model of selecting outcome based purely on diagnosis (Edbrooke-Childs et al. 2015).

Through this research, some key goal areas that may not be captured by existing standardized measures were also identified, including innate and existential attributes such as resilience, confidence, and understanding. CORC supports its members to make suggestions wherever they find gaps in outcome measurement, through the process of think tanks, whereby practitioners and others discuss the best ways to collect outcomes with certain population groups; one example of this was a family therapy think tank, whereby a measure of family functioning was subsequently included in the dataset specification (SCORE-15; Stratton et al. 2010).

While the potential benefits of collecting and using outcome data are widely acknowledged, it is still not always done in practice (Wolpert et al. 2013). Several years of learning among CORC members, alongside published research, have highlighted a range of barriers that can arise when implementing outcome measurement in the UK, which may be at the practitioner level, or be ingrained in the type of service and its ability to affect change (Boswell et al. 2013; Handy 1993). These barriers have been identified as related to three broad areas: the content and format of measures; the process of using measures; and the use of data derived from them (Wolpert et al. 2016). We are sure these barriers are applicable to the international community and a lot of overlap has also been seen in the adult mental health and well-being community (Mellor-Clark et al. 2016).

Which Measures to Choose?

Practitioners, children and young people, and their caregivers have all expressed concern about the ability of a single measure to accurately reflect changes in their day-to-day lives (Stasiak et al. 2013). Practitioners can feel that measures do not accurately capture their work or case complexity, or can be misinterpreted (Wolpert et al. 2013), and children, young people, and their families can feel measures do not accurately capture their experience (Law and Wolpert 2014). "Outcomes tools can be really useful, not only for the therapists but for the young people. They allow you to evaluate where things are going well and where they could be improved. Feedback is important for us to learn and grow. However, I do think you must use outcomes tools with the correct intention and in the right way." (Young person; Law and Wolpert 2014, p. 28).

No one measure is perfectly able to capture all the complexities of an individual case, and as such, suggests using multiple measures that relate to a range of key areas, with a focus on what is most important to the individual receiving therapy (Jacob et al. 2015. See also Fig. 15.1). By informing practitioners about the strengths and weaknesses of different measures, practitioners can be empowered to help the children and families they see to select those that complement their work together and are most appropriate to the individual's needs. CORC supports this through training programs like U-PROMISE (Using Patient Reported Outcome Measures to Improve Service Effectiveness), which involves on-site and e-learning training modules delivered by clinical, quality improvement, and service user experts (see EBPU 2015) and through direct support from the CORC team

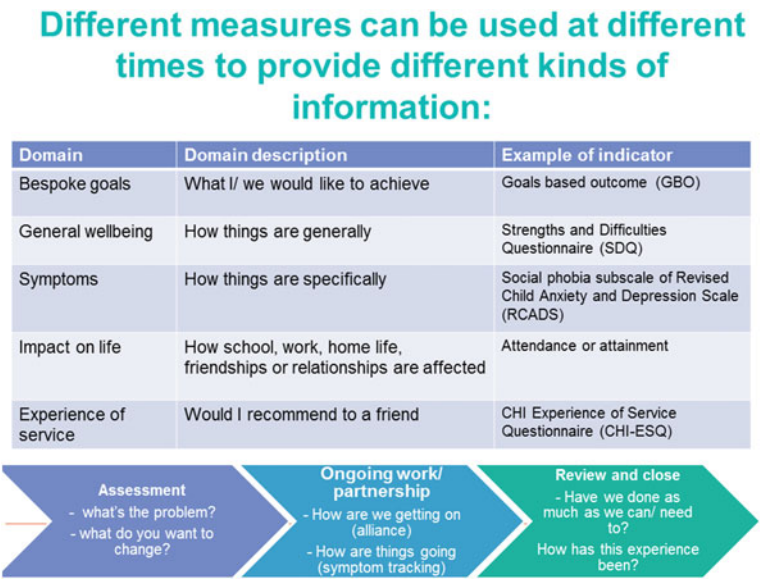

Fig. 15.1 Taken from Wolpert (2015)

(Fleming et al. 2016). Practitioners' positive attitudes to and self-efficacy when using patient-reported outcome measures (PROMs) and feedback have been shown to be more positive after attending this training (Edbrooke-Childs et al. 2016). The triangulation of information from standardized measures with other sources of information, for example, goal setting, may be particularly useful when the child or young person's symptoms are not expected to vastly improve within the timeframe of therapy (Batty et al. 2013).

How to Use Measures Clinically and Meaningfully

Some practitioners have misgivings about how measures fit into their work, either not feeling they are helpful or in some cases believing that they are harmful to the therapeutic process (Abrines-Jaume et al. 2016). The risk associated with these attitudes is that using outcome measures becomes a "tick-box" exercise, one that is viewed as an additional administrative task as opposed to a helpful resource, particularly when the collection of this information is tied to service-level targets. Feedback from children and young people suggests that for a measure to be acceptable to them and for them to respond accurately, how it is presented is more important than the process of completing the measure itself. Concerns were expressed about being asked to complete measures without knowing why, and about who would see the information (Stasiak et al. 2013). Some young people have said they find measures easier to complete than speaking directly to a practitioner about sensitive issues, but are reluctant to provide accurate answers without good rapport and knowledge about what will happen to the information (Stasiak et al. 2013). "Clinicians must ensure that the feedback they give is understandable to the young person…if it feels like random form filling just for the service, tagged on at the end of each session, then this has no meaning for young people." (Young person; Law and Wolpert 2014, p. 28).

One of the main barriers cited to using these measures is a lack of training or awareness, with the process feeling strange to practitioners unless the whole approach of introducing working with these measures has been implemented in a well-considered way, which includes open conversations and training (Batty et al. 2013; Troupp 2013). "Measures should be introduced to the client so that they know what they are about and what they are for and how you are going to use them together. No one wants to fill in forms when they are unsure of their purpose and nothing would be worse than a young person feeling pressured to fill them in and then doing so in a way that gives inaccurate and unhelpful data." (Young person; Law and Wolpert 2014, p. 47).

In order to use outcome measures to *foster* therapeutic alliance and engagement, it is important to explain to children, young people, and their families the purpose of the measure they are being asked to complete. This can be aided by information leaflets and consent forms, as well as through direct conversation with practitioners. The experience of practitioners already using routine outcome monitoring/measures

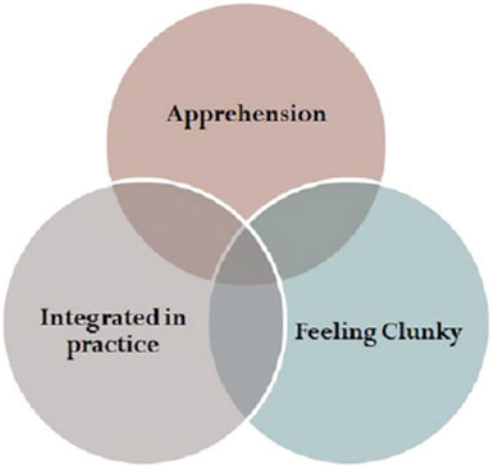

Fig. 15.2 States of implementation of measures, taken with thanks from Abrines et al. (2016, p. 6)

(ROMs) in practice, as well as training videos available online, is useful resources for facilitating the introduction of ROMs into sessions as CORC members are able to learn from the experiences of others within the collaboration (CORC 2013; Fleming et al. 2016).

Feedback from practitioners has identified three phases to the implementation of these types of measures and tools: "apprehension," "feeling clunky," and "integrated into practice." Practitioners will begin the process of using outcome measures and feedback tools by feeling wary and uneasy about their use; as time goes on, they tend to go through a necessary phase of "feeling clunky" and even when they feel as though for the most part, measures are integrated into their practice, they can switch between the three modes (Abrines-Jaume et al. 2016). Figure 15.2 demonstrates the relationship between these stages.

One of the mantras in CORC is: "Start where you are and keep going," which means don't try to wait until you have everything in place to start collecting outcome information—just start where you are with whatever you have and with whomever you have on board with you, willing to try.

Decision Making for Service Development

Time and Resources Involved

Even if all the "hearts and minds" (emotional and intellectual support) barriers have been addressed, there can still be the added time and resources that implementing

outcome measures can involve, which have been cited as some of the main barriers to their use in practice (Johnston and Gowers 2005). Often IT systems need to be updated or renewed to allow for data collection and storage, and use of paper measures can increase data entry and admin time for existing staff. CORC recognizes this can be a huge challenge for even the most enthusiastic services, but it does not have to be an insurmountable one. CORC can provide guidance to service providers and commissioners about how to resource and support this activity (CORC 2013) and offers free database solutions to members while they implement their long-term IT system plans.

CORC's learning from the Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT Outcomes and Evaluation Task and Finish Group 2011) and further evidence submitted to the House of Commons review (House of Commons Health Committee 2014) has shown us that many services are struggling with inadequate systems that are not fit for purpose. Therefore, rather than tackle this all in one go, we encourage services to start small and scale up and we always say in training that "…all you need to measure outcomes is a pen and paper" (Fleming et al. 2016). We place the focus on the practical use and embedding of ROM with curiosity, which means that entering the information onto computer systems is an additional step rather than a requirement from the start. "Knowing when and how to use the outcome measures is important. They must become an integrated part of the session—not something that is kept as an abstract form-filling exercise." (Young person; Law and Wolpert 2014, p. 28).

CORC's advice is to begin by implementing outcome measures with a few practitioners and a few service users in order to provide the opportunity to "work through the bumps" in the processes (Edmondson et al. 2001). Small-scale implementation can make initial administration and time demands more manageable, allows for challenges unique to individual services to be encountered and overcome, and for practitioners to discover the most meaningful ways for them to use ROMs in their practice. Trying out outcome measures on a small scale will also give a better idea of what will be needed once the project is scaled up, and will provide knowledge of what may be required of an IT system or staff to support their meaningful use.

The CORC team also supports its members by visiting services and facilitating "process mapping" exercises to explore where systems can be streamlined. Once a system that works on a small scale has been established, the enthusiasm and experience of early adopters can be harnessed to help spread implementation to other practitioners across the service. Evidence from implementation science suggests that a whole systems approach, which functions at the service user, practitioner, and organizational level, is most effective in terms of being successful in implementing change in this way and also in the actual outcomes achieved (Handy 1993; Pinnock et al. 2015).

Data Quality, Reporting and Using Information from Measures

Perhaps one of the most important barriers to implementation is skepticism surrounding the results from measures themselves, which can lead to the inappropriate or lack of use of the data they generate. If measures are not seen to provide meaningful information to practitioners, children, and young people, and the service as a whole, there will be little motivation to work them into regular practice and resulting data quality is likely to be poor. However, it has been shown that feeding back results to children, young people, and families within a session can be used to spur meaningful discussion about progress, and any challenges or successes occurring over time (Bickman et al. 2011; Hannan et al. 2005; Miller et al. 2006). It is also an opportunity for the practitioner to check results against their impression of that individual's progress, and for the child or young person to see tangible evidence of their improvement. "I think it is really important to establish goals at the start of a treatment programme because it gives the young person something to work towards and makes them feel as though recovery is worth something and they are achieving something." (Young person; Law and Wolpert 2014, p. 129).

Outcome measures can be used on a service level to evidence the impact of the hard work staff put into providing care, as well as potential areas for service-level improvement. They can also be a valuable resource for funders and for further research. Although evidence has shown that there is a substantial improvement in the implementation and use of routinely collected data in services following the CORC approach (e.g., from 30 to 60% in an independent audit; Hall et al. 2013), the volume of useable data from measures that is available for detailed analyses at an aggregate level is often limited (Wolpert 2014). The aim is of course to have the most complete, reliable, and robust data from which to draw conclusions. However, especially in early stages of implementation, this is rarely the case. For instance, because routine collection lacks the control of experimental studies, the data may be incomplete or not consistently recorded (e.g., missing contextual information, perspectives, or measurement occasions; Powell et al. 2003), complex (e.g., it can be difficult to define "positive change" at a group level; Slade 2002), or not precise enough (e.g., due to measurement error or use of an inappropriate measure; Powell et al. 2003). Further, there are added complexities when services and practitioners collect data from different measures to one another; this makes aggregation and analysis difficult. CORC works to have a dataset specification which is iterative in nature, to include measures that its members find useful, so that there is one set of measures that the entire collaboration can choose from, in part to increase overlap in use.

Despite the potential flaws in the data, CORC strongly believes it is important to not disregard it and the hard work that went into collecting it, and that having something to start conversations and engage stakeholders is better than not making use of it. The MINDFUL approach to using outcome data, developed by CORC, encompasses seven key areas: Multiple perspectives, Interpreting differences, Negative differences, Directed discussions, Funnel plots, Uncertainty, and Learning

collaboration (Wolpert et al. 2014). These MINDFUL areas will be presented in more detail here.

The multiple perspectives aspect recognizes the value of triangulating information and taking into account the viewpoints of the child, the family, and the practitioner. When interpreting differences, the framework suggests that a suitable level of granularity (e.g., team-level, service-level) is collaboratively agreed by the stakeholders prior to questioning the data. If a service appears to be performing less well than others, the approach encourages the exploration of possible areas of differences, for instance case mix, the nature of the measures, and potential data entry errors. CORC recommends that approximately 25% of the time should be devoted to such directed discussions, with the remaining 75% spent considering what it would mean if the data were suggesting genuine issues, or negative differences (Wolpert et al. 2014).

CORC also encourages the meaningful display of information via graphics such as funnel plots, which allow for a more accurate representation of random variation and also provide easily accessible resources to aid in the understanding of statistics (Spiegelhalter 2005; Whale 2015) (see Fig. 15.3).

The framework also emphasizes the importance of understanding the uncertainty in any data and considering it in any interpretation. Finally, our framework has collaborative learning, both at the local and at the national level, at its core, which includes frequent networking events for members and fostering helpful and supportive relationships between members. CORC supports its members to approach their data in these ways and we also work to make the presentation of data as accessible as possible, for practitioners and young people, with a view to making

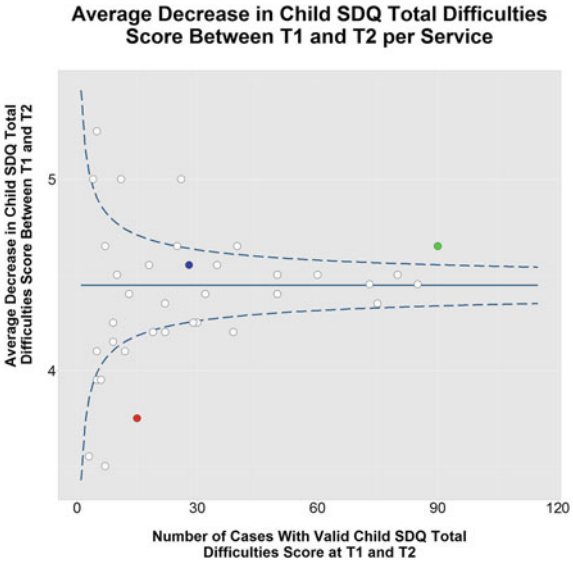

Fig. 15.3 Sample funnel plot

outcome information more accessible and useful. Figure 15.4 is a poster we presented at a national conference, which details some of this ongoing work (Raby and Sheppard 2015).

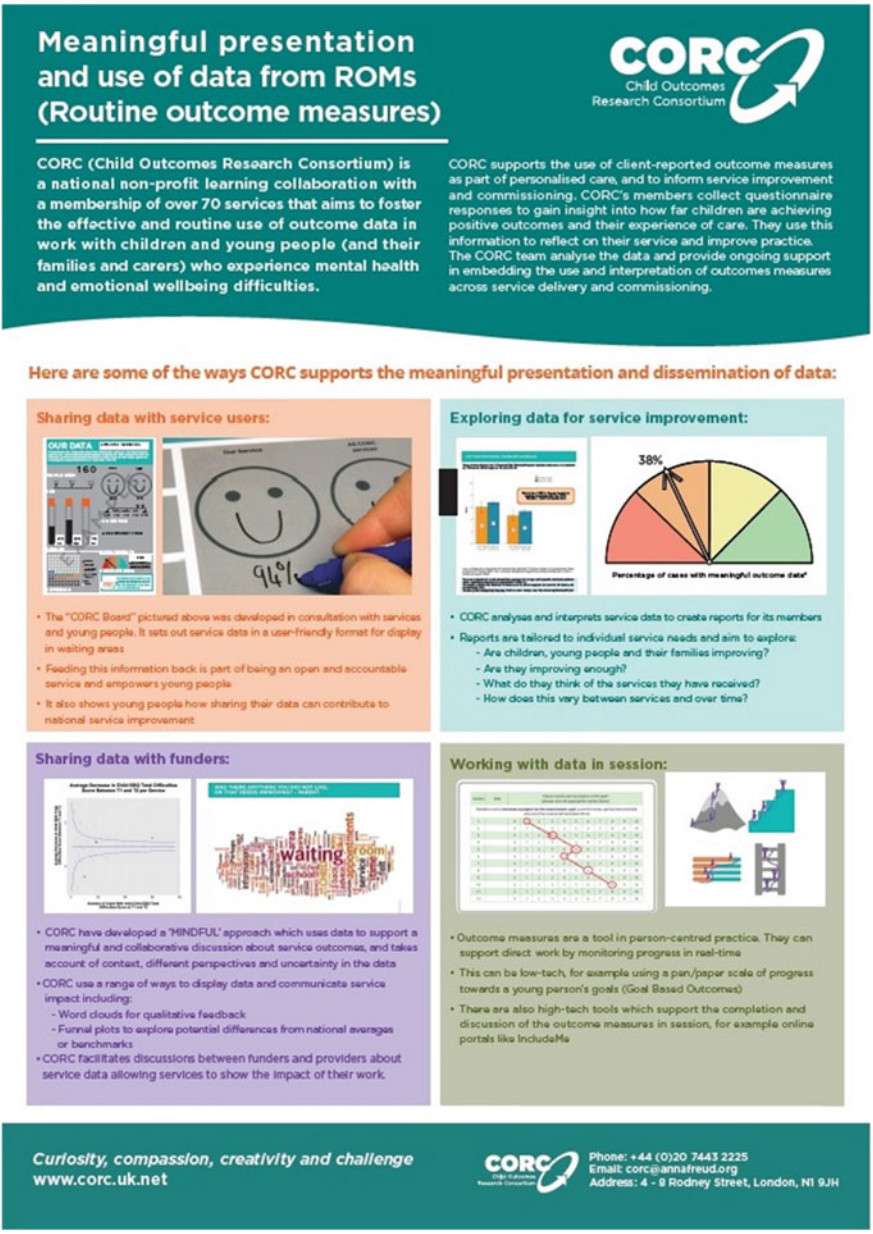

Fig. 15.4 Meaningful presentation and use of data from ROMs

The "all CORC" dataset, which is made up of the measures data that its members submit each year, now contains data on approximately 306,000 episodes of care between 2006 and 2015. These data are used for disseminating relevant information on outcomes and for advancing research in the field (e.g., Edbrooke-Childs et al. 2016; Jacob et al. 2015). Prior to data submission, we encourage members to think about what they would like to find out through their data. Our research team then maintains close correspondence with key contacts in the member service, to discuss any bespoke analyses and reporting requirements.

CORC has been producing reports for members since 2007. These are a comprehensive analysis and collation of both outcome and demographic information submitted by services, with service data then subsumed into the CORC dataset to give a "Rest of CORC" sample against which members can compare themselves. Members are offered a choice between detailed reports and more accessible, graphic-focused "dashboard" reports.

The dashboard report focuses on four areas that take the reader through a child's journey in a service:

- "*Who are we seeing*" encompasses demographic information about the children referred to and seen by the service;
- "*How well are we addressing their needs?*" includes information about both the severity of difficulties and movement in this severity over time, based on responses from child/young person-, parent-, teacher- and practitioner-rated outcome measures;
- "*What do service users think of their support?*" includes feedback from children, young people and their parents about their experience of receiving therapy, encompassing perceived experience of care (e.g., "I felt listened to") and perceived experience of the physical environment (e.g., "appointment times were convenient");
- "*How good is our evidence on what we are doing and what could we be doing better?*" gives an indication of the data quality.

Figure 15.5 shows an extract from a replica dashboard report, focused on experience of service.

CORC members have said that practitioners find the feedback on the experience of service included in their reports particularly useful for thinking about immediate service improvements and the care provided. The information about meeting the needs of the children seen is viewed as more useful on a strategic level, e.g., evidencing the service to commissioners.

Once a report is produced, someone from the CORC team visits the member service to encourage them to interpret their data "mindfully" using our framework. This includes inviting members to look at their report not as a definitive assessment, but rather as a starting point for interesting discussions about their service. We recommend that the report is never taken in isolation, but rather, combined with as much additional information as possible, in order to start creating an overall picture of the activity in the service.

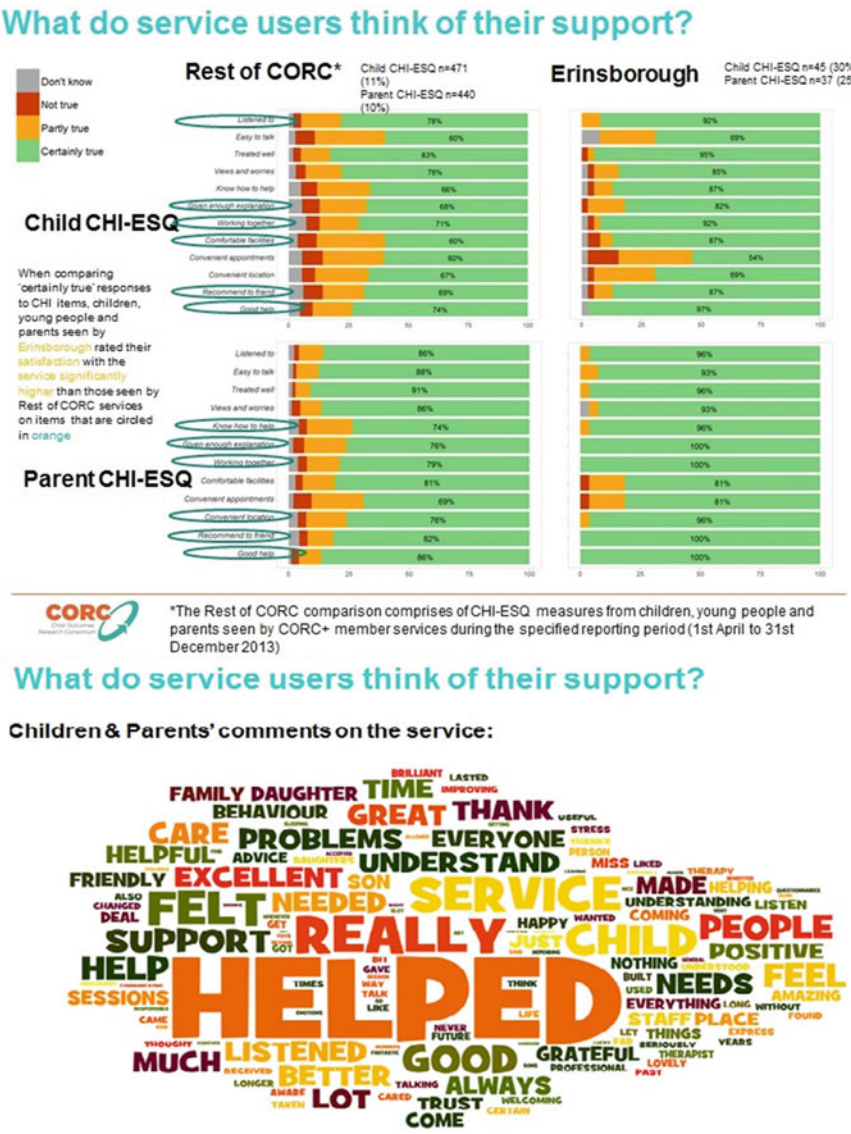

Fig. 15.5 CORC dashboard report excerpt: What do service users think of their support?

CORC strives to tailor reports to be as meaningful as possible, allowing members to choose which variables and measures they wish to have analyzed and as far as possible specify which types of service are included in the "Rest of CORC" comparison group. Improving the reports to make them more accessible and as meaningful as possible is an ongoing piece of work within the CORC team, with continuous improvements being made to the content in terms of statistical analyses,

infographics, and interpretation of the data. No dataset is perfect, and given the importance of these types of report in a growing culture of outcomes-based commissioning, information is presented tentatively and caveats are made explicit in order for results to be interpreted with appropriate caution in line with the MINDFUL approach outlined above (Wolpert et al. 2014).

Services are encouraged to make use of the reports and to feed back to CORC to help us hone and develop member reports in an iterative process. Most services inform us that their reports are circulated internally, often throughout teams and to managers. Some members choose to display relevant portions of the report in waiting rooms for services users to see, and others discuss reports with commissioners and other key stakeholders. "CORC has been invaluable in enabling us to consider and demonstrate our impact, show how and with which children we are making a difference, as well as guiding us through areas of improvement. Support from CORC enabled us to put improvement plans in place and we have seen a real difference in the impact we have with our young people." (CORC member).

Thinking back to the "hearts and minds" barriers, it is often thought that practitioners of different disciplines vary in how useful they perceive outcome measures and service-level reports to be. In particular, those using psychotherapeutic modalities can be less convinced of the utility of outcome data as sometimes psychotherapy is not considered a measureable entity (Margison et al. 2000). However, evidence has shown that overall the feelings members have toward CORC reports (i.e., clarity, utility, ease of interpretation, and overall benefit) does not vary by discipline (Tong Gong 2015), indicating that the psychotherapists in the sample in fact found the reports as useful as other practitioners. Positive experiences of goal setting as a means to track outcomes have also been evidenced in psychotherapy services (Troupp 2013).

Research

The "all CORC" dataset now comprises over 300,000 episodes of care from children and young people seen by mental health and well-being services across the UK, and it is currently the largest dataset of its kind in this country. We use these data to explore original research questions suggested by members and disseminate the results in peer-reviewed journals, at conferences and via our Web site, to help our members and the wider community understand outcomes and other aspects of children on whom we have these data routinely collected. One of the biggest challenges we have is due to the routinely collected nature of the dataset and some of the barriers already discussed here, there is a high proportion of missing data. The team explore appropriate ways in which to deal with missingness in analyses and also adopt the MINDFUL approach when exploring any findings.

CORC sees itself as in part a practice research network. The central team are keen to assist our members with research projects they conduct on a local level and conduct joint research with them. We also work with other key researchers in the field to collaborate on exploring the dataset on behalf of our members to advance knowledge in this area.

Summary

It is important to recognize that there are challenges associated with the collection and use of routine outcome measurement data within the child and family mental health and well-being community. Our learning collaboration has pioneered an approach that does not deny the complexities but capitalizes on the information that even flawed data can provide, and promotes its cautious but meaningful use to inform and transform services for the better.

CORC supports all its members to apply best practice and build on recent research findings to use outcomes data to strengthen service provision. CORC disseminates to and engages with service providers and commissioners through case studies, its Web site, individual visits on-site, and events. Working with diverse providers, CORC is also helping to increase engagement between commissioners and supporting them to better incorporate outcome measurement in contract management. CORC is also increasing engagement with education providers to help them to assess therapeutic interventions in their settings and explore whole-school approaches to mental health and well-being. Going forward, CORC plans to continue to develop and use its unique expertise and experience to further promote and improve children's mental health and well-being, including influencing policy.

The active use of service user-reported data lies at the heart of person-centered services, and CORC is working with members to ensure this is embedded in delivery and decision making about planning of services. "Bridging the worlds of research, service evaluation and clinical decision-making remains a complex and challenging agenda. CORC certainly does not have all the answers and daily obstacles remain. We hope that by sharing our experience we can help advance further work in this challenging but worthwhile area." (Fleming et al. 2016, p. 4).

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Part V
Concluding Remarks

Chapter 16
Epilogue

Terje Tilden and Bruce E. Wampold

Editing this book has inspired further reflections. First of all, we are grateful for the opportunity we were given from the EFTA and the publisher to edit this book. Second, we appreciate the willingness and eagerness of the chapter authors to contribute. Any volume cannot cover adequately a subject as broad as couple and family therapy (CFT), even if the focus has been on practices in Norway. Nevertheless, we are confident that this contribution discusses developments and issues in CFT not only in Norway, but throughout the western world. CFT in Norway, as discussed in several chapters, borrows from the CFT and psychotherapy communities in many western societies, and thus, our experience reflects larger contexts in CFT. In this final chapter, we share our reflections of the field, informed by our experience as well as the chapters of this book.

Changed, but Still the Same?

I (BEW) was trained in strategic family therapy, heavily influenced by Paul Watzlawick and John Weakland (I spent a week at the Mental Research Institute in Palo Alto with Weakland and Dick Fisch—and what a week it was!). So, I have nostalgic affiliation with CFT from that experience and there remains an attraction for the influences from this group and other related strands of CFT. But I have a positivistic thread to my existence as well (after all, I was trained in mathematics and the sciences) and have spent time immersed in the world of evidence-based treatments, for better or for worse. Personally, I have never seen CFT as outside the psychotherapy universe, but clearly there are schisms and differences that place CFT at the margins. In my view, these are external forces as well as internal. The

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health delivery systems in Western venues for the most part are individual focused, despite a nod to biopsychosocial models. In medicine, diagnosis, treatment, and payment almost exclusively considers only the individual patient. Individual psychotherapy has prospered because in many countries, it has been accepted as a medical practice. Simply, it is difficult for the medical field, used to diagnosis and treatment of an individual, to understand the essence of family therapy. But of course, there is an internal force in CFT that finds the medical context distasteful and inappropriate philosophically and pragmatically. This leaves CFT and conventional health delivery systems somewhat at odds. Personally, I find this distressing, but was one of the factors that motivated me to edit this volume.

I (TT) was trained in family therapy with the emphasis on child and adolescence problems, and before that, I was trained in psychodynamic individual therapy. Working at the Family Unit at Modum Bad (through a biopsychosocial and integrative approach) was very formative for me, experiencing the mutual and complementary ways knowledge from psychiatry and psychology of the individual could be fruitfully blended by perspectives from systemic therapy, enabling synergy. What in particular appealed to me from the systemic approach was the rebellion against dogmas; e.g., there is no "universe," but several "multiverses" of truths and opinions. I really liked that the family therapy field functioned as the bold and challenging student in the psychotherapy class. Or to use the family metaphor: Regarding the family therapy field as the adolescent member of the psychotherapy family who tested boundaries, was in opposition to the parents and who sought for other sources for inspiration and beliefs. But as we know from family life, more often than not, as the youngsters enter adulthood, they make surprisingly many of the parents' values and habits their own. And this is also how I see (and hope) will happen for the family therapy field; rather than becoming an outsider, we have established a solid identity as a branch on the psychotherapy tree, and we should make use of our experiences from our youth revolt to impact on the rest of the psychotherapy family. Regarding the systemic approach more as an attitude than methodology, our field represents some characteristic reminders to the rest of the psychotherapy field of, e.g., showing respect, admiration, and humbleness for the client's own view and knowledge. Further, this addresses more of the common factors that all professionals share, e.g., searching for change mechanisms that can be described in meta-theories. I find this perspective to be confirmed throughout the different contributions in this book, addressing that one tool—systematic feedback—seems to unite clinical practices despite different contexts and theoretical approaches.

CFT Part of the Psychotherapy Family?

As discussed in many places in this volume, the development of the systemic CFT, for a myriad of reasons, established a distance from mainstream psychiatry and psychotherapy. The work done by pioneers to establish alternative approaches have

been seen as humanistic alternatives to what many saw as de-humanizing psychiatric practices. We realize that this is an ongoing fight against powers in society that measure helping services for humans based on economic and New Public Management models. However, there is a risk of "throwing the baby out with the bath water" if this implies that the CFT field by principle is opposing everything that goes along with mainstream psychiatry and psychotherapy. But what if knowledge from psychology (developmental and social, say, as well as clinical psychology) and psychiatry, including various nosologies (e.g., ICD and DSM) might be used to facilitate client progress and improvement? Operating autonomously outside the "psychotherapy family," in academic institutions, in health delivery institution, and in government organizations (e.g., as in the New Public Management model) might not be in the best interest of clients—and that is an empirical rather than a philosophical question. We see some risks of excluding oneself from a greater field of natural professional kinship and attachment.

Evidence-Based Practice

In Norway—and we assume in probably many other western countries—the APA's evidenced-based practice policy, which integrates the best available knowledge from research, clinical experience, and the client's preferences and values (APA 2006), has influenced therapeutic work. This policy emphasizes user involvement without discounting evidence acquired through scientific inquiry. In relation to many systemic professionals' concern that New Public Management and official guidelines will threaten their professional autonomy, we think this can be viewed from a different perspective when making use of the principles enshrined in the "evidence-based practice" model. Utvåg et al. (2014) explored this concern of losing professional autonomy in relation to what is regulated by Norwegian legislation and governmental guidelines. Their conclusion was that if research knowledge and/or clinical experience come in conflict with the client's preferences and values, the latter should have priority. Because the therapist in such a situation is the one to weigh these different and conflicting interests against each other, this actually strengthens the therapist's discretion, which is an important aspect of autonomy. Therefore, evidence-based practice seems to safeguard important elements embedded in the role of a therapist while it at the same time strengthens the voice of the client. By systematically inviting feedback from the clients as presented in this book, this information adds to the knowledge needed for the therapist to work in agreement with evidence-based practice.

One Size Fits All?

It would be naïve to aim for one psychotherapy (or CFT) model to fit all treatment contexts, clients, and therapists. Without doubt, the diversity is great, and the need for tailoring treatment according to these factors is crucial. However, if we relate to research aiming to identify the treatment of choice for a specific disorder, the general conclusion is that no model is superior from another (for further reading, see, e.g., Wampold and Imel 2015). This does not mean that making use of a specific model or methods is irrelevant and unimportant. On contrary, every professional clinician needs to be well trained in the use of one or more specific models in order to deliver psychotherapy. And these specific approaches need to be put into practice within a health promoting environment by a warm, empathic, and affirmative therapist who is aware of the elements of Bordin's (1979) concept of therapeutic alliance. Due to current psychotherapy research, the focus of the field is gradually moving from "specific treatments for specific disorders" to "change mechanisms" that either seem to be common across a diversity of disorders, or are disorder specific. As such, the rest of the psychotherapy field seems to move closer to what has been the focus within systemic CFT characterized by an emphasis on tailoring the treatment to every client's needs and preferences according to principles of common factors in psychotherapy.

ROM/POR

Several of this book's chapters have addressed and described the use of feedback as routine outcome monitoring (ROM) within a frame of practice-oriented research (POR). The ROM/POR development is a promising means to resolve the dichotomy that may exist between paradigms within the field. For instance, the gap between the positivistic and mainstream psychiatry on one side and the postmodern systemic field on the other side represents different values and approaches. Further, the introduction of evidence-based practice may from a systemic view be regarded as a typical positivistic and New Public Management effort. Lastly, the traditional quantitative research design has been claimed to produce results on a group level that the average therapist does not find relevant for clinical practice, ending in a "clinician–researcher gap." This can be reduced by the use of POR where research is brought into the clinical surroundings without manipulating any treatment conditions for research purpose. For instance, this enables therapists and clients to be directly involved in research so that each therapy can be a case study for those involved. By the use of ROM, this increases the chance for user involvement and to adjust treatment that does not lead to the desired goal. Further, implementing ROM as part of therapy implies the clinical use of research methodology (e.g., asking systematically clients about their perception of process and progress, testing one's clinical hypotheses, interpreting results), demonstrating that research applies

directly to clinical use. The examples in this book on how ROM and POR are implemented in clinical practice should pave the way for a new type of psychotherapy practice that to a greater extent informs the therapist directly through feedback from the client so that the therapist becomes empirically informed. This approach will likely influence the relationship between the therapist and clients, in particular when the therapist uses this ROM information as a conversation tool, for instance by inviting the clients to interpret their own results. This way the clients may enter a more active and empowered position in therapy so that this truly becomes a collaboration as the best means of achieving the clients' goals.

Where Are We Heading?

Summing up from the foregoing, we see a clear tendency within the broader psychotherapy field toward integrative models, based mostly by the fact that research in general does not find significant different results between the use of different treatment models. Hence, one is rather increasingly focusing on knowledge of the mechanisms of change in order to optimizing the tailoring of treatment to the individual's preferences and needs. And we are already on our way to find some major principles of change that seem to be independent of personal differences, disorders, contexts, therapists, etc. (meta-models that are typically integrative), and how these can be adapted and blended with specific models and methods that are tailored to the single client/couple/family in line with the "evidence-based practice." If this tendency holds true, one may predict that the CFT field and the broader psychotherapy field in the future will share a greater deal of the same mission than before. After all, our motives and goals of helping our clients are the same even though we should appreciate the "multiverse" of different means.

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