The Narratives Which Connect…

A Qualitative Research Approach to the Narratives which Connect Therapists' Personal and Private Lives to their Family Therapy Practices

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ITHAKA

As you set out for Ithaka
hope your road is a long one,
full of adventure, full of discovery.
Laistrygonians, Cyclops,
angry Poseidon - don't be afraid of them:
you'll never find things like that one on your way
as long as you keep your thoughts raised high,
as long as a rare excitement
stirs your spirit and your body.
Laistrygonians, Cyclops,
wild Poseidon - you won't encounter them
unless you bring them along inside your soul,
unless your soul sets them up in front of you.

Hope your road is a long one.
May there be many summer mornings when,
with what pleasure, what joy,
you enter harbours you're seeing for the first time;
may you stop at Phoenician trading stations
to buy fine things,
mother of pearl and coral, amber and ebony,
sensual perfumes of every kind -
as many sensual perfumes as you can;
and may you visit many Egyptian cities
to learn and go on learning from their scholars.

Keep Ithaka always in your mind.
Arriving there is what you're destined for.
But don't hurry the journey at all.
Better if it lasts for years,
so you're old by the time you reach the island,
wealthy with all you've gained on the way,
not expecting Ithaka to make you rich.

Ithaka gave you the marvellous journey.
Without her you wouldn't have set out.
She has nothing left to give you now.
And if you find her poor, Ithaka won't have fooled you.
Wise as you will have become, so full of experience,
you'll have understood by then what these Ithakas mean.

Konstantinos P. Kavafis (1911)

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Contents

Abstract

Subject

The major aim of this research project is to look into some meaningful and important connections between Norwegian family therapists' personal and private lives and how their clinical practice may be created and constructed. The narratives that connect personal and private life to family therapy practice have long been overlooked or treated to minimal attention in family therapy education in Norway. Little research has been done on this topic in Norway, or in the wider field of psychotherapy research.

These questions are asked: How do we understand that so little research has been done on the links between the psychotherapist's own personal and private life and her/his clinical practice? How does the therapist's own life history and personal and private experiences influence the way he/she understands and practises systemic family therapy? What are the influences of being a systemic family therapist on the therapist's own life and how she/he thinks about the way she/he lives it?

Method

I have used Grounded Theory as the framework for this research and have interviewed seven family therapists using semi-structured interviews. The Grounded Theory method of study is essentially based on three main elements: 1. concepts; 2. categories; and 3. propositions. In addition, Thematic Analyses are used to analyse the videos of the first family therapy session of my first four research participants. The benefits of Thematic Analysis are connected to the representation of an individual's own point of view and their descriptions of experience, beliefs and perceptions. It gives more voice to the participant than to the researcher.

Findings, discussions and further research

Probably it is in understanding the nature of ***evidence-based practice*** and the ***scientist practitioner*** model and its position in the field of psychotherapy that we can best understand why the link between the therapist's personal and professional life is not very central in psychotherapy and in family therapy education.

In the discussions of the key findings, the research shows that both the practice of family therapy and the therapist's personal life may be influenced. Family therapy education in Norway is challenged by these findings of how personal and private influences may affect

clinical practice. I suggest that it is time to make personal and professional development programmes compulsory in Norwegian family therapy training.

In summing up the project, I have developed a middle range theory named ***"The map of resonance"*** where I use the concept resonance to understand both the relationship between the therapist's personal ideas and professional practice and between the therapist and the client. In this middle range theory, I develop some ideas about pitfalls for therapist, and suggest how PPD-work and supervision can ensure professional development both in education and in general practice. The perspectives from a supervisors angle are also included.

The ethical considerations, among others, point to the need for ethical guidelines for family therapy practice in Norway. This research project may also be seen as an invitation to rethink how family therapy practice could be understood. The project shows that personal and private experiences sometimes form a main framework for understanding sequences of family therapy practice. This realization should not be overlooked in the future and calls for further development.

The areas for further research are numerous in the field of patterns that connect family therapists' personal and private lives to their clinical practice. The areas of parallel connections and life cycle theory alone offer frameworks for several research projects. Research projects that both open up questions about connections between the therapist's personal and private life and her or his clinical practice and look at the entire therapeutic process could be initiated. Research projects that investigate and develop education programmes could be started. Some of this research could look into the meaning of introducing our own therapy as a part of family therapy education.

Preface and Reader's Guide

"It takes two to know one."
Gregory Bateson, lecture, Esalen 1980

"Everything said is said by someone."
Umberto Maturana and Francisco Varela, 1986, p. 27

A dark and freezing cold evening one fall, when I was a young boy, I found a can I had never seen before. I found it out in the street, close to my home. I sat down to look at it, and curious as I was, I picked at it with a stone to see what was inside. Something red as blood appeared. I dipped my finger into it to taste it. I had never tasted anything like it, but it tasted good, a little bit sweet and a little bit like fish.

I brought the can home to my mother. When I came into the kitchen, my mother sat there as she usually did in the evenings. I just knew that my father sat in the living room with the door open, as always. I showed the can to my mother and said: *"Look what I've found, a strange can."* My mother looked at it and saw what I had done to it, and spontaneously replied: *"You shouldn't have picked it up!"* When my father heard this dialogue, he growled in his characteristic voice from the living room: *"Pick up everything you find!"*

In my world, this is a key story that allows me to recognise my curiosity and my orientation of openness and interest in picking the object up, looking at it, analysing it, trying out some explanations and adjusting my worldview. I hope some of this inquisitiveness will show in this thesis.

The thesis is divided into section A and section B. Section A contains chapters 1 to 4. In chapter 1, the research project is introduced and the main terminology of the thesis is presented. In chapter 2, the literature review is presented, and is divided into three main parts. The first part will focus on the field of psychotherapy research, the second part will focus on family therapy education and the third presents different views of family therapy training.

Chapter 3 is divided into two main parts. The first part clarifies the design of the study including the methodology while in the second I go through the research process in this project. The first part presents the different elements in my research plan. These include the design of the study, the material, the Grounded Theory procedure for the interviews, and theme analysis of the videos and the idea about constructing paradigm cases. The second part clarifies the Grounded Theory research process in this project. The actual ideas behind re-

cruitment and the actual research flow chart are presented. Examples of how I ask questions to the participants and the transcribing procedures are documented.

In chapter 4 the analytic process itself is accounted for. This includes how memos are used throughout the entire research project. The coding procedures are presented with examples and the analysis flow charts illustrate the initial analytic process. These processes are central to identification of the narratives, which connect the interview transcripts with the videos, and both of them with the literature review. This process shows the way to saturation and the development of grounded theory categories and relationships between them.

Section B contains chapters 5 to 9. Chapter 5 is divided into three parts. Part A introduces the participants in this research project presenting their background, their contemporary and private lives and their professional lives. Their motives for entering into family therapy are examined along with some of their personal values and experiences. On part B the findings connected to the influence of private and personal experience on clinical practice and vice versa are presented. Several categories are presented and some paradigm cases that attempt to illustrate the categories and relations between categories. In part C the paradigm cases are presented.

Chapter 6 opens up the relation between the researcher and the research process. Reflexivity and self-reflexivity are the topics presented.

In Chapter 7 the lack of interest in the therapist's personal and private life in psychotherapy research is discussed. Then follows a discussion of key findings. Chapter 8 is called: "Toward a middle range theory of systemic family therapy." Here the map of relational resonance is presented. Further, I look at consequences for family therapy education and training. In Chapter 9 I look at some areas for further research.

I have made introductions and summaries to help the reader keep an overview throughout the reading of the thesis. It has been a great joy for me to conduct this project and I hope some of this joy is reflected in the reading.

Section A: Introduction, literature review and methodology

Orientation to chapters 1 - 4

Section A contains four chapters. Chapter one is the introduction to the research project. The background for the project is here outlined. In chapter two the literature review is presented and chapter three contains the design of the study. In chapter four the process of analysing the material is presented.

1. Introduction to the Research Project

> "The family therapist usually has the same problems in his own family that are present in the families he sees professionally and that he has a responsibility to define himself in his own family if he is to function adequately in his professional work."
> Murray Bowen, 1978

"Every Schoolboy Knows…"[1]

The major aim of this research project is to look into some meaningful and important connections between Norwegian family therapists' personal and private lives and how their clinical practice may be created and constructed. The main research question is: ***"How does the therapist's own life history and personal and private experiences influence the way she/he understands and practises systemic family therapy?"***

The narratives that connect personal and private life to clinical family therapy practice have long been overlooked or treated to minimal attention in family therapy education in Norway. Little research has been done on this topic in Norway, or in the wider field of psychotherapy research. In Bergin and Garfield's "Handbook of Psychotherapy and Behavior Change" Beutler et al. claim that: "…recent research is noticeably sparse, or even absent, on the effect of therapist personality, well-being, personal values, and religious viewpoints on outcomes" (Beutler et al., 2004, p. 290).

Janine Roberts, a North American practitioner, makes a distinction between a personal and a professional relationship, and this distinction is crucial to my research. She says:

> "Clients and therapists are in an intimate paid relationship, not a personal relationship, but nevertheless, one with many personal aspects. Safeguards come with this contract,

[1] The heading of Chapter II in Gregory Bateson's *Mind and Nature* where he quotes Lord Macaulay.

> along with limitations. Therapists and clients together have to create in each therapy a comfort with the personal within the professional relationship" (Roberts, 2005, p. 62).

The context for my research is the therapy room on the one hand, and the therapist's own personal and private life on the other hand. In my research I seek to understand why we continue to separate what we say, we know is important, from what we actually do in family therapy practice and training.

Eggs

In *Mind and Nature* Bateson claimed, "Without context, words and actions have no meaning at all" (Bateson, 1979, p. 24). If I were to rephrase this quotation and say, "Without context, a research question has no meaning at all" he would probably have agreed with me. In the fall of 2004, a story dealing with life and death was reported in the Norwegian media (Aftenposten, 11.03.2004).

A young boy, Mehmet, with the hereditary and fatal disease of thalassemia, needed cells from a sibling without the disease in order to survive. To provide him with a sibling with the genes he needed, the doctors had to screen his mother's eggs. However, the screening of human eggs is in violation of Norwegian legislation.

Two medical professors took opposing viewpoints in this case. One professor claimed that we needed to change legislation so that Mehmet could receive the best possible treatment, because this could save his life. The other professor claimed that this kind of treatment was experimental, uncertain and unethical. The debate continued for weeks and months, involving a great many participants, and with the two professors at the centre.

In May 2004 the professor who believed that we needed to change the law "outed" the other professor, and said that he believed that this professor was a Christian. The "outed" professor was offended, and claimed that for him "… it is my objective as a professor to try to be neutral, especially when dealing with my patients and colleagues. As a professor, I consider it unacceptable to ask people about their religious beliefs, political convictions or other private views. A philosophy of life is something people have an absolute right to keep within their private sphere." The other professor asserted, "… I have presented this viewpoint on grounds of pure principle. It is my opinion that in the field of research and development, in particular, which has a profound influence on our values and our philosophy of life, everybody should be obligated to be open about his or her philosophy of life. It is much too widespread a trend for

so-called professionals to give the impression that they are only professionals. Such a thing does not exist."

These two different positions can serve as illustrations of how the topic of the relationship between the therapist's personal life and her/his clinical practice is viewed in the field of family therapy. When I asked MRI brief therapist Richard Fisch how he viewed the topic of my research project, he replied in a written communication that this issue is not considered at all at MRI, and that he does not think a therapist can be more effective by examining his culture and family of origin. Lieberman quotes another North American family therapist, Murray Bowen, whose statement can illustrate the opposite view:

> "The family therapist usually has the same problems in his own family that are present in the families he sees professionally and that he has a responsibility to define himself in his own family if he is to function adequately in his professional work" (Lieberman, 1987, p. 205 citing Bowen, 1978).

I have formulated a research question that lies between these two positions. With my project I want to enter into this landscape and explore how new meanings can emerge from my research question, which is found at the interface between these two positions.

The Therapist's Family of Origin

From about the mid 1960s Murray Bowen saw that it was necessary to include the therapist's own family in the understanding of family therapy. Bowen was puzzled about how little help he had got from the psychoanalytic tradition to deal with the problems he experienced with people that were closest to him, his own family (Kerr, 1984, p. 5 and 7). In 1967 Bowen presented his own family of origin instead of an academic paper at a conference in Philadelphia (Young et al, 2003, p. 132). The first published article on the need to work with the therapist's family of origin was written by Bowen and published in 1968 (Lieberman, 1987 p. 207ff).

In the years to come, some work was done and articles and books were written about working with the family of origin from the transgenerational perspective of Bowen. Bowen also claimed that those of his trainees who "conducted ongoing differentiation work within their own families became better therapists" (Young et al, 2003, p. 132). In 1972, Guerin and Fogarty published the first systematic attempt to describe both the work on one's own family and the task of the family therapy supervisor of such work. In the UK, the first attempts to work with the family of origin in training occurred in the mid 70's, and Lieberman explored a model in 1980.

In Norway, Bowen's transgenerational theory has had little influence and his theory has not been a part of the curriculum in family therapy education in Norway[2]. Probably this is because Bowen's theory is closely linked to psychodynamic theory and for many years, the idea that systemic family theory should be "pure" or "clean" and not mixed with either behavioural or psychodynamic theory has held sway. The Bowenian approach to working with the family of origin in family therapy training is therefore not well known in Norway.

The Pattern which Connects

The scientist and communication theorist Gregory Bateson was in his work looking for pattern connecting living creatures (Bateson, 1979, p. 8). Bateson elaborated this concept by saying: "The pattern which connects is a meta-pattern. It is a pattern of patterns. It is that meta-pattern which defines the vast generalization that is indeed the **patterns which connect**" (Bateson, 1979, p. 20).

In this research project, I am looking for the patterns which connect narratives from our own personal and private life with narratives from family therapy practice. The narratives that I want to study in this context are the interrelations between therapists' private and personal narratives and their professional narratives. I here use the word "narrative" in a general sense, and I do not link it to any family therapy tradition. I use it as it is defined in the dictionary (Ordnett.no) as "story," "tale," "plot" or "storyline". In this sense, I will look for the narratives which connect private and personal life with life as a family therapist.

Frameworks that Form the Background for the Project

Two positions can be seen as embodying the classic division in contemporary philosophy, exemplified by the technical and mechanistic views of the Enlightenment and the humanistic, subjective and contextual framework of Gregory Bateson and others.

Very few teachers in the field of family therapy training in Norway have worked with pedagogical theory and curriculum development. This means that most teachers in family therapy education in Norway master the bodies of knowledge that belong to their profession and to the field of family therapy. Discussions of pedagogy and educational policy are not central in family therapy education, and the lack of debate in this area has an influence on how our education programmes are designed. The student's own personal and private back-

[2] We do not have any accreditation body for family therapists in Norway. We have some accredited curriculum and a Master degree in Family Therapy and Systemic Practice, but they do not give access to clinical practice recognized by the Government.

ground is an example of a topic that is for the most part left out of family therapy education programmes.

As already mentioned the first published article on the need to work with the therapist's family of origin was written by Murray Bowen and published in 1968 (Lieberman, 1987, p. 207ff.). In subsequent years, a great deal of work was accomplished in this field, and articles and books were written about working with the family of origin from Bowen's perspective especially in the United States. It was a time when there was general agreement that exploration of the therapist's own family in association with personal therapy led to one being a better family therapist (Munson, 1984, p. 63). Working with the family therapist's own family was not only linked to the Bowenian way of doing therapy and training therapists, but also to systemic, strategic and structural family therapy (Forman, 1984; Aponte, 1992).

The Current Situation in the UK and the USA

The American Association of Marriage and Family Therapy (AAMFT) has, for example, included in its ethical standards the requirement that therapists "… provide services to diverse populations and that they be competent to do so." To achieve this, professionals also have to cultivate the links between their own personal background and their clinical practice because The AAMFT build on the idea that personal culture and personal values influence clinical practice (Halevy, 1998, p. 233).

In the UK, the Association for Family Therapy and Systemic Practice (AFT) refers to Personal and Professional Development[3] (PPD) as follows:

> "Personal and professional development: – at present there is no requirement for students to undertake personal therapy although many do so. In a systemic training there is a strong emphasis on small group experience to explore the interaction between the personal and professional. Students are required to be open to and participate in such exploration of, for example, their own family of origin and key influences in their lives." (Information on Training, Information Sheet, Revised September February 2007 at http://www.aft.org.uk/training/-documents/InformationOnTrainingSept-2007.pdf).

In this text, the message is not clear. It states, "…at present there is no requirement for students to undertake personal therapy although many do so." Should they? In the UK the details on accreditation of family therapy education are presented in the AFT *Blue Book*. In the chapter on clinical practice (p. 13, §4), personal and professional development is described as

[3] When I searched PPD in connection with family therapy on the Internet, I found about 13,700 sites.

something that "…should be addressed in all domains of the course but particularly in the supervision group and personal and professional development groups."[4]

The American Association of Marriage and Family Therapy (AAMFT) drew up a framework for family therapy education in 1974. In 1978, the United States Office of Education officially recognised this framework. This recognition is also valid in Canada. According to the AAMFT´s "Accreditation standard"[5] (Version 10.3) this framework consists of accredited programmes in family therapy that comprise twelve main areas. The title of Area III is: **"Individual Development and Family Relations".** It says that family therapy training should include: "… content on individual development across the lifespan" and "…will include content on family development across the lifespan."

One example of why it is necessary to work with personal development and family relations can be found in the AAMFT´s ethical requirement to provide services to diverse populations. Culturally competent therapists are those who understand "their own assumptions and biases and who can communicate effectively with colleagues and clients like and unlike them – students must be willing to examine facets of themselves that they are not required to expose in many other courses" (Halevy, 1998, p. 234).

This is an example of one area of personal life and personal experience that could be applicable to family therapy education and training. It has never been included in a training programme in Norway, although during the past thirty years our society has grown to include many groups from different nations and cultures.

Many examples could be cited to understand and clarify the lack of interest in and energy devoted to working with the relationship between a professional's personal and private background and the practical or clinical fields. Examples could be cited from the educational programmes for nurses, psychologists, social workers and medical doctors, or from the criteria used to authorise various types of clinicians. However, I will focus on psychotherapy research to illustrate my point. I believe that the field of psychotherapy research illustrates how it is possible on the one hand to claim that the connection between clinical practice and the therapist's personal and private life is crucial, and on the other hand to ignore it almost completely.

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[4] For example: the University of Southampton requires "Personal and Professional Development Group (8 x 2 hours per academic year; 4 of these will take place during the specialist academic weeks; the other 4 will be outside of this time)." At the University of Leeds, PPD 1 and 2 together amount to 10 credits.

[5] http://www.aamft.org/about/coamfte/97stnds.htm

The Current Situation in Norway

Norwegian authorities do not give any certification of family therapists or other psychotherapists. The medical and the psychological union certify on behalf of the Government. This means that the Government does not have any criteria for recognition (Jensen, 2005).

For the time being, there are seven family therapy education programmes in Norway. These programmes last from one year part-time to four years part-time. One of the programmes offers a masters degree in family therapy and systemic practice and another program has asked for this recognition from the Government. One of the education programmes[6] has currently developed and implemented a PPD module. The other programmes do not offer any regular PPD-work.

Terminology

Many years ago, I read an article in a journal for nursing research called: "Development of an Instrument to Measure Hope[7]." There was something in this title and in the article that made me wonder, "Is it necessary to measure everything? Is it possible to measure hope? Why call it an instrument? What would such an instrument look like? Is it possible to do research on hope in another language and what would that language be like?" Language forms our worldview and our understanding of practice and therefore it is of the greatest importance in research.

This doctoral work has led me deeper into two main areas, scientific methodology and psychotherapy research. My voyage into these two topics has involved much learning and many new insights. One interesting aspect of this work is connected to the terminology or rhetoric in these two areas. These are areas that are closely linked together and I will not separate them here. Some of the concepts that are used in these areas are closely linked to a mechanistic and medical language. Here are some examples of mechanistic concepts from some textbooks that are often used in research: basic elements, rating scales, clinical effectiveness, clinical efficacy, effect sizes, facts, instruments, measuring, mechanism, products, randomized controlled trials, rates, etc.

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[6] It is the Master program in Family Therapy and Systemic Practice at Diakonhjemmet University College in Oslo.

[7] Miller J. F., Powers M. J., Nursing Research (1988), Jan-Feb;37(1):6-10

The Scientific Language

In my research, it will be impossible to separate findings from theory. Scientific languages are constantly in flux. Gilbert and Mulkay mention that in their research material, scientists undermine each other's choices of theory by drawing attention to the 'improper interpretation' of data (Gilbert and Mulkay, 1982, p 398). In this work, my point of departure is that "reality" is constituted by language. This is different from the rationalist tradition. "The rationalistic tradition regards language as a system of symbols that are composed into patterns that stand for things in the world (Winograd and Flores, 1986 p. 17).

Unless the rationalistic language tradition or mechanistic and medical language is part of a topic I am exploring, I will seek to avoid this rhetoric and make an effort to find a more humanistic scientific language. However, that is not always easy. Language choice concerns mainly communicative purposes, so I will keep a pragmatic mind in my use of language.

In the following section, I will present some of the main concepts of my thesis. These are also a part of my research, but it is hoped that my research will also foster new and fruitful concepts with which to illuminate my research question.

Constructivism

> 'You have to choose', roar the guardians of the temple,
> 'either you believe in reality or you cling to constructivism'.
> Bruno Latour, 2002

Constructivism is a basic concept in family therapy theory. It is natural for me in this piece of work to build on the basic premises constructivism offers. In an annotation in "Realities and Relationship" Kenneth Gergen claims that the concepts constructivism and constructionism are used interchangeably, remarking further that it is good there is no court of law to decide on the use of concepts (Gergen, 1997, p. 291).

Constructivism is a philosophy founded on the premise that, by reflecting on our experiences, we construct our own understanding of the world in which we live. Each of us generates our own "rules" and "mental models," which we use to make sense of our experiences. Understanding, explaining and learning, therefore, is simply the process of adjusting our mental models and language.

In my thesis, I will use the concept *constructivism* to cover different aspects of philosophical and theoretical positions in these traditions. These include Radical constructivism, as we know it from Ernst von Glasersfeld (1984), Social constructivism, as we know it from Berger and Luckmann (1966) and Social constructionism as we know it from Kenneth Gergen

(1997). All constructionisms concern our joint negotiation of social reality in one way or another. Influenced by anthropological cultural relativism and phenomenological philosophy, most contemporary constructivists trace the roots of their points of view to Systemic communication theory, the Chicago School of Sociology and post-modern philosophy, especially the work of French philosophers Jacques Derrida and Michel Foucault.

On a line between a positivistic and a relativistic position, I would choose "realism" as my position. My position is therefore closely linked to what is called "critical realism" or "fallibilistic realism". Fallibilistic realism claims that the world "….exists regardless of what we happen to think about it. If by contrast, the world itself was a product or construction of our knowledge, then our knowledge would surely be infallible, for how could we ever be mistaken about anything?" (Sayerin Robson, 2002, p. 29).

Context

> I offer you the notion of context, of pattern through time.
> Gregory Bateson, 1979, p. 14
>
> A phenomenon remains unexplainable as long as the range of observation is not wide enough to include the context in which the phenomenon occurs.
> Paul Watzlawick et al., 1967, p. 20

The concept of context forms some basic premises for this research. A contextual framework offers meaning for how we can build an understanding of how stories from the therapist's personal and private life are linked together and can form meaningful complete stories. In this sense, I am ready to denote this point of view "contextual understanding."

During the past few centuries, we in the Western world have chosen to take those parts of nature that we have wished to study out of their context and into the laboratory in order to study them in controlled circumstances. In the areas of both medicine and psychology, the laboratory has emerged as an essential source of knowledge about human beings. There is no doubt that this method has generated knowledge that has solved problems in many areas. However, this approach has a number of weaknesses, and we have missed a great deal of key knowledge by relying on this method.

Bateson introduced the concept of context as a means of expanding our understanding. He emphasised that context is our mental or psychological frame of understanding. It does not refer to an external, observable situation, as the word is often used in ordinary speech. When Bateson refers to context, he means the communicable, meaningful frame we perceive within ourselves, which helps us to interpret what we understand within this frame. Further, he said

that "…every meta-communicative message is or defines a psychological frame" (Bateson, 1972 p. 188). In other words, the frame itself or its prerequisites convey how communication within the frame will be understood. We could determine the frame "This is a game" or for this research, "This is therapy," and everything within this frame, or everything that occurs, is to be understood as a game or as therapy. We communicate to one another which frame gives meaning and enables us to understand our own minds. We often agree about when something can be understood, for example, as a game or a joke.

Context can be said to function as meta-communication (Jensen, 1994). As we will see later, context is often connected with the non-verbal level of communication because it is often analogue communication that defines context. This non-verbal communication aspect is connected to my research as an analytic tool in understanding how stories from clinical practice are linked to the therapist's personal and private life. Through using the videos from the participants' therapy sessions in the research, the analogue language will be a part of the analytic process of interview transcripts in this research.

How we perceive the context in which we understand a phenomenon depends on what we regard as information. A context could be said to classify or categorise a phenomenon for us. Context communicates a standpoint on how a message or a type of behaviour can be understood. For example, we can perceive one type of behaviour as reasonable, and another as insane. Different interpretations are ascribed to an event depending on the person or persons who are observing it.

When faced with a phenomenon, we automatically "choose" a frame within which we can understand it. Information will always be presented within a context, and can at the same time alter our understanding of the context. Despite having similar cultural backgrounds, we can find that a context communicates entirely different meanings to different participants. In this way Bateson says that "… 'context' is linked to another undefined notion called 'meaning' (Bateson, 1979, p. 15).

Circular epistemology

One of Bateson's basic assumptions is that human interplay can only be understood cybernetically (in a circular fashion), and not linearly (cause-effect). He points out that the "epistemological error" in difficult situations is due precisely to the fact that a linear understanding (epistemology) is used as a basis. If we get stuck, this is due to what Bateson calls an "epistemological error" (Bateson, 1972, p. 480). In my attempt to understand how a therapist's personal and private life are connected to clinical practice it is, in my opinion, necessary to

abandon a linear epistemology and build instead an understanding that is based on a circular way of knowing. An epistemology consists of the rules that are followed in order to create an understanding of reality. Having an ineffective epistemology means, in this context, that our way of perceiving our world and ourselves is inappropriate, and results in one or several of us being unable to break out of deadlocked situations.

As a result of the shift from mechanistic to systemic paradigms (Jensen, 1994), the focus has moved from the study of the individual's or the thing's properties and details to the study of relations between human beings and between human beings and nature. The systemic paradigm takes interplay and interaction as its points of departure in generating understanding. It could seem as though this is a simple intellectual shift, but shifting the focus from the individual's characteristics to relations between individuals is actually a profound and comprehensive change.

Liberating oneself from the Western scientific culture's Newtonian paradigm is only one of the problems we face, and perhaps not the greatest one. There is also a linguistic problem. Gregory Bateson clarifies this issue. Our entire language is constructed around naming things, persons and places. The thing in itself is given a name, and is thus a part of its own creation. We can name a specific type of object, for example, a stone. A stone is a stone, and the thing has been given a name. Bateson writes that we are "told that a 'noun' is 'the name of a person, place or thing', and that a 'verb' is 'an action word', and so on" (Bateson, 1979, p. 14).

By a certain age, children have learned that when they need to define something, they do so by finding out what the thing is in itself. It is not its relation to other things that defines the thing. We can see that small children, who have not yet learned the names of things, create the thing in terms of their relation to it. When a child does not know that a stone has the name "stone," he or she can call it, "…the thing we throw" or "…the thing we sit on".

Shifting focus from characteristics to relations and interactions, therefore, demands a new way of referring to the phenomenon. We must try to find concepts and explanations that are appropriate for understanding and describing interplay and people's relationships with each other. In this project the concern will be relational building on circular epistemology. That means that it is the therapist's relation to the clients and the therapist's relation to her or his private and personal history, values and experiences that will form the understanding and create meaning in this research.

Meaning

Gregory Bateson developed several concepts, which he used to understand and describe the cognition of human beings, or more precisely of the living world. How do we think about the world, how do we develop knowledge about the world, how do we understand and interpret what we see? He said that it is basic that we always understand phenomena in a context.

> "And "context" is linked to another notion called "meaning". Without context, words and actions have no meaning at all. This is true not only of human communications in words but also of communication whatsoever, of all mental processes, of all mind, including that which tells the sea anemone how to grow and the amoeba what he should do next" (Bateson, 1979, p.24).

Bateson uses the concepts "context" or "meaning" closely related to the psychological frame in which we understand phenomena. A person will construct a meaningful context, which helps him or her to interpret and understand. This happens often automatically and involuntarily, because people are looking for meaning and trying to understand. Interpretation and the search for meaning are typical for the world of the living as opposed to the world of the non-living.

We give meaning to our experiences. To give meaning to something is not merely a cognitive process or a conscious action. It can be intuitive and inarticulate. In this way everything affects everything. These ideas will be relevant both in the designing of the grounded theory research and in the interpretation of the findings. Charmaz says: "Throughout the research process, looking at action in relation to meaning helps the researcher to obtain thick descriptions and to develop categories." (Charmaz, 1995).

Narratives which connect

In this research project, I am looking to see if there are patterns that connect narratives from our own personal and private life with narratives from clinical family therapy practice. The scientist and communication theorist Gregory Bateson proposed a method of classifying the phenomena of pattern. Bateson deduced, in the same way as Immanuel Kant, that the individual can never encounter the world as it actually is. We do not have repetitive access to the "territory," as such, but only to "maps" of the "territory" and our descriptions are part of that "map". He asks:

> "What pattern connects the crab to the lobster and the orchid to the primrose and all the four of them to me? And me to you? And all the six of us to the amoeba in one direction and to the back-ward schizophrenic in another?" (Bateson, 1979, p. 8).

Bateson elaborates this concept by saying: "The pattern which connects is a meta-pattern. It is a pattern of patterns. It is that meta-pattern which defines the vast generalization that is indeed **patterns which connect**." (Bateson, 1979, p. 20). Bateson moved about laterally. He worked by connecting patterns and relationships abductively and by linking ideas within a flowing together of different circles. This flowing together allows for the discovery of the extension of related ideas.

A pattern is different from a connection. A connection may be accidental and not filled with meaning. A pattern appears when something adds meaning to a person's history and is repeated in a way that a person recognises as part of their own personality and personal history.

Beyond this presentation and discussion of terminology, I will, as much as possible, apply research participant's own terms, concepts and notions in my thesis. However, I will also develop my own terms when this is appropriate.

The Personal and the Private

The concepts "personal and private" are here used as a phrase or as the denomination of an area or a field for exploration. The personal and private experience and knowledge are mainly obtained outside clinical and professional practice. Professional experience may be transformed and included in the personal and private field. In the same way, personal and private experience can be included in professional practice and family therapy. In this thesis I do not sustain the traditional division between the personal and the private. I choose to view the private as a section of the personal.

Summary

This chapter forms the introduction to the research project. Some general comments on the links between professionals' personal and private lives and their professional practice seek to form a context for this research. A more specific context is constructed through looking at the status of Personal and Professional Development as part of family therapy education programmes and certification processes in Norway and some other Western countries. At the end of chapter 1, the main terminology of the basic thinking for my research is presented.

2. Literature Review

> "A basic requirement for the research student is that they should understand the history of the subject they intend to study" Chris Hart, 1998, p 27

Introduction

The interest for understanding the connections between professional's personal and private background and her or his professional practice is not new. For example in pedagogy, Ivor F. Goodson and his colleagues, have performed several research projects that examine connections between teachers' personal life history and their professional lives for many years (Goodson, 2000). It is, however, difficult to find this kind of research in the field of psychotherapy in general and in the field of family therapy specifically.

This literature review is divided into three main parts. The first part will focus on the field of psychotherapy research that deals with the therapist's role and person as part of the therapeutic process. The second part will focus on family therapy education. The third part concerns different views on family therapy training.

In the first part, I will seek to give a picture of psychotherapy research with the aim of understanding the lack of interest in the therapist's personal and private background for understanding the therapeutic process. The idea of evidence-based psychotherapy will be explained and discussed as a framework for understanding the lack of interest in the therapist's personal and private life as an important part of psychotherapy research.

In the second part I will discuss the relation between modernistic and constructivist views of psychotherapeutic education. I will show how the modernistic perspective has influenced psychotherapy education and outline the difference between these two points of view.

Finally, I will sketch different views of the necessity of working with one's own family in family therapy training. The field is here divided into several different viewpoints that differ greatly and that might be seen as in opposition to one another.

The Lack of Research on Including the Meaning of the Therapist's Personal and Private Life in Psychotherapy[8]

The Theoretical Examination of the Therapist's Role in Psychotherapy

This theoretical examination was an important step into the world of psychotherapy research. This examination brought me into the broader field of psychotherapy research and evidence-based practice and came up with a new understanding of how the therapist as a person was viewed in these traditions. This part of my work also gave me the challenge to write an article that presented an understanding of how the therapist as a person is viewed in important areas within evidence-based research.[9]

Little research has been done on how to understand the links and patterns that connect the therapist's personal and private life with his/her clinical practice. In the field of family therapy, I have not found any research that elaborates this area. The fact that the personal and the professional are divided in our understanding of psychotherapy needs to be discussed. When I investigate how to understand this situation, I can choose many angles. I have chosen to use psychotherapy research as an entry to the field. I will do this because I think that different perspectives on psychotherapy research illustrate my concern in an exemplary way.

The French philosopher Pierre Bourdieu gave us the concept "doxa" to help us understand what we immediately and unconsciously apprehend as the values of a field. These are the values that are not explicitly formulated, but that work on an unconscious level. When the participants have a homogeneous praxis, the doxic understanding will be kept unchanged. Bourdieu talks about this as the "ortho-doxic" condition (Bourdieu, 1990, p. 68). I first want to examine psychotherapy research. I will show how the evidence-based model gives a rationale for excluding the therapist's personal life from the understanding of therapy. I will then present psychotherapy research that opposes this point of view.

Psychotherapy outcome researchers have often tried to minimise the influence of the individual therapist when they study the efficacy of specific interventions. However, research shows that variation in outcome across methods or therapeutic traditions is smaller than variation in outcome among therapists within methods or therapeutic traditions. "The conclusion is that it makes a bigger difference who the therapist is than which method is used" (Rønnestad

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[8] Some of the material in this section is used in an article called: "How to understand the lack of research that include the meaning of therapist personal and private life in psychotherapy" (unpublished).

[9] The article was referee evaluated and approved for publication in the spring of 2006. It is called: "How might "the great psychotherapy debate" influence the understanding of family therapy research? Which therapist can best serve which client?" and published in "*Fokus på familien*," no.2, 2006, Scandinavian University Press.

and Skovholt, 2002, p.3). This is one of the important starting points in developing an understanding of the links between family therapists' personal lives and their professional practices.

Several researchers (Jennings et al., 2003) underscore the significance of the therapist as a person. Interest in studying how therapists develop has been increasing (Wampold, 2001, p. 196). In their article, Rønnestad and Skovholt sum up ten years of research on the development of psychotherapists (Rønnestad and Skovholt, 2002). Through summarizing of the main findings and perspectives from a cross-sectional and longitudinal qualitative study of the development of 100 counselors and therapists, they identify 14 themes that are important in this process. Some of them are "Professional development involves an increasing higher order integration of the professional self and the personal self," and, "The cognitive map changes: Beginning practitioners rely on external expertise, seasoned practitioners rely on internal expertise." I will discuss themes such as, "Personal life influences professional functioning and development throughout the professional life span" (ibid. p. 38), and "Interpersonal sources of influence propel professional development more than 'impersonal' sources of influence" (ibid. p. 40). Some of these themes deal with the fact that experienced family therapists have most confidence in their own expertise, that their personal lives influence their professional work throughout their careers, and that interpersonal sources are the driving force in their development (Rønnestad and Skovholt, 2002, p. 40).

In the foreword to his book *The Great Psychotherapy Debate*, Bruce E. Wampold expresses his views on science by stating,

> "I would happily give up my perspective if the scientific evidence supported the current trend to conceptualize psychological treatments as analogues of medical treatments" (p. xii).

Wampold does not discuss the importance of the therapist's personal and private experiences specifically, but in general he claim, "…ignoring therapists in design can lead to catastrophic errors" (Wampold, 2001, p. 187). He describes how, for example, previous research acquires entirely new values if one considers the therapist when interpreting the results. In a study comparing the effects of cognitive therapy with those of analytic therapy, the former proved most effective. He uses a "nested design" and a "crossed design[10]" to include the therapist in psychotherapy research. When Wampold and his colleagues re-examined the

[10] About "Nested Design" and "Crossed Design" in psychotherapy research, see B. E. Wampold, 2001, Chapter 8.

results and included the effect of the therapist as a part of the treatment, it was then impossible to define one type of therapy as more effective than the other.

His conclusion is that the evidence is clear. The type of therapy is irrelevant, and it is pointless to try to follow a manual slavishly. Nevertheless, the therapist, who is an integral part of all forms of treatment, makes all the difference. He closes by saying that it is now clear that what is absolutely decisive in treatment is which therapist is carrying out the therapy, and that this conclusion supports a contextual perspective of psychotherapy (Wampold, 2001, p. 200ff). In the prolongation of these findings Wampold argues that psychotherapists should be validated "to benefit patients rather than curtail costs" (Wampold, 2006, p. 208).

Psychotherapy Research

> "…of all forms of abuse in our time, exploiting science is the most profitable." Tor-Johan Ekeland, 1999

In the USA, the number of psychotherapists has increased by 275 per cent since the 1980s, and the use of psychotherapeutic methods has increased by 600 per cent since 1960. Today it is estimated that there are over 200 therapy models and over 400 methods that are based on these models. In the first DSM manual (1952) there were 66 diagnoses, and in the most recent (1994) there were 286 (Ekeland, 1999; Hubble, Duncan, Miller, (eds) 1999).

Today there is broad agreement that psychotherapy works and has beneficial results. It has been shown that clients who are well suited to therapy profit from therapy three times as often as less well-suited clients (Høglend, 1999). Some practitioners emphasise the client's qualities in defining what works in therapy. The claim is made that the personal characteristics of clients are of primary importance in both the therapeutic alliance and the result of the therapy. A significant number of studies indicate that the therapeutic alliance is decisive in the outcome of therapy (Høglend, 1999). This research also indicates that clients undergoing the most successful therapies respond in a positive manner early in the process (Brown et al., 1999, p. 390). The importance of the therapist as a person has been underlined by a number of researchers, but has often been overlooked in psychotherapy research (Jennings et al., 2003).

In addition, research has shown that the greatest sources of error in psychotherapy research are the researchers themselves. It has come to light, in fact, that the therapy tradition that the researcher personally supports most strongly has a clear tendency to achieve the best result in that researcher's work (Luborsky et al., 1999, p. 95). In 1975 Luborsky introduced the concept "therapy allegiance" to help understand how psychotherapy researchers results

were coloured by their allegiance to the therapy tradition they represented themselves. Luborsky et al. shows that different researchers come up with different results when they examine the efficiency of the same methods. For example, if the examined method is behaviouristic and the researcher belongs to the behaviouristic tradition, the result of the research seems frequently to be more successful than when the researcher comes from a psychodynamic tradition, and vice versa. Therapy allegiance becomes an important element when differing research results are to be explained (Luborsky et al., 1999, p. 103).

In David Orlinsky and Michael Helge Rønnestad's major research project about how psychotherapists develop,[11] therapists' perceived sources of currently experienced growth. are included. These are divided into positive or negative types of influence. When they asked therapists what experiences from personal life mean to their development as psychotherapists, 60% rate this as positive and 5% rate it as negative. When the same question is asked connected to the influence on their career development, 66% rate this as positive and only 4% as negative. Only experiences with clients, formal supervision and personal therapy are rated higher as positive influences. "In contrast to these professional factors, experiences in personal life are the next most salient among the influences to which most therapists attribute their development – ranking ahead of academic resources, such as taking courses or reading books and journals" (Orlinsky and Rønnestad, 2005, p. 137).

However, it is worth mentioning that these personal experiences are not given any content in Orlinsky and Rønnestad's research project. In a chapter on future studies they say that: "A sequel to the present report will focus on the therapists' lives and personalities and relate those to the currently reported finding on therapeutic work and professional development" (Orlinsky and Rønnestad, 2005, p. 205).

Most of the international research that is based on family therapy and psychotherapy has received little or no attention from family therapy circles in Norway. That is probably because we do not do much family therapy research in Norway and that the first masters degree in family therapy and systemic practice in Norway is a recent development.

However, about seven Norwegian research projects developed between 1980 and 2005 have served to develop the area of family therapy and systemic practice in Norway. None of these projects takes the relation between the therapist and his/her personal life into special account.

[11] The research project includes about 5000 psychotherapists from many countries and therapeutic orientations.

The Relationship between Research and Therapy

In his 1950s research on the psychotherapeutic treatment of mental illness, Hans Eysenck claimed that clients in therapy and those who had not had therapy showed the same level of progress after two years. As a result, for many years it was believed that psychotherapy played no role or had no effect in the treatment of mental illness (Hubble et al., eds 1999, p. 1; Kazdin and Weisz, eds 2003, p. 4).

As could be expected, clients, therapists, researchers and government authorities are interested in discovering whether the therapeutic activities being carried out have any demonstrable effect. Therapists often claim that they can verify the effects through their own experience, but politicians and governing bodies need to validate their subsidies with *documented* effects - knowledge based on research – preferably expressed in numerical form. Such documentation has appeared in substantial amounts in recent decades. In the 1980s, researchers even claimed that individual therapy provided effective treatment for around 75 per cent of those seeking help. This research also showed that children and adolescents who had undergone psychotherapy enjoyed greater benefits from treatment than 75 per cent of a comparable control group (Kazdin and Weisz, eds 2003, p. 439). A major analysis from the early 1990s indicates that family therapy has approximately the same result (Nichols and Schwartz, 1998, p. 504, and Carr, 2000, p. 487). It is obvious that practitioners, too, are very interested in such investigations. If one could prove that couples therapy was the most effective form of treatment for depression, then one would at the same time be justifying the form of therapy itself[12].

When research is placed on the agenda, there is a tendency to pay most attention to a discussion of research methods. This discussion often concerns whether qualitative or quantitative methods are to be given priority. Does research consist of words or numbers, and is its purpose to create new insights or to measure effects or outcome? These discussions may, at times, become irreconcilable and deadlocked. Some of the background for this situation can be found in the literature on methodology, in which there is a tendency to focus more on method than on basic assumptions. This literature deals with either qualitative or quantitative methods, or both. However, I am convinced that the scientific, theoretical basis for both research and practice comes before methodology, and that the methods that are applied in research and the results of this research should be interpreted using our basic assumptions as a starting point. From this point of view it is irrelevant whether the method is qualitative or

[12] Ref. for example Leff et al and the London Depression Intervention Trial

quantitative, or a combination of the two. It is the framework of reference for the research and the interpretation of research results that are decisive in developing insights.

Evidence-based Research

Evidence-based research deals with comparing knowledge from many different research projects about the same phenomenon or the same diagnosis. The objective is to reach a conclusion with standardised treatment procedures based on these research results. This is the research method most often emphasised as the ideal in evidence- based research. This kind of research carries the hallmark of efficacy research.

Efficacy research has six primary characteristics: (1) it occurs within a controlled laboratory clinical setting; (2) it is focused on a specific psychiatric disorder: (3) it involves at least two groups – an experimental condition in which clients receive the treatment under investigation and a control condition in which clients receive either no treatment or an alternative treatment; (4) clients are randomly assigned to either the experimental or the control condition; (5) the experimental and control treatments are specified with manuals; (6) all clients are measured at least once pre- and post therapy on standardised outcome measures. In addition, follow-up beyond termination has been added to this list (Pinsof & Wynne, 2000 p. 1).

Evidence-based Practice

We encounter the concept of evidence-based practice in many contexts. Another term for this concept is "knowledge-based practice". However, there are many types of knowledge within many different spheres, and in this connection, we are not referring to just any type of knowledge. Yet another term for this concept is "empirically supported practice". Here I use the term evidence-based practice in order to clarify the view of knowledge upon which the concept is based (Kazdin & Weisz eds 2003, p. 43).

According to this evidence-based perspective, the therapist's job is to deliver the intervention. The principle is the same as when the physician gives the patient a pill. It is the active substance in the pill that works. Similarly in therapy, it is thought to be the intervention that works. In this perspective, it is important that the therapist get the necessary training to be a scientist practitioner when it comes to making the right interventions. However, in this approach, the therapist's personal and private background is not considered important in developing this competence.

The Scientist Practitioner Model

The scientist practitioner model formed the basis for the curriculum for psychology students at the University of Bergen from 1969 (Kolbjørnsen, 2001). The scientist practitioner model is still the model for the psychology education program in Bergen, Norway.

B. F. Skinner believed that it was the intervention that determined the extent to which therapy should be judged successful. It was the method that proved effective that determined what good therapy was. Starting in the early 1950s, this viewpoint was supported by Hans Eysenck, among others. They believed that valid results could only be gleaned from research that could demonstrate effects. This goes a long way towards explaining the situation we have today. It was the behaviourists who could show scientific results, and who thus determined which standard would be used (Bachelor and Horvath, 1999, p. 134; Haugsgjerd et al, 2002, p. 125).

Fulfilment of the following three requirements are necessary in order for a method of therapy to be called evidence-based according to rigorous scientific criteria, and to be regarded as having achieved the "gold standard":

1. The approach must have been proven effective through double-blind treatments and control groups with replication in at least two independent studies.
2. The course of treatment must have been transferred to a treatment manual.
3. The treatment must have been used for a specific portion of the client group, and for specific problems, such as adolescents with depression (Larner, 2004, p. 18).

The concept "evidence-based" is found primarily within the field of medicine, where it probably originated, and is then referred to as evidence-based medicine. The claim was made that only a small amount (10 to 20 per cent) of medical practice was based on solid science (Ekeland, 1999). This was considered a serious criticism of medical practice. As an extension of this recognition, detailed manuals have been written on specific subjects, describing the procedures to be followed in treating specific illnesses. In this way, both doctors and politicians can discover what actually works, so that energy and money are not wasted on ineffectual treatments.

Research has traditionally been carried out on therapy techniques that have been utilised over a long period. After a specific technique has developed within an area of treatment, research has provided a means of monitoring and further developing the technique. With evidence-based practice, this order has been reversed. Now it is research that comes first and technique afterwards. It is only when research has determined what works that a particular

technique becomes validated within some academic traditions. Afterwards, the particular technique is initiated based on a detailed manual that shows, step by step, how one should proceed with the psychotherapeutic treatment of specific problems (Jensen, 2006). This framework around psychotherapy is constantly gaining new supporters and acceptance in new spheres. An example of such an approach in most Norwegian counties is "multi-systemic therapy" (MST), which is offered to families with problem adolescents. In its most extreme form, this form of psychotherapy endorses the viewpoint that all therapy can and should be based on research. "When taken to its extreme, we can immediately see that science then becomes ideology – that it, so to speak, oversteps its own borders by stating not only how things are, but also how they should be" (Ekeland, 1999).

Over 70 per cent of the evidence-based research connected with the treatment of children and adolescents consists of behaviouristic and cognitive treatment models. Within this tradition some attention has been paid to psychodynamic therapy and family therapy, but a number of other forms of therapy have been disregarded completely (Kazdin & Weisz eds, 2003, p. 441). Gradually, however, an increasing number of therapeutic models are being included within evidence-based research.

Within the field of family therapy, the movement for managed care in The United States has changed the landscape of research and practice. For example, both the American Psychological Association and the American Psychiatric Association have developed evidence-based practice guidelines. "These efforts have brought empirical evidence and systematic treatment models into the forefront of consideration in MFT" (Sexton, Alexander and Mease, 2004, p. 593).

There are many supporters of an evidence-based practice within the field of family therapy. In a major article presenting an overview summing up research in family therapy, Myrna L. Friedlander (Nichols & Schwartz, 1998, p. 504) only asks two questions: "How effective is couple's and family therapy?" and "What makes family therapy effective?" Using these questions as her point of departure, she discusses an extensive amount of research within a number of problem areas, examining what types of couples and family therapy work. In this research, the effect of different types of couple's and family therapy is measured in relation to various problems.

Using the same approach, Irish psychologist Alan Carr states, "…it is expedient to review research on the effectiveness of treatment with reference to the prevailing medical-model framework" (Carr, 2000, p. 488). In this connection, he refers to the American (DSM

IV-TR) and international (ICD 10) psychiatric diagnostic systems. Using this as his point of departure, he demonstrates that there exists evidence-based practice based on family therapy that has an effect with regard to physical child abuse and neglect, behavioural and emotional problems in children and adolescents, and psychosomatic problems. Further, he focuses on research as a basis for an evidence-based practice with regard to marriage and marital problems, psychosexual problems, anxiety disturbances, disturbances of affect such as depression, psychotic disturbances, alcohol abuse, chronic pain and neurological impairment of the elderly, such as in Alzheimer's disease, in the context of the family (Carr, 2000). A relatively recent example of this type of research was the manual developed by Elsa Jones and Eia Asen (2000) for couple's therapy when one member of the couple was suffering from severe depression. This manual was part of Julian Leff's research project, the London Depression Intervention Trial (Leff et al, 2000).

Psychotherapy research indicates that couple's and family therapy is not harmful, and does not result in an increase in problems for the people who take part in it. No studies indicate that people who participate in therapy are worse off than members of control groups who do not do so (Dallos & Vetere, 2005).

How Can We Understand what "Works"?

In order to help us understand the difficulties we confront when we ask questions about what works, Stephen Soldz and Leigh McCullough use the following two examples:

1. Imagine that you are sitting across from a man who is desperate. He insists that he wants to go home to his room, get a gun, and kill himself. He is not joking. You are his therapist, and are yourself on the brink of panic. That day and in the subsequent weeks, you take action in a number of ways in hope of saving his life. After a great deal of worry and several sleepless nights on your part, the man calms down, and the life-threatening phase is over. You feel relieved, and you know that you have contributed to helping him through his crisis. You have a vague idea of what you did, but it would be difficult for you to point to precisely what the deciding factor was. However, you are sure that you saved his life.

2. Imagine that you are sitting at your computer and analysing data from a course of treatment, which has taken many years to collect. It deals with a particular therapeutic intervention that you have spent months defining precisely so that researchers can register what occurs. The only thing that the research shows, however, is that your hypothesis is not supported by the numerical material. The result is the opposite of what you expected. Although this may serve as a contribution to science, it may also be linked to the fact that clinical

knowledge often comprises intuitive and personal knowledge that cannot always be captured through traditional research methods (Soldz & McCullough, 2000, p. 3ff.).

When we ask about "what works" in psychotherapy, we are reminded that psychotherapy is often compared with the effects of chemicals from the pharmaceutical industry. In other words, we are invited to use the same rhetoric about psychotherapy as we use to describe chemical effects. The question has been raised as to whether it is possible to capture the essence of systemic family therapy through the evidence-based model. Glenn Larner, for example, claims that a distinctive feature of systemic family therapy is its process orientation and relation orientation, and that it is thus impossible to recreate in a manual a course of therapy that can be repeated by others. Thus, at present, systemic family therapy will be "unable to join the evidence-based club" (Larner, 2004, p. 20). Many will disagree with this. Peter Stratton in Leeds has designed and used manuals and as mentioned earlier, Elsa Jones and Eia Asen created a manual in The London Depression Intervention Trial in which are made many references to evidence-based family therapy practice (Carr, 2000; Stratton, 2005).

In 1977, Smith and Glass showed, using meta-analysis, that different therapeutic approaches have nearly the same result with regard to the effect of therapy. They thus confirmed what Rosenzweig had suspected as early as 1936. Today there is broad consensus that little or no difference can be ascertained in the results of different types of therapy. This is called the "dodo effect". The metaphor originated in *Alice in Wonderland*, where the dodo bird decides the results of a race by saying, "Everybody has won, and all must have prizes." Wampold concludes that the research that has been carried out in the past 30 years indicates that there is little or no difference between forms of treatment (Wampold, 2001, p. 118). This acknowledgement has made it possible to emphasise the "common factors" that are present in therapy. Such factors were highlighted by psychotherapy researchers over 40 years ago (Ekeland, 1999; Wampold, 2001, p. 22).

The American family therapists M. A. Hubble, B. L. Duncan and S. D. Miller (Hubble, Duncan, Miller, (eds) 1999, p. 8ff.) claim, taking their point of departure in the works of Michael Lambert in 1992, that research has identified four "common factors" that are present in all forms of psychotherapy regardless of theoretical orientation (psychodynamic, cognitive, etc.), mode (individual, group, couples, family, etc.), dosage (frequency and number of sessions), or speciality (problem type, professional discipline, etc.). These four common factors are the following:

1. The therapeutic relationship

2. Expectancy (placebo effects)
3. Techniques
4. Extra-therapeutic change

In judging what contributes to change, they maintain that these four factors appear in about the following proportions:

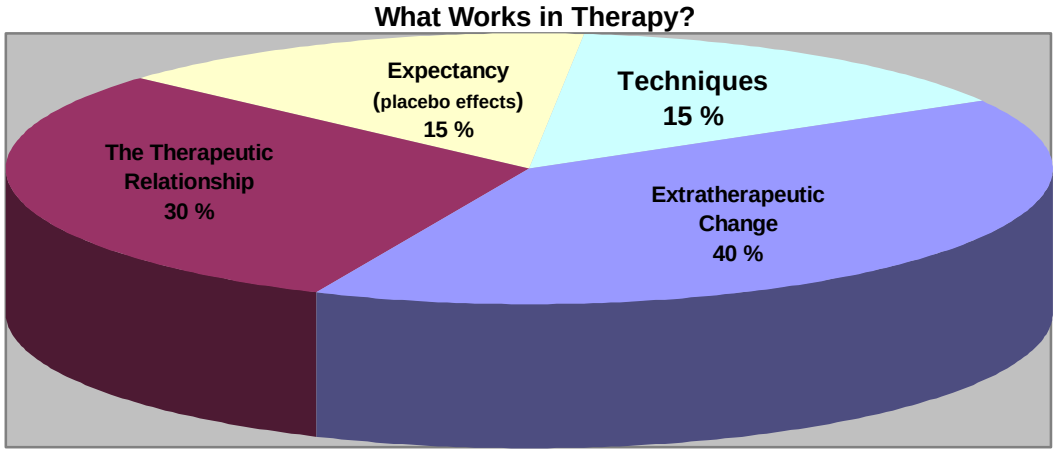

Table 1: The Heart & Soul of Change, p. 31

They maintain that these proportions apply regardless of the therapy tradition and choice of methods. The weights given to each sector, however, are not based on research (not evidence-based), but are estimated by Lambert on the basis of experience and visual inspection (Beutler et al., 2004, p. 282). Based on meta-analyses however, Beutler et al. claim that the weight of therapeutic relationship is less than 10 % (Beutler et al., 2004, p. 282).

It is remarkable to make the claim that only 15 per cent of the therapeutic effect can be ascribed to therapeutic techniques when the evidence-based model seeks to demonstrate which therapy techniques have the best effect on specific mental illnesses.

Seen in this light, it could seem as though the rivalry between therapeutic schools of thought and the therapeutic tradition's emphasis on its own excellence are somewhat exaggerated. However, there is no indication as to how these percentages have been calculated or determined. However, supporters of "common factors" use them frequently as a framework for understanding psychotherapy. The 1999 book *The Heart & Soul of Change*, subtitled *What Works in Therapy?* (Hubble, Duncan, Miller, (eds) 1999), can in many ways be seen as an entry in the debate on what is called "managed care" in the USA. American health-care institutions and insurance companies give priority to evidence-based forms of treatment. The book

gives a comprehensive presentation of research that focuses on "common factors" as a framework of understanding.

When the common factors approach is the basis for education and clinical practice, the therapist's personal and private background are important in understanding clinical practice. If the therapist as a person and the relation to the client is part of what "works," it will also be important to focus on this aspect in both education and practice.

Alan Carr points out that among family therapists who base their work on constructivism and social constructionism; there is considerable opposition to a unilaterally evidence-based practice. He also points out that family therapy and systemic practice are based on a fundamentally different viewpoint than is evidence-based practice (Carr, 2000, p. 487). Nevertheless, we shall also see that the arguments against an evidence-based and medical model can be found in psychotherapy research.

The Therapeutic Relationship and What does the Therapist Bring?

The relationship between therapist and client represent the core of the matter, *in medias res*[13]. The relationship between therapist and client is one of the common factors that are most frequently mentioned in the literature on psychotherapy (Asay and Lambert, 1999, p. 33; Wampold, 2001; Skovholt and Jennings, 2004; Lambert, 2004; Orlinsky and Rønnestad, 2005; Simon, 2006; Blow, Sprenkle, and Davis, 2007). The relationship between therapist and client has been discussed since Freud developed psychoanalysis. Freud operated with three central aspects of this relationship:

1. Transference: the client's subconscious ascribes to the therapist characteristics held by people in the client's past life.
2. Counter transference: the therapist's subconscious ascribes to the client characteristics held by people in the therapist's past life.
3. The client's friendly and positive linking of the therapist with benevolent and friendly people from his or her past.

Humanistic psychology, such as that described by Carl Rogers, introduced an alternative to these models by perceiving the therapist-client relationship more as an existential meeting between two people than as a meeting between an expert (the therapist) and a patient (the client). The therapist had to be empathetic, authentic, and able to show unconditional positive regard (Bachelor and Horvath, 1999, p. 134).

[13] Into the middle of a narrative; without preamble.

The field of family therapy has been, and remains, influenced by the fact that viewpoints on this issue cover a wide range of positions. At the two extremes of the continuum, we can mention Richard Fisch at the MRI, who said,[14] "Only two things are important: finding out exactly what problem the client wants solved, and then solving it. Everything else is bullshit," and on the other side Tom Andersen, who prefered to refer to "conversations" rather than psychotherapy, and believed that we must liberate ourselves from all theories and methods (Andersen, 2002).

Research does not tell us much, for example, about how we can train good psychotherapists. Høglend claims that there is nothing that indicates that a psychologist or psychiatrist with many years of education, who has undergone therapy, and who has long experience, achieves better results than a social worker or psychiatric nurse with less training and experience (Høglend, 1999). In their standard work on evidence-based psychotherapy for children and adolescents, Alan E. Kazdin and John R. Weisz claim that research on what helps therapists to establish a warm and empathetic relationship in their therapy is inadequate. This situation is surprising, since most people believe that the quality of the therapeutic relationship among children, adolescents and their families is a decisive factor in the success of the therapy. It is also often the case that children ascribe the greatest significance to their relationship with the therapist. Despite this, only a modest portion of the research being conducted is devoted to these aspects directly (Kazdin and Weisz eds, 2003, p. 443). On this basis it seems reasonable to claim that, "Altogether, this indicates that research should be directed towards (…) the development of therapists" (Rønnestad and Skovholt, 2003).

The therapeutic alliance between therapist and client or family has, however, received attention in several research connections. Wampold uses the alliance between therapist and client as a good example of the general effects of psychotherapy. He emphasises that research shows that relations between client and therapist play a key role in therapy, and that this is a necessary feature of therapy regardless of the specific type of therapy in question (Wampold, 2001, p. 158).

In order to emphasise this, he also points out that the therapist's belief in and faithfulness to his or her own professional convictions are communicated to the client through the therapist's own enthusiasm (ibid. p. 183). Wampold concludes that the therapist is a part of the therapy, and cannot be detached from it. "Clearly, the person of the therapist is a critical factor in the success of therapy" he states (ibid. p. 202).

[14] In a conversation with the author at the MRI in autumn 1997.

In order to bridge the gap between the evidence based model and the common factor model Simon (2006) suggest that we should bring the therapist to the centre of the discussion. The consequence for family therapy education programmes should be to help the student find the way to the family therapy model that is in tune with the therapist's world view and cultural background.

The consequence for the understanding of practice should be "… that the route to maximum effectiveness for any therapist is to experience the therapy that he or she does as being "his" or "her" therapy, a mechanism for self-expression of his or her deeply held view of human condition" (Simon, 2006, p. 343). However, it might seem that Simon does not include in his understanding of how therapists develop that also their "deeply held view of human condition" develops and changes. On the other side, Simon (2007) claims that his model needs much more research to develop and to conclude.

In an article about the role of the therapist in common factors (Blow, Sprenkle and Davis, 2007) the question is asked if who delivers the treatment is more important than the treatment itself. They conclude by saying:

> "…we believe that an intensified focus on the role of the therapist in change is warranted. Such a focus would include therapist inherent and learned qualities, how therapists think and make decisions in therapy, and how therapists choose to shine light on some things but not on others so that therapy moves forward and deepens" (p. 313).

Summary

To understand the lack of research on the connections between therapist's personal lives and their professional practice, I have shown how the idea of evidence-based practice and evidence-based research has dominated psychotherapy research. The idea of evidence-based practice excludes the therapist's personal and private life from the field of interest in understanding the therapeutic process. However, some of the critiques of evidence-based practice claim that it is necessary to include the therapist as a person in understanding the therapeutic process.

Views of Psychotherapeutic Education

The relationship between the therapist and the client has been a theme since Freud developed the psychoanalytic model. Early on, personal therapy as part of qualifying as a practitioner of psychotherapy came to be a part of psychoanalytic training (Kringlen, 1972, p. 418).

From Theory to Practice and Back Again

The first part of the following discussion is connected to reflections on how it is possible to keep the split between what "every schoolboy knows" and what we do in family therapy training. The starting assumption for this project is that personal experience and knowledge are decisive in the formation of family therapists. I want to examine what aspects of personal experience have a major influence on clinical practice and how this understanding can find a relevant place in family therapy teaching.

Patricia Benner (1984) claims that experience that leads to change of practice by an experienced clinician seldom is useful in a direct way for others. This is among other things connected to the point of view that the complexities of the experience make it inaccessible or impossible to transmit to others by means of theories and explanations. She claims:

> "However, many paradigm cases are too complex to be transmitted through case examples or simulations, because it is the particular interaction with the individual learner's prior knowledge that creates the "experience" – that is, the particular refinement or turning around of preconceptions and prior understanding" (Benner, 1984, p 9).

However, these clinicians can tell stories as "paradigm cases". In this way, the stories may be told as important narratives both by the storyteller and the listener. These types of narratives form some patterns that can help us understand the process we have to go through on our way from novice to expert. A major part of clinical practice remains outside the narratives or the stories we can share in an oral form. The analogue part of communication that is connected to body language and moods cannot be fully passed into a story told. This is an aspect of knowledge that can be captured only within our own experience (Kottler and Carlson, (eds) 2002).

The Relation Between Modernistic and Constructivist Educational Theory

To look into the relationship between modernistic and constructivist educational theory in family therapy education I will look at what is called "The Linguistic Turn" (Buur Hansen, 2000 p. 68). Most teachers in the field of family therapy come from social work, medicine, psychology and other health professions. That means that very few if any, have a background from pedagogy and from theory connected to curriculum development.

Norwegian educational politics have during the last decades moved towards standardization and formalization (Jensen, 1999). Like the rest of the western world, Norwegian educational politics have been caught in a logocentric tradition of knowledge. This means that our

education programmes have been characterized by a strong belief in the superiority of "learning outcomes" that is abstract and without context. This superiority is also emphasized and connected to the solving of practical problems. To illustrate this point I will mention clinical training in nursing and family therapy in higher education in Norway. Although the Ministry for Health demands practices to be a part of nursing education, they do not get any academic credit for clinical training. That means that students that go into a clinical education program like nursing have to do much more work to get the same credits as other students. It is even more important that practice still does not seem to get recognition in the academic field.

In family therapy education, we are allowed to include practice, but we have to build traditional academic programmes and all clinical practice and supervision come as extra work for these students.[15] "From this way of thinking the scholastic model is brought out and made into a moral standard for all education, as well as the occupation- and profession related educations" (Jensen, 1999, p 6).

In the prolongation of this way of thinking, a division has occurred between the place in which knowledge is applied and the place in which knowledge is picked up in Norway. The distance between university on the one hand and working life on the other are growing. The kind of knowledge we can only acquire through practical work has little or no room in the academy today. This has moved us towards a narrow definition of our view of knowledge. At the same time, this process has led to a rise in status of many educations and professions. A somewhat contradictory example is that medical doctors and psychologists get most of their clinical training through their Norwegian unions ***after*** they have finished academic training. The Norwegian Government recognises these training programmes.

Personal Knowledge

As a part of this development, many forms of knowledge have lost priority or been totally lost inside our Norwegian educational system. One kind of knowledge that in many ways has lost priority or has never established its own domain is ***personal knowledge***. Michael Polanyi emphasises this knowledge and the pursuit of "… an epistemology of personal knowledge" (Polanyi, 1958, p 255). Jeff Faris refers to Donald Schön when he argues that:

> "The relationship between the personal epistemology embodied in therapists' practice and the discourses of espoused theory about therapy seems central to this process" (Faris, 2002, p 92).

[15] In 2003 there was a reform of higher education in Norway resulting in the establishment of bachelor -and master degrees. In this reform clinical practice and supervision will for the first time became a part of an academic degree.

Inside the field of family therapy education in Norway, this kind of knowledge is almost lost, or we find only fragments of it. It is the aspect that forms the "personal epistemology embodied in therapists' practice…" in family therapy education I want to put into focus in this research project.

In recent years, we have seen a shift in the view of knowledge and learning. Many alternatives to the logocentric model have emerged. Today we see examples of the pendulum swinging in the opposite direction in the discussion on education. Some emphasize the work place as a main field for learning. Others emphasize practice in a way that suggests it is the only field of knowledge that carries weight. From my point of view, a major challenge remains for the university and the practical field to work together in an educational process to benefit the individual student.

From my point of view as a Norwegian family therapy trainer working in a university college, we need to find models that address the whole educational process. Jean Laves' theory about what simulates learning (Akre and Ludvigsen, 1999) and Hubert and Stuart Dreyfus' theory about intuitive expertise (Dreyfus and Dreyfus, 1987 and 1989) are examples of such models. Based on one of these new models I will in my research illuminate and discuss the space ***personal knowledge*** has in family therapy education and discuss how a new curriculum can be built.

Psychotherapeutic Education

In the field of psychotherapy we find many different schools (cognitive therapy, behavioural therapy, psychoanalytic therapy, gestalt therapy etc.) and some of these schools do not require personal therapy as a part of their education programmes. Although psychotherapy research shows that the schools of psychotherapy have roughly the same "effect," some of the psychotherapeutic schools that do not require personal therapy or reflection on our own family background, as for example cognitive behavioural therapy, traditionally claim to have the most effective tools in psychotherapy (Haugsgjerd et. al, 2002, p. 124).

Psychotherapeutic education traditionally consists of a blend of theory, clinical practice, supervision and going into personal therapy. When the first family therapy educations started in Norway in the beginning of the 1970s this model was followed. At this time the education program was not particularly well defined or theoretically delimited. Part of the program concerned traditional psychiatric knowledge and some of the theories and methods were not aimed at working with families. In the beginning of the 1980s systems theory and

family theories received greater space in the education program. Some of the students started asking challenging questions about the need for going to therapy as a part of the program. Their experience was that their personal therapists had a different theoretical approach to what they had learned in the theoretical part of the family therapy program.

These "personal therapy" therapists were, as mentioned earlier, for the most part individual therapists in private practice that had a psychodynamic or psychoanalytic base. Some students felt that psychodynamic or psychoanalytic therapists undermined the theoretical basis for the family therapy training and that the demand for going into this kind of therapy diluted this training. This conflict of models caused confusion for some students. One of them wrote a letter in the mid-1980s to the board and asked to be exempted from this part of the education program. The board discussed this application and this issue and decided, not only to accept his application, but to remove personal therapy as a part of the whole education program. Today we have several family therapy education programmes in Norway. Only Diakonhjemmet University College has Personal and Professional Development work as a part of the program, beginning in the fall of 2004.

Even in the field of family therapy, some traditions emphasise family of origin differently from others. In 1987, Lieberman wrote: "A search of the literature reveals a paucity of material which discusses the issue of going back to one's own family of origin. The seminal article was published anonymously (1972) at first…" As mentioned earlier it became apparent that Murray Bowen wrote this article and that he had presented this material at a research conference in 1967.

It has to be taken into consideration that most students in these educations have a great deal of experience and come from different fields in health and social work. The emphasis will be on the meaning of personal knowledge and personal experience as elements in the process. Personal experience and knowledge will be extracted from both private and professional fields. Most of the students at for example the Master program at Diakonhjemmet University College are between 35 and 50 years of age when they start. This means that most students are established with work, family and children and in life cycles where leaving home for longer periods to gain further education demands great expense for family life and for their professional and economic life. About two thirds of the students are women. Saying this however, it is good to be reminded of Bernard Shaw when he says that twenty years of experience can be one year's experience repeated twenty times and that wisdom does not necessarily correlate with chronological age.

Transference and Countertransference

The psychoanalytic ideas of transference and countertransference encompass the idea about links between professional practice and the therapist's personal and private life (Haugsgjerd et al, 2002). Transference represents the client's endeavour to give meaning to the therapy through resuming conflicts and feelings from childhood in therapy sessions and the therapy process.

Countertransference, however, represents how a therapist that can be stuck because of transferring ideas about the client based on the therapist's own experience. Countertransference is basically a therapist's counter- reaction of own repressed feelings to the client. This is viewed as a challenge it is necessary to overcome in therapy. It may, however, also be viewed as beneficial in some situations because it provides empathy with the client.

The Feminist Perspective

We often say that it was feminists who first articulated that the personal was political. After this statement it was difficult to preserve the separation between the private and the public domains of experience and learning. It was even more difficult after this to officially maintain the separation between a discipline and the person who practises the discipline. This matter is closely linked to my research aim of explaining how personal and private experiences can influence clinical family therapy practice and how clinical family therapy practice can influence personal and private life.

It is common in the field of family therapy to accept that it is impossible to take on a neutral position. From the end of the 1970's feminists have represented a strong voice in the family therapy field (Nichols and Schwartz, 1998, pp 326 ff). With stamina and intellectual power, they have continually reminded us that there are two genders in the world and that power in our society is unevenly distributed between them. They have clearly pointed out that family therapists who keep their eyes shut to this perspective on reality refuse to take the distribution of power in our society seriously. Thus they are at risk of serving one particular political interest. For example, in areas connected to violence in couple- and family life, feminists have influenced the field in a very fundamental way. The last twenty-five years have seen the establishment of shelters for battered women all over Norway.

Systems theory and family therapy have ignored the issue of gender to a certain extent. It is claimed that this is connected to the types of system definition that leave out culture, history and gender from the understanding. For example, Selvini Palazzoli in 1978 defined the family as "a self-regulating group system which controls itself according to rules formed over

a period of time, through a process of trial and error," Rosine Jozef Perelberg points out that this perspective has some specific consequences. "The family becomes not only asexual but also ahistorical" (Perelberg, 1990, p. 35). In this understanding of systems theory the person, with his or her specific history and culture, was in danger of disappearing.

It is also emphasised that circular causality has led family therapists to look at complementarity in relationship rather than viewing problems in terms of someone being oppressed or as a victim (Burck and Daniel, 1990, p. 83). Feminism can be seen as an extension of the systemic perspective so it will be possible to include an understanding of gender, power and oppression and whether "victims" want to be described as "victims".

The gender perspective is, however, still differently emphasised by family therapists. Some claim that gender seldom or never comes forward as a topic in clinical work. That point of view has also been linked to the influence of systems theory. Thelma Jean Goodrich says:

> "Systems theory is so abstract that it can provide a seemingly coherent account of family phenomena while leaving out significant variables, i.e., power, gender, and the link between the two. Since systems theory focuses entirely on the moves rather than the players, who has power over whom, and with what regularity, never has to be noticed" (Goodrich, 1991, p. 17).

As I see it, systems theory is a meta theory and there is nothing in it that asks us to exclude political contexts. Rather it allows for examination of system levels. Others claim that the gender perspective is superior in all clinical work, and that the therapist has to include gender in their understanding in meeting families; the question is only one of how (Burck and Daniel, 1995, p. 19).

Within feminist theory, it is not usual to talk about women and men, but about the feminine and the masculine in our culture (Burck and Daniel, 1995). In this way, we can avoid linking all explanations and patterns to a single man or woman. Inside this frame, the feminist project tends to deconstruct science and theory as explanations created by men to continue their power over women. The feminist project is primarily to uncover the repression of women.

It is very important to remember that knowledge of women and men deals with women as a group and men as a group and that what characterizes these groups does not need to be relevant for one particular woman or man we might meet in the therapy room. In this context, the knowledge about women as a group and men as a group works in the same way as knowledge of black and white people as groups. The knowledge belongs to the group level and if it is used in meeting one particular human being, it will function as a bias. In our en-

deavours to be politically and culturally correct, we have to avoid overlooking the individual woman or man we do not recognise within this general knowledge of women and men.

Thelma Jean Goodrich draws out the connections between feminist ideology, family therapy and the therapist's personal and private life when she says:

> "To increase our abilities to empower women in therapy, we consider using resources and methods perhaps not previously familiar to us – men's groups, couples' groups, women's groups, study groups, individual therapy, and our own therapy. This extending of ourselves is necessary, but narrow in focus. How much can we expect that psychology of the oppressed to change until the condition of the oppressed is changed? Is there any integrity to our working in therapy to empower women if we are not also engaged in social activism? (Goodrich, 1991, p. 33).

The feminist view will also have some consequences for how we plan and implement family therapy education. By focusing on sex role, power and oppression, it will put forward questions about how relations between men and women can be understood. Relations between men and women will occur both in the lecture room, in supervision and in clinical practice.

> "Exploration of sex-role stereotypes and expectations as they impact on the experience and work of both trainees and supervisors early in family therapy training will assure greater competence and comfort for women clinicians throughout their careers in a field that places special demands on them" (Caust, Libow and Raskin, 1981).

Emphasising what often are seen as female culture and feminist values has changed aspects of educational programmes and clinical practice and opened for more sensitivity and action especially concerning the physical and psychological oppression of women. It has also opened up for a more intuitive and experience-based practice. In one of the important books about feminism and family therapy from the 1990's Lucy Papillon claims:

> "My interventions with clients are almost always instinctual on my part… I lead from my intuition and go from my heart into their hearts. I believe that we must teach ourselves to hear with our hearts. We must learn to understand with our intuition, with our higher wisdom, not with our minds, or with our necessarily biased intellect" (Papillon, 1991, p. 247).

Some will probably say that Papillon takes it too far by denying mind and intellect as the basis for clinical practice. On the other hand, she opens up a wider definition of how to understand the frame for describing clinical practice.

In an article from 1991, Virginia Goldner points out that both feminism and family therapy are in transition (Goldner, 1991). She points out how post-modernism challenges both traditional "feminist" ideology and the concept of "family therapy". She also emphasizes that

feminism is a corrective to parts of post-modernism. Feminism will for example represent particular values that will always challenge aspects of the relativism embedded in parts of post-modern theory. It will be an important part of this research project to examine if such values are a part of what governs therapists in their clinical practice.

Multicultural Perspectives

Cultural perspectives are closely linked to this research project through the focus on the therapist's own cultural background. Such a focus can increase our awareness of our cultural biases. It is important to point out that social science theories are formulated largely in the cultural context of Western Europe and white North America (Tamasese and Waldegrave, 1993). Family therapists have taken four positions to include cultural variables in clinical practice. These are the universalist position, the particularist position, the ethnic-focused position and the multidimensional position (Falicov, 1995).

The universalist position states that families are more alike than they are different. Most family therapists would probably agree that families in general support their children with love, cultural discipline and care. But the universalists go much further. They claim that all families or emotional systems are basically the same and that they always have been. In this perspective there is little need for cultural training. From this perspective it should not be necessary to reflect on the possible links between one's own cultural background and one's clinical work.

The particularist takes the opposite position. They state that all families are more different than alike. They avoid any generalization and claim that each family is unique. This is very much the same view as that every person is unique. Culture is something that changes from family to family and this makes it unnecessary to focus on a larger culture.

The ethnic-focused position agrees that families differ, "but assumes that the diversity is primarily due to one factor: ethnicity" (Falicov, 1995, p. 374). Falicov claims that this position has been enormously influential in developing sensitivity to cultural differences. The limitation, however, is that this position is based on a view of members of ethnic groups as much more alike than they might well be. This can lead to generalizations that may disturb contact between the family and the therapist because the therapist may think he knows when he or she actually does not know.

The multidimensional position seeks to address the complexities of culture. In that way the multidimensional position differs from the three others by going beyond the one-dimensional definition of culture. "A fundamental objective of the multidimensional compara-

tive framework is to *take culture into the mainstream* of all thinking, teaching, and learning in family therapy" (Falicov, 1995, p. 377). Two of the four parameters Falicov identifies are family organization and family life cycle.

Families are organized differently in different cultures. It is important to understand the diversity in family organization and to keep in mind that we all are members of such an organization. Kiwi Tamasese, and Charles Waldegrave (1993) claim that when the therapist is of the same culture as clients he or she is "...more likely to understand and facilitate the strengths of families of those cultures as they attend to the stresses that bring them into therapy." According to them this is a matter of accountability and family therapists need such accountability.

Family life cycle theory is a compulsory part of most family therapy education programmes and of most family therapists' professional considerations. Most family life cycle theory reflects an Anglo-American urban middleclass lifestyle from the 1950s to the current day. Most of this theory will not offer much meaning in a different culture such as for example in Fiji or in many other Asian cultures. But it is a useful framework to explore our own western model. In this tradition the supervisees have to make and work on their own cultural genogram (Pedersen, 1982; Hardy and Laszloffy, 1995). These processes also challenge what is typical in the present group and for ourselves and our clients. This will also help us to discover the culture-bound nature of our theories and techniques (Falicov, 1995, p. 386). This perspective is important because it includes personal aspects when it is used as a tool in clinical training. It means that one deconstructs one's own ethnicity rather than taking it as the reference point for understanding others, and can appreciate difference as a relational contrast rather than as a property of the other.

Self Disclosure and Challenging Encounters

Reflexivity and self-reflexivity connected to self-disclosure are closely connected to my research. Therapy constitutes arenas for self-disclosure. Personal and professional themes and self-disclosure meet in the same arena, in therapy. However, there is not much research in this field of family therapy (Protinsky and Coward, 2001; Hurst, 2001; Roberts, 2005). When it comes to the question of how to handle self-disclosure in the therapy room Janine Roberts says:

> "Little attention has been given in models of family therapy to guidelines about disclosure, or how social identities are intertwined with disclosure. Therapists, trainees, and supervisors have a responsibility to try to ensure that disclosures do not create a

> prejudicial experience for clients. What creates enough safety to share personal aspects of social identity? What constraints exist? Further, there has been minimal focus on what it means in teaching and supervision to intentionally crisscross private and public boundaries" (Roberts 2005, p. 47).

Janine Roberts tells a story that illustrates how clients need protection from unsafe disclosures from therapists. She tells about a commonly used training video where the therapist works with three generations of an Anglo Mexican family. It concerns an 8-year-old girl who usually lives with her grandmother and her great-grandmother. The girl's mother expresses guilt and frustration. She would like to see her daughter more often. The mother's economic situation is also poor. The therapist stresses that the mother has to take charge of the family and do this in communication with all participants, and then shares a story from his own life. According to Roberts, the therapist says: "My daughter lives with my wife and me all the time so we can make the decisions for her." This disclosure highlights the differences in social class between the therapist and the mother in an inappropriate way and it gives the client a number of points on which to feel criticized and oppressed. In this example, self-disclosure functions in opposition to the feminist view of it as a step towards a more democratic direction for therapy (Roberts, 2005, p. 46).

In an investigation of seasoned marital and family therapists Howard Protinsky and Lynn Coward point out that:

> "Little has been published regarding the development of therapists during their professional careers. ... The main developmental theme that emerged was the integration of their personal and professional selves" (Protinsky and Coward, 2001, p. 375).

They say that it is typical for seasoned therapists to claim that… "a good therapist must have the self-awareness and self-assessment to integrate personal life experiences into their professional work" (Protinsky and Coward, 2001, p. 377). They claim that after about ten years of clinical practice, therapists seem to have integrated their personal and professional selves in a way that benefits the therapeutic process (ibid p. 382). "Synthesis of the personal and professional selves manifests itself in the boundaries between therapist and client, between educator and trainee" (ibid p. 382). In this way, the best of this integrating process reaches both the clients and the therapist. To sum up the topic of self-disclosure in family therapy, I will quote Roberts:

> "Therapy is a ''dialogue between degrees of transparency … and reflectivity.'' ... And each of the life journeys of a client and a therapist - their ''vessel''- is illuminated in

quite different ways. But the core of the therapeutic work is the human connection that comes with the reflective possibilities between lives" (Roberts, 2005, p. 62).

Self-disclosure can also be used in a more political sense. Self-disclosure will offer a more democratic therapy room where the participants no longer retain hierarchical positions. Some feminist family therapists use it this way and Janine Roberts claims:

> "Feminist therapists advocate directly for self-disclosure … This is in keeping with their high value on demystifying any types of therapy, increasing collaboration, decreasing hierarchy, affirming shared and diverse experiences of women, and acknowledging power differentials" (Roberts, 2005).

With inspiration from Maurizio Andolfi in Rome, Russel Haber points out that there is a risk of personal involvement in the therapeutic relationship. He claims that the therapist could become undifferentiated in the system and lose perspective with the result that the therapist can feel unable to intervene in a proper way (Haber, 1990, p. 377). Situations like this may occur when the therapist enters into families and clients who match the therapist's own bad experiences or problematic life topics. It can be connected to alignment or distance with regard to sexual topics, emotional expressions, dogmatism, timidity, over-responsibility, religion, political statements or other troubling personal topics for the therapist (ibid p. 375). He points out that when either the therapist or the family become overly anxious they can start to exchange repetitive behaviors. These kinds of repetitive behaviors may prevent change. He quotes Carl Whitaker when he says: "If this therapeutic impasse persists over time, "an unhappy bilateral symmetrical dance" occurs in which each of the members of the therapeutic system becomes rigidly defined in relation to one another" (ibid p. 377). This situation could lead to the therapist, the family and the identified patient being trapped in a pattern which excludes change.

Focusing on this area should develop the self of the therapist and expand opportunities in clinical work. The goal of this kind of work is to help the trainee both to engage and separate more clearly and flexibly within the therapeutic system (ibid p. 383). This should probably be a more focused area in supervision both for inexperienced and experienced therapists.

Summary

In this section, different views of psychotherapy education have been presented and the differences between modernistic and constructivist views of psychotherapy education discussed. The meaning of personal knowledge is viewed in for example feminist and cultural perspec-

tives. Self-disclosure is presented as one element in introducing the therapists personal and private life in the therapy room.

Views of the Necessity of Working with One's Own Family in Family Therapy Training

Several attempts have been made to find ways to work with the relation between personal and private background and psychotherapy. Cross and Papadopoulos (2001) point out that our own family, culture, gender and ethics, are four areas to focus on. In this literature overview, I have chosen to divide the literature connected to the views of working with our own family in family therapy training into two main topics connected to my research question. These are "the therapist's own family of origin" and "contemporary life".

Three points of view emerged from my reading of this literature and from conversations with colleagues in the field of family therapy. These three points of view are relevant for my project and for the subsequent analyses. The three points of view (see below) are connected to how the family therapy literature discusses and views the patterns that connect family therapists' personal lives with their clinical practice. I will discuss these points of view under The Therapist's Own Family of Origin.

The Therapist's Own Family of Origin

In "Family of Origin as a Therapeutic Resource for Adults in Marital and Family Therapy: You Can and Should go Back Home Again" (Family Process, 15, 1976) James L. Framo (1976) argues that this turn home is necessary in therapy. I will consider if the return to home also could be meaningful in the developmental process of becoming a family therapist. There are three relevant points of view:

1. Our own family of origin is irrelevant to clinical training.
2. Working with one's own family is optional.
3. Working with the relationship between our own family and clinical practice is compulsory.

Working with Our Own Family of Origin is Irrelevant to Clinical Training

In modernistic thinking and positivistic research the idea of neutrality and objectivity is central both to understanding practice and as a guideline for clinical practice. From this perspective our own family can be viewed either as irrelevant or as a disturbance. In cognitive behavioural therapy (CBT) working with our own family is not a part of clinical training. These

therapists take the stand that it is the therapeutic intervention that works. Therapists need to be well trained to deliver the interventions, but the therapist's personal background and culture does not influence the therapeutic intervention. Jennings refers to Daws, who is one of the critics of the notion of the therapist as an expert, and Jennings notices that according to Daws the experts simply exist. Jennings refers to Daws' claim that "the experience level of the therapist was not a significant factor. Daws claims that the effects of therapy and counselling are almost entirely determined by the client" (Jennings et al., 2003, p. 60). This builds on the idea that change as a therapeutic effect is only a result of the client's personal effort.

In the psychoanalytic tradition the idea of the therapist as a neutral medium for the patient's transference demands that the therapist clarifies his / her relationship to their own family history. This work should be done to keep neutrality through therapy and to manage transference from the therapist to the patient.

Strategic Family Therapy

In "Teaching Family Therapy" (Draper et al., 1991) working with one`s own family is not mentioned as a topic at all. Jay Haley and the strategic family therapy tradition do not view the therapist's own family as relevant. In Haley's book about learning, and learning the teaching of family therapy from 1996 is the claim that if trainees' biases should cause problems in therapy these should be dealt with in supervision. Personal therapy is not the solution, he remarks (Hildebrand, 1998, p. 3). As mentioned earlier, Richard Fisch at the Mental Research Institute in Palo Alto, claims that the Brief Therapy education program supports the same viewpoint. In a brief comment on my project, he responded[16]:

> "In any of the training I do, I do not use the concept that a therapist can be more effective in examining his family of origin. That concept implies that current problems stem from earlier experiences, e.g. within the family. This is a very different model (concept) than what I find useful in problem resolution. That model explains problems as a result of persistence by the client in attempting to resolve his/her problem by methods that continue to fail to resolve the problem, what we call 'the Attempted Solution'.
>
> As you can see, such an explanation would find 'the past' as irrelevant as well as the notion that one's problem is a reflection of an enduring influence by others in the past. Those concepts are much more related to earlier methods of 'family therapy' developed by Virginia Satir and Murray Bowen, among others. They differ from the 'Brief Therapy' model also in retaining the idea that current problems reflect psychological or social pathology, e.g. 'the dysfunctional family'. We discarded the notion of

[16] He sent this email in spring 2004 after I asked him for response to my research idea and he has consented to its publication.

pathology altogether since we did not see that it was useful and, in fact, prolonged therapy unnecessarily. I hope all this clarifies my position and I appreciate your interest in what we have been doing."

Working with Our Own Family is Optional.

The Trainee's "Trigger" Family

Monica McGoldrick (McGoldrick, 1992) writes about the meaning of working with the relationship between personal life history and clinical casework as a part of family therapy training. She states that: "There is much need for research to determine the value of work on the therapist's own family in training" (ibid p. 19). Here I will point out three topics from her article that I find important and interesting because they are directly linked to my research question.

The first topic concerns a trainee meeting his or her "trigger family" and how it is possible to work through a process in family therapy training that gives new meaning to both personal history and development in one's own clinical practice. The "trigger family" in this case study by Monica McGoldrick is defined as a family where the relation between the issues in the trainee's own family and the family in therapy "…were so close to his own" (ibid p.17). The second topic is connected to the idea that this type of work is optional in the education program she writes about. The third topic comes from a footnote where she claims that in the eight years she has done family therapy training only one trainee "was able to maintain his level of clinical competence while going through a separation or divorce" (ibid p. 37).

"A Quantum Leap"[17]

McGoldrick argues strongly for trainees to work with their relationship to their own family. She writes: "It is our impression that such work benefits the trainee's clinical work, and that is particularly helpful in aiding trainees to shift from linear to systems thinking" (ibid p. 19) and that: "Understanding one's functioning in his/her own most important system, his/her own family, seems to facilitate the ability to understand the operation of other natural systems and the ability to generate hypotheses about families on a systems level" (p. 20). She sums up by stating that: "…it is my strong impression that one tends to get blocked with clinical families in the same ways one does in one's own family" (p. 20).

[17] A quantum leap is actually a very, very small leap, but in daily language it is used like this, as a metaphor for a huge leap.

McGoldrick tells the story about "Peter" (the trainee) and the "Arthur" family. Through a supervised process, "Peter" identifies common themes from his own family in working with the "Arthur" family. He finds himself stuck, but through supervision and willingness to open up and bring these themes into the therapy room through self-disclosure, he gains new experience both with his own family and as a family therapist. McGoldrick states that: "Successful work on their issues and clarifying the connection to the trainee's own (family) may produce a quantum leap in clinical development" (p. 17).

Optional

McGoldrick argues that the part of the program that is connected to working with the relationship between the trainee's own family and clinical practice should be optional. "Many factors influence a trainee's willingness or interest in pursuing work on his/her own family, and such pursuit cannot be dictated by a training programme" (p. 20). Everybody is encouraged to take part in this process and about 50% did it in the program from which she reports. As mentioned earlier, according to AAMFT´s "Manual of Accreditation" from 1997, all students must finish the module named: **"Personal development and family relations."**

Crises and Training

In this article, McGoldrick connects "Peter's" story to his family of origin, and it can be useful to make a distinction between family of origin and current family issues. This indicates that the links between personal life and clinical training and possible clinical practice are significant. In this perspective and from her own arguments and from the stories she tells about "Peter" and the "Arthur" family it is not obvious that this part of the program should be optional. To understand this position I believe it will be fruitful to look at our educational traditions within family therapy in Europe and the USA and within the psychotherapy field.

Re-membering

In "*Narratives of Therapists' Lives"* (White, 1997) Michael White clarifies how re-membering is used to create new narratives. Re-membering is a way of connecting someone in your history to your own life today, to become a "member" of your history again. Barbara Mayerhoff calls re-membering "a purposive, significant unification" (White, 1997, p. 22). Going into a re-membering process is like re-creating thick descriptions of one's history. For White, "thin" and "thick" stories are alternatives to "surface" and "depth" (ibid p. 63) and these alternatives help avoid the expert position.

In the intensive training courses at Dulwich Centre, the participating therapists have the opportunity to be interviewed about their lives and work. These interviews are structured in four phases with an outsider-witness group as part of the session. Through interviews like this, White shows how therapists' personal and private experiences from life can be connected to their professional practice as family therapists.

Working with the Relationship between our Own Family and Clinical Practice is Compulsory.

As mentioned earlier Personal and Professional Development is a compulsory part of family therapy education in some countries. It is not obvious however, that PPD work involves working with the relationship between our own family and clinical practice. Judy Hildebrand's book "Bridging the Gap, A training Module in Personal and Professional Development" (1998) focuses only indirectly on the relation between the trainee's own family and the trainees' clinical practice. The situation is much the same in Barcelona[18] and Cardiff[19].

Finally, I wish to point out that in addition to the family of origin, family therapists are influenced by contemporary family life and by private and personal values and cultural influences over time.

Contemporary life

The area of contemporary life includes working with the therapist's personal and private life and working with the therapist's cultural, political personal and private values.

In some family therapy traditions (e.g. Bowen Family Systems Therapy) the link between one's own family and clinical training and clinical work seems obvious. Family therapists who combine parts of psychoanalytic thinking with the family perspective seem to take students' and clients' own families as important parts of both training and practice (Framo, 1976; Lieberman, 1987).

When students are working with genogram and cultural difference, PPD work may offer an opportunity to link clinical work closely to own family. However, the culture of origin is larger than one's family. It refers to the major group(s) to which an individual belongs (Hardy and Laszloffy, 1995), such as social, work, community, faith etc.

[18] At Universidad Autónoma de Barcelona and Escuela de Terapia familiar Servicio de Psiquiatría del Hospital de la Santa Creu i Sant Pau in Barcelona, Spain.
[19] At Cardiff Family Institute at University of Glamorgan, Wales.

"What are your motives and what's your agenda?"

Odell and Campbell advise teachers in family therapy programmes to ask students who want to study family therapy: "What are your motives and what's your agenda?" (Odell and Campbell, 1998 p. 10-14). They point out both internal and external motives. They claim that most often students tend to emphasize external motives when they must explain why they have chosen the profession. However, they claim that internal motives play a more important role and should be examined. The agendas students have for becoming a family therapist may be connected to how they believe family life should be lived and to their own experiences of family life.

An interesting example of how to think about links between personal experience and the choice of profession are given by Kim Larsen (2006). In an article in the journal for the Norwegian Psychological Association, he gives an example of how he thinks some persons' personal and private experiences make them unsuitable for vocational rehabilitation through certain education programmes. He also discusses whether, for example, an experience such as "incest sufferer" can be viewed as a qualification for a position working with "incest sufferers". According to Larsen, a person's personal and private experience might make him or her unfit for some professions. Larsen points out that occupational psychologists should more often give priority to the best interests of society and clients instead of the subjective interests of persons who want to use their traumatic background in an effort to help clients with similar experiences.

Ways of focusing on the therapist's own family are many and different, from political (White, 1997) to private and personal (Hildebrand, 1998; Faris, 2002; Burck and Campbell, 2002). Julia Halevy claims that her fundamental belief is "…that in order to become competent and ethical practitioners, students must understand themselves and how they see others" (Halevy, 1998, p. 233).

Bridging the Gap?

In her book "Bridging the Gap" Judy Hildebrand (1998) gives a rationale for including personal and professional development (PPD) as a part of family therapy education. She describes the aims and the process of the group meetings and she presents in detail 27 exercises that have been used in PPD-work in two different family therapy education programmes in England. In Institution A they had a large group and in Institution B a small group. A survey from these practices is presented along with her reflections about the future.

She says that they started this work to help "…linking the past to the present, the personal to the professional" (ibid p. 4). As an alternative to depicting this process as a critical endeavour she emphasises it as a process of self-reflexivity (ibid p. 6). Her aim is, among other things, to include "professional dilemmas" and "personal experience" in each group meeting (ibid p. 12). The cores of the PPD module are 27 experiential exercises. They are meant to link the past and present experiences with current professionals' dilemmas. After my careful reading of the 27 exercises, it appears that only seven focus on the link to clinical work. Every exercise that focuses on the link to clinical work does so in a general way. That is in line with what her experience is when she claims:

> "Much of the time in the PPD module is spent in general discussion about issues brought up by the participants, as well as in doing exercises relevant to the feelings and subjects that they raise" (ibid p. 11).

In my research, I look for how personal and private experiences influence the therapist's own clinical practice. None of the exercises in Judy Hildebrand's book *"Bridging the Gap"* invite the student to reflect directly on the possible links between the student's own personal history and their specific clinical practice. Even when role-plays of clinical situations are a part of the exercise, students are only invited to do general reflection on the consequences for clinical practice (ibid p. 52).

In *"Becoming a Therapist"* (Cross and Papadopoulos, 2001) have developed a manual for personal and professional development. Here they ask some very relevant questions like: "What does my family have to do with my practice as a therapist?" (p. 5), "What does culture have to do with how I work as a therapist?" (p. 28), "What does it mean to be male or female, and, perhaps more importantly, what are the implications of these meanings?" (p. 48), "What is the relationship between my personal morals, values and professional ethics? (p. 60) and "What can I personally bring to the practice of therapy? (p. 68). They do not intend to answer these questions but have developed the manual for professionals in training.

In their article "*Arts and literature in a personal development process and systemic psychotherapy training"* (Cox, Faris and Hardy, 2004) about their "Personal Development Group" (PDG) program, Brenda Cox et al from The Family Institute at the University of Glamorgan point out that: "Not since Hildebrand (1998) has there been a focus on the nature and process of PPD in the training context." They claim that their shift to second order cybernetics, among other things, has contextualised the choice to "focus upon the therapeutic relationship."

In their article, they use three examples. The first example they call “Desert island discs,” the second is called “Back to the future,” and the third they call “Cultural project”. Yet, none of these three examples focuses on the relationship between the student’s private and personal history or experiences and their clinical practice.

Joyce Scaife and Sue Walsh point out areas in which the connections between experience from work life and private life may influence clinical practice and they say that:

> “Supervision may provide the only context in which it is possible to stand back from relationships in order to analyze and understand the interpersonal processes taking place and to construct action plans in order to alleviate the distress arising from them” (Scaife & Walsh, 2001, p. 34).

To bridge the gap between psychotherapy and the influence on psychotherapy from the therapist’s private and personal history and life, is the background for this research project. By illustrating how therapists’ personal and private backgrounds influence therapy, it may give inspiration to further develop the work on personal and professional relations.

Summary

In this last section, the different views of the necessity of working with one’s own family in family therapy training have been examined. The views here move from the idea that own background and own family are irrelevant, to a position where working with own background and family is viewed as compulsory. Also contemporary life and own cultural and political as well as religious affiliation are highlighted as relevant areas to examine.

3. Design of the Study

Introduction

Many elements combine to form a family therapist. The therapist's professional background may comprise being for example, a health- and social worker, or the type of clinical family therapy education taken, or supervision and the master therapist that leads the way for the student. In this research, we will not take many of these aspects into account. The focus will be on the patterns that connect the family therapist's private and personal background with her or his family therapy practice.

In this chapter, I will first restate the aims of my research and my research questions. Then the design of my research project will be presented with sampling procedures and data analysis procedures. I will give the background for my choice of qualitative research method and reasons for my choice of methods. I will give a presentation of the entire research process and finally I will present the procedure, the research flow chart, recruitment and the process of semi-structured research interviewing.

I have chosen to use two main qualitative research methods that are part of **an approach to interpretative theme analysis**. My reasons for choosing interpretative theme analyses are connected to my aim to "understand and represent the participants' point of view" (Dallos and Vetere, 2005, p. 53). I also assume that these points of view are relatively stable over time and I want to know which kind of processes move these points of view and what happens when they change.

This is a Grounded Theory research project that uses both semi-structured interviews and video analysis.[20] Theoretical Sampling is an integrated part of Grounded Theory and formed my participant selection process. In this research, I also use Theme Analysis. The videos were analysed using Theme Analysis. Finally, I will say a few words about how this material is analysed and present an overview of my material.

The pilot work of visiting family therapy institutes and discussing their PPD programmes helped me shape the research question and develop the semi-structured interview.

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[20] One of my personal reasons for choosing Grounded Theory (GT) should be mentioned perhaps because it is psychological. I have read that working with GT is an iterative process (Pidgeon and Henwood). That sounds a little bit like me and it's systemic!

Research aims

The title of this research project is:

The Narratives Which Connect: Looking for narratives that connect therapist's personal and private lives with their clinical practice.

I have formulated these research aims for this project:

1. To develop an understanding of the lack of knowledge and interest in the field of psychotherapy research for the links between the psychotherapists own personal and private life and her/his clinical practice.
2. To develop new knowledge and theories to help expand an under-theorized area of family therapy training and clinical practice.
3. To explore how personal and private experiences can influence family therapy practice.
4. To explore how family therapy practice can influence personal and private life.
5. To explore how sequences of personal and clinical practice can be understood as one meaningful episode.
6. To explore implications of what consequences the integration of personal and professional development could have for family therapy practice.
7. To discuss what ethical standards should be considered when practicing systemic family therapy.

With this as the point of departure for my research, it is necessary to formulate some research questions to more clearly establish within which frames the research should be located.

Research Questions

1. How do we understand that so little research has been done on the links between the psychotherapist's own personal and private life and her/his clinical practice?
2. How does the therapist's own life history and personal and private experiences influence the way she/he understands and practises systemic family therapy?
3. What are the influences of being a systemic family therapist on the therapist's own life and how she/he thinks about the way she/he lives it?
4. How will the researcher and the research process influence the participant and vice versa and create meaning for the relationship between his or her personal life and clinical practice?

Qualitative Study and Grounded Theory

I have utilized a qualitative research approach in this project. I have decided to use a qualitative research approach, since the research will be concerned primarily with processes rather than outcomes or products (Creswell, 1994). Additionally, a qualitative research approach permits the exploration of processes by which people construct opinions when a limited number of participants are involved. By basing my research on a qualitative method, the process is inductive. As a researcher, I play an important role as an instrument for this process to work successfully (Creswell, 1994). Aspects of self-reflectivity are captured through my use of a research diary, research supervision, and Grounded Theory memo writing.

I have used Grounded Theory as the framework for this research. Charmaz divides Grounded Theory into two main schools. One school she denominates as Objectivist Grounded Theory and the other as Constructivist Grounded Theory (Charmaz, 2006). In objectivist grounded theory, the data are removed from the social context from which they emerge. "An objectivist grounded theorist assumes that data represent objective facts" (p. 131).

Constructivist grounded theory "…places priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants and other sources of data" (p. 130). One important consequence of this point of view is that any analysis is "…contextually situated in time, place, culture, and situation" (p. 131). This means that any research is a co-creation that emerges as part of a process in which everyone involved is seen as a participant and where the observer position becomes impossible. It will not be possible to take a stand outside what is studied. From this point of view, we are all participants. I agree with Charmaz when she claims: "I view grounded theory methods as a set of principles and practices, not as prescriptions or packages" (p. 9). In my research, I have chosen the constructivist grounded theory position.

Grounded Theory

The Grounded Theory method of study is essentially based on three main elements: 1. concepts; 2. categories; and 3. propositions. Concepts are the major elements of analysis. "A concept is a **labelled phenomenon.** It is an abstract representation of an event, object, or action/interaction that a researcher identifies as being significant in the data" (Strauss and Corbin, 1998, p. 103). Theory is developed from the conceptualisation of data, from the specific elements in the research material.

> "The grounded theorist undertakes close and systematic exploration of the data, generating, as she goes, an array of categories and theoretical propositions intimately linked, in demonstrable ways, to the body of data. The overall aim is to produce some theory, grounded in the data and linked to the relevant literature, which illuminates an under-researched domain" (Wren, 2000, p. 96).

Theory gains meaning by being grounded in "…good, powerful, convincing examples." This is the basis for grounded theory (Dallos and Vetere, 2005, p. 53) and this is the aim of my research. Grounded theory focuses on understanding how people make meaning of their experiences, (Charmaz, 2000). In grounded theory research, context is rooted in the phenomena that are being studied, and therefore an individual or therapist's process of meaning-making cannot be understood outside of the context in which it occurs, (Ward, 2005). Charmaz (2000 and 2006) calls this type of grounded theory ***"constructivist grounded theory."***

The Rationale for Grounded Theory

Research methods tend to start with theory and derive data from the theory. Grounded Theory is a research method in which the theory is developed from the data. That makes this an inductive approach, meaning that it moves from the specific to the more general rather than the other way around.

I will explore the data and looked for meaningful links between therapists' personal and private lives and their clinical practice. It is therefore the **trustworthiness** of my examples that creates the meaning of this research. According to Grounded Theory, these considerations should be taken into account:

1. A site or group must be chosen
2. A decision must be made about the types of data to be used.
3. Another consideration is how long an area should be studied.
4. Initially, the number of sites or interviews depends on access, research goals and time.

I decided to interview Norwegian family therapists of different ages, genders, experiences and numbers of years as a therapist. My data emerge from transcribed interviews, videos, genograms, e-mail reflections and Grounded Theory memos. The area was studied until the analysis reached saturation.

Once these decisions were made, I developed a first list of semi-structured interview questions and areas of observation. This list was based on the relevant clinical literature and research and my own experiences as a family therapist and family therapy supervisor and on

my pilot interviews with family therapy trainers that did PPD-work. They are not only questions from "the real world," but they are also questions that changed during the research process. These questions were provisional at first and either discarded or developed as new questions developed and took new directions when data were analysed.

In this process, I used Theoretical Sampling as a tool to guide me through the selection of participants. Theoretical Sampling was the method that I used to choose new participants. That meant that I had to do much Grounded Theory analytic work during my sampling process. Each subsequent participant was chosen based on the material I had sampled and analysed from the previous participants, and how this analysis had developed the emergent theoretical ideas.

Design

The initial flow chart plan that is presented here shows the ideas for the research flow chart. The actual research flow chart that was conducted through the research process is presented on page 70.

Research Design Flow Chart Plan

STAGE ONE		STAGE TWO						
Pilot with PPD trainers. Prepare interview, find 1st participant.	→	1.First person, first interview. 2.Reflections from participant after interview (Pilot)	→	Analyses of a video of a first session of FT from 1st participant	→	Second interview, same person. 1. Genogram 2.Reflections from participant after interview	→	Prepare interview, find 2nd participant
								STAGE THREE
1.Second person, first interview. 2.Reflections from participant after interview	→	Analyses of a video of a first session of FT from 2nd participant. Prepare interview.	→	1.Genogram 2.Second interview, same person. 3.Reflections from participant after interview	→	And so on till all 4 participants are completed	→	Prepare special topics. Three further interviews about parallel connections with three new participants

Table 2. Research design flow chart plan.

The primary purpose of this research is to explore in depth, with seven participating systemic therapists, the patterns that connect their own personal experiences and lives with their clini-

cal family therapy practices. Theoretical sampling helped in selecting each participant, based on Grounded Theory analysis of the previous participant's material, and the constant comparison with each previous case. This was part of preparing for the semi-structured interview questions that were asked of each new participant. All analysis was within a Grounded Theory design. Some of the participants were also treated as "case studies" for a separate analysis of their narratives of connection, using the notion of "paradigm case". The paradigm cases are intended to be a complementary analysis, to enrich and illustrate some of the Grounded Theory research categories.

Two interviews were conducted with each of the first four therapists, punctuated by watching a video of a first family therapy session. The second interview provided an opportunity to present my analysis of possible links between the first interview and the video and provided a validity strategy or "member check" for the first interview and its subsequent GT analysis by myself. The final three therapists were interviewed once only. This helped establish the GT process of saturation.

Sampling Procedures

Step 1

Using the theoretical sampling strategy of Grounded Theory (GT) my primary strategy has been to recruit therapists with differing lengths of practice from inside Norway. Of the first four therapists (full case studies, i.e. two interviews plus video analysis) one is a beginner and three are experienced family therapists.

Of the second group of three therapists interviewed about working as therapists while dealing with similar problems at home as those they are working with in therapy (parallel connections), one is a relatively recent beginner, one has intermediate experience and one is very experienced in family therapy. All three participants are very experienced practitioners in the fields of social work, nursing and clinical psychology. I developed the semi-structured interview guide for the first research interview based on my literature review, teaching and practice experience, and on my pilot work (see Appendix 4).

Step 2

I then designed a contract outlining some basic principles for the research cooperation. These principles included the amount of time for interviews and video recording. Furthermore, the contract stipulated how to resolve the issues of research confidentiality and anonymity properly (see Appendix 2 for a copy of the contract).

Step 3

Step 3 consisted of conducting the semi-structured interviews and collecting the video of a first family therapy session. GT was used in analysing the interviews, and theme analysis for the videos. The next interview was prepared and the next research participant selected up to four participants.

Step 4

Preparing and conducting the research interviews about special topics (parallel connections) based on the combined Theme Analysis and GT analysis sofar, with three new family therapists.

Step 5

Doing Grounded Theory analyses (open coding and axial coding) of all transcribed interviews (N = 12). Then doing theme analysis of the four videos. Then analysing the whole material to create categories and sub categories to formulate a middle-range theory about the patterns that connect the systemic family therapist's personal and private life with their clinical practice.

My material

My material consists of 12 transcribed semi-structured interviews (including the first pilot interview with Elisabeth) with seven therapists, their genograms, e-mail reflections from the therapists after interviews, and four videos of the first four therapists' first therapy sessions with clients. The e-mail reflections are an invitation to reflexivity and self-reflexivity both for the participants and myself. All seven participants were invited to send me their reflections after each interview. In the fall of 2006, when I was writing my thesis, I invited all of them to give some comments on their current views. All of them responded to this invitation.

The Pilot work

The pilot study consisted of three main elements. The first element was a literature review to discover the purposes and content of Personal and Professional Development work in different family therapy traditions. The next element was study trips[21] to Cardiff, Barcelona and Dublin family therapy training institutes to meet people in charge of PPD programmes.

[21] Permission obtained to cite their names.

In preparation for my project, I interviewed [22]Billy Hardy, Jeff Faris and Brenda Cox, [23]Susana Vega and [24]Jim Sheehan, all family therapy trainers at leading Family Therapy training institutes. They accounted for how they ran their PPD programmes as a part of their family therapy education programmes and they gave me inspiration to go on with this research project. They also inspired me to investigate areas that I probably would have left out or included much later in the process. This also helped in developing the semi-structured interview. The last element of the pilot work was a first interview with a family therapist.

As a part of my preparation, I also interviewed one family therapist as part of the pilot work. This first participant helped me adjust the research questions and the interview, and gave me important new ideas for both the content of my research and the procedure. For example, I had planned to start interviewing her about her background and personal life history. However, before I started this topic, she told a story from her professional life in which her personal and private experiences were deeply involved in her clinical decision-making. I discovered that she had prepared for the main topic in the interview. This made me reorganise the semi-structured interviews and from then on I began by asking if they had thought of any specific connections about the relation between their personal and private lives and their clinical practice since they agreed to participate in this research project.

After this first pilot interview, I decided to have the first interview with a participant when the participant had completed the video of a first family therapy session and brought this with them to the interview. I also asked each one to send me an e-mail after the interview with their eventual reflections.

My first participant, Elisabeth[25], was initially meant to be a part of my pilot study. However she presented such rich material that I decided to include her as a full participant in my research. Following the pilot interview, we decided to have a second "first" interview and then follow the procedures that are a part of the Grounded Theory design. I have, however, also included the first (pilot) interview as a part of my material for analysis.

The Experience from the First Participant

The first participant was a rather newly educated family therapist. She had been a student in the school of nursing when I was a teacher there, about twenty years ago. I did not know her

[22] At Cardiff Family Institute at University of Glamorgan, Wales.
[23] At Universidad Autónoma de Barcelona and Escuela de Terapia familiar Servicio de Psiquiatría del Hospital de la Santa Creu i Sant Pau in Barcelona, Spain.
[24] Dept. of Child & Family Psychiatry of Mater Misericordiae Hospital, Dublin, Ireland.
[25] All names have been changed in this thesis.

personally but I remembered her as a very verbal and reflective student. I knew that she was divorced and that she had re-married and had children some years ago. When I called her to request her participation in the research, she agreed without hesitation. I sent her the Information Sheet and made an appointment with her for a first interview. I told her that this was probably a pilot interview but that I might use it as a part of my research if it was complete.

I found this first interview very interesting. Immediately after the interview, she visited one of my colleagues that she knew beforehand. She told my colleague about the interview and my colleague found her reflections after the interview interesting. She encouraged her to go home, write her reflections into an e-mail, and send it to me. She did that, and I realised that these kinds of e-mail reflections should be a part of my data collection method from now on, as they help substantiate and validate the analysis.

Next she was required to make a video of a first family therapy session as soon after the interview as possible. She worked in a psychiatric outpatient clinic and she said that it could take some time before she got a new patient, but she would try. I waited some months before I called her again. She said she had not managed but she would still try. After some more months and after transcribing and analysing the first interview I contacted her to ask for one more interview to test my analytic procedure. We met and we had one more very informative interview, but she still had no video. I decided to go on with theoretical sampling and I used the knowledge I had from my first participant as a background for the next participant.

Recruitment

To be included as a participant in this research project they have to be a Norwegian family therapist. In addition, they had to sign a paper where they accepted that their materials were used in the research project (see Appendix 2).

The recruitment strategy is based on my knowledge of the family therapy field in Norway. I have sought to avoid people with whom I have or have had a personal relationship. This has not been possible all the way, but personal relationships have not disturbed the research in any significant way. I also have used colleagues to help me find possible participants in the sampling process. In looking for variation amongst my participants I have presented a possible "case" for a colleague and he or she has pointed to some therapist who could meet as many of my criteria as possible. I thought between six and ten participants would be appropriate for saturation. I ended up with seven participants.

Participants

Of my seven participants, four of my participants have been included as full case studies. The four case studies have been treated as paradigm cases, complementary to the Grounded Theory analysis. That means that I have had two interviews (three interviews with Elisabeth because she was originally meant to be a part of my pilot study), one video from each one of them and e-mail reflections from most of them. All interviews have been transcribed, and analysed using Grounded Theory, and the videos have been analysed using Theme Analysis as described by Dallos and Vetere 2005.

Of the remaining participants, the last three participants have been interviewed once each to cover "parallel connections" between a family therapist's private and personal life and the client's life problems. This is a situation where for example, a couple therapist herself is about to divorce when she meets couples that are about to divorce. All together my material from my seven participants consists of 12 interviews and four videos. In addition, I have Grounded Theory memos and e-mail reflections from participants that are connected to the interviews.

Details of participants

My participants consist of two psychologists, three nurses and two social workers that all have family therapy training. There are two men and five women. When I interviewed them they worked in adult psychiatry, in child- and adolescent psychiatry, Family Counselling Offices and in private practice. Everybody, except one family therapist that was asked to participate in this research project, said "yes" to participate and to contribute to my research. I interviewed them in order of appearance:

Name and profession[26]	**Workplace**	**Experience as family therapists**
1. Elisabeth f. (46), nurse	Family Counselling Office/ Family unit, psychiatry/private practice	10 years
2. Erik m. (62), psychologist	Child- and adolescence psychiatry /Family Counselling Office	33 years
3. Adam m. (45), nurse	Child- and adolescence psychiatry and private practice	18 years
4. Karen f. (62), social worker	Child- and adolescence psychiatry/ Family Counselling Office	33 years
5. Evelyn f. (57), psychologist	Family Counselling Office/ Child- and adolescence psychiatry/ private practice (parallel connections)	24 years
6. Anne f. (50), social worker	Family Counselling Office (parallel connections)	6 years
7. Janne f. (52), nurse	Child- and adolescence psychiatry (parallel connections)	8 years

Table 3. Participants

[26] The participants are anonymised.

Procedure

In this grounded theory research study, I have been through a complex and multifaceted process. The literature review showed that little was done connected to my research question. A part of my project became to give an answer to how this situation could be understood. The next step was to make a pilot study to prepare for the interviews and video observation of the therapists. This was a motivating process where coding and analysing was integrated in a theoretical sampling voyage.

Writing memos became a central activity in this period. In this process my project was reshaped and supplemented with some new ideas. It was for example supplemented with interviews with therapists that had particular experiences connected to a link between their own life and clinical experiences.

The next analytic process involved an analysis of the entire material to form categories and write new memos. All of the memos formed the basis for my categories and as part of my thesis.

The Case Studies

For the purpose of theoretical sampling, it was very useful for me to keep the idea of variation in my mind. My second participant was chosen because he was as different as I could think from my first. He was a very experienced family therapist with many years from child- and adolescent psychiatry and the last 20 years from a Family Counselling Office where he now was the leader. From my first participant I learned that I should not have the first interview before the video was ready. When he had made a video, he contacted me and we met for a first interview. After my analysis of my transcriptions and of the video and the comparison of the two, I prepared for the second interview. When this second interview was finished, I analysed all my material to select the next participant. Some important aspects from this therapist besides that he was very experienced were that he had never married, and in this sense, he did not live a traditional family life. He also underlined that therapy is a rather rational process where the therapist's own personal and private experience should not influence the therapeutic process.

My third participant was a therapist of medium experience that I knew was a more traditional family man who was active in church and a dedicated therapist. I knew him as a former student (fifteen years ago). He worked in a family unit in child- and adolescent psychiatry. He has had this position for many years. I prepared the first interview with him and used

the two former participants as background for this interview. Especially the questions about what working as a therapist has meant for his personal and private life was of special interest because I did not have much material from that area. I carried out the interview and got his video. The video was impossible to use and he had to make a new one. This was also without sound and impossible to use. He had to make a third. He did, and I could make my next interview with him.

One day I was surprised to get an e-mail saying that my first participant had made a video. She now worked part time in a Family Counselling Office and that she now could make a video more easily. I decided to analyse the video and I found it very interesting. I therefore decided to include her as a participant in my project. We agreed upon a new meeting and I analysed the two former interviews and the video and prepared the second research interview. I found some rather vague connections between the interview material and the video. However, I decided to test my ideas. She told me that my ideas were to the point in an astonishing way. She said: "It could have been me and my husband. We have been into therapy for almost two years with the same problems." I then realised that I was about to miss some obvious topics. I had to find out what was happening when the therapist and the clients were in a parallel situation. What happened in therapy when the therapist for example was in a process of divorce when she or he met a couple that wanted to divorce? This is the method of constant comparison that influences the development of the research question. I had to include questions around parallel connections in my research.

With this background, I decided to invite the final full participant. She was a very experienced therapist that had worked many years in a Family Counselling Office and in child- and adolescent psychiatry for many years before that. I knew she had been married more than once and that she was described as a colourful therapist and person. I also wanted to ask her especially about how her clinical practice has influenced her personal and private life. This is the other side of influence between personal and private life and clinical practice.

I found out that I needed to supplement my material with stories about what I first called "obvious connections." This is about what is going on in the therapy room when the therapist is part of the same kind of problems in her or his private life as the clients she or he works with. These topics are developed as "parallel connections" in this research project.

The Semi-Structured Interviews

If a questionnaire and the interview are structured, then participants may only answer these questions and may not bring forward other topics and stories that are relevant to them (Strauss and Corbin, 1998, p. 204).

I therefore chose to ask more open questions using a semi-structured format. Some of my questions were as open as possible so I could be connected to the participant's own language and the participant's genuine understanding of his or her own life experiences and clinical work.

The interviews were planned beforehand and the participants were asked to read through the questions when we met and before the interview started. The themes and the questions were based on several sources. They were based on my own experience and interest for the patterns that connect therapists' clinical practice to their personal and private lives. The themes and the questions were also based on the pilot work, the literature review from my proposal, my experience as a family therapist and teacher in family therapy and from my knowledge of friends' and workmates' experience.

As previously stated, each therapist was initially a part of the constant comparison process and formed a separate case that helped form the interview for the next participant. The procedure was identical for the four full case participants. When collecting the data I conducted two semi-structured interviews, where the last one was based on my viewing a video of, and the theme analyses of, a first session of family therapy. All my semi-structured interviews were transcribed and analysed using coding procedures from Grounded Theory (Strauss and Corbin, 1998).

Grounded Theory Coding Procedures for the Semi-Structured Interviews

First, I used open coding on the interviews because I think about my research as an analytic process "… through which concepts are identified and their properties and dimensions are discovered in data" (Strauss and Corbin, 1998, p. 101). The aim of open coding is among others to keep the data collection process open to all possibilities in the early stages of analysis. The next step is to do axial coding of my transcribed interview material to help cluster and categorise the open codes.

In my first analytic work with my transcriptions, I used line-by-line open coding. Through the process of interviewing participants, I wrote memos. Memos are my interpretation and analysis and give direction and questions for further data collection. This process was

the basis for developing concepts and categories. Memos are made between coding sessions and form the framework for the thesis. The thesis is based on the developed categories and "…the categories reflect the interaction between the observer and the observed" (Charmaz, 1995, p. 32).

Asking questions

Here are some examples of questions that I used to maintain as much openness as possible:

> "Can you tell a story about a personal crisis or incident that influenced you in your work as a family therapist?"
> "What was your experience with therapy before you started your training as a family therapist?"
> "Can you tell me a story about how it came to be that you chose to work with family therapy?"
> "Can you see any obvious connections between your own private experiences and what you do in family therapy?"
> "What happened when you conducted a therapy session that was difficult for you?"
> "Tell me what you think about what's important for couples to develop a good relationship?"

Trying to avoid putting concepts and words in the mouth of the participant, I formulated for example a question about values or truth to one participant in the following manner (M=me, P=participant):

> "M: If you are going to say something about, in a way, what you consider as truth, or what is right, or, I don't know which word you would use. Some people talk about values…
> P: … yes, values…
> M: … right, there are many words, where you, in a way, have something such as truth and right in relation to what is a mistake or wrong or…do you have something like…?
> P: … like head lines, yes…
> M: … like main head lines?" (8, 220 – 224)

The participant chose the word **"head lines,"** and I joined in on that way of designating the area. In this way, I tried to be as open as possible to the participant's own value system and language (see Appendix 6 for an example of a semi-structured interview).

Process of semi-structured interviewing

The interviews were conducted in my office at Diakonhjemmet University College, in the participants own office, one in my home and one in a participants home. The interviews lasted between 70 and 100 minutes.

I had prepared in written form before the interview but I did not follow the interview guide slavishly. My intention was to keep an open mind and a curious approach.

When I was preparing the tape recorder before the interview started, I asked the participants to read my questions, just to get some flavour of what it was all about. All participants used this opportunity. Towards the end of the interview I glanced through to see if I had missed some important topics.

Transcription

Of the twelve interviews, I transcribed most of them my self. A secretary transcribed three interviews. However, transcribing myself, helped me to immerse myself in my material and made me a part of the material in another way than I could with the three interviews that were transcribed for me. In the transcribing process, I changed names and other identifying details on all participants to take care of their anonymity.

Thematic Analysis of the Videotapes

Thematic Analyses are used to analyse the videos of the first family therapy session of my first four research participants. There are differences between interviewing therapists about their life history and then using Grounded Theory analysis, and between watching videos from family therapy sessions in which I use Thematic Analysis. When I use Theme Analysis (Luborsky, 1994; Braun and Clarke, 2006) I think it is reasonable to use my own theoretical background and own experience from supervision and clinical practice, in a way that I can show the reader how I derive the themes.

Thematic Analysis is characterized "…not as a specific method, but as a tool to use across different methods." However, Thematic Analysis may also be considered as "…a method in its own right" (Braun and Clarke, 2006, p. 78). In this research project I choose the first position that views Thematic Analysis as a tool to be used within my Grounded Theory research project.

The benefits of Thematic Analysis are connected to the representation of an individual's own point of view and descriptions of experience, beliefs and perceptions. It gives more

voice to the participant than to the researcher. The researcher seeks to learn from the person that is in the focus for research (Dallos and Vetere, 2005, p. 62). Themes can provide insight into cultural beliefs and values, and can be readily described and coded. Theme analysis can be used both in qualitative and quantitative research.

"Themes are … the manifest generalized statements by informants about beliefs, attitudes, values, or sentiments." "…the term topic or main points, rather then theme, should be used when summarizing the content of replies by many people to a question" (Luborsky, 1994, p. 195). A theme is connected to one person and it becomes "a topic" when the themes are summed up. Theme analysis has often been viewed as simple and not very important in qualitative research. In most textbooks, it is not mentioned at all or just with a few paragraphs. In contrast to this situation, Luborsky claims that: "One hallmark of qualitative methods is the search for themes in human experience" (ibid p. 189).

According to Theme Analysis the identification and analysis of themes and patterns comes to the fore. "By seeing meaning everywhere, qualitative researchers perpetuate their own enterprise and cultural paradigm" (ibid p. 194). We are looking for the most frequent or most important experiences or actions and are sensitive to what can be learned from these therapists. I used Theme Analysis to analyse the videos from the therapists' first session and to try to make connections to the knowledge I have gained through my interviews with the same therapists. GT Memos have been made in between coding and analyses and after coding for each participant. This has been a GT constant comparison process aiming to develop variation and diversity in my material.

Video Analysis: Issues and Dilemmas in the Interpretation of Themes

"Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data" (Braun and Clarke, 2006, p. 78). Theme analysis is always a part of a cultural context. This means that the participant and the researcher mainly are members of the same culture. "The concept and practices in studying themes resonate with fundamental cultural ideals and taboos" (Luborsky, 1994, p. 191). "…the vocabulary of science is plainly rife with culturally laden moral terms in that the same terms apply to ideals for individuals and research" (ibid p. 192). We protect "dependent" and "independent" variables and we "control" variables. We talk about the statistical "power" of a study and of "trustworthiness" of another. We use the same concepts in our daily life. It is because they carry the cultural impact that they are of such use for qualitative research.

A topic that comes up in an interview is meaningful and important to a participant and in that way it adds meaning to the research. Some studies that have used Theme analysis have pointed out that the process has inflamed dormant conflicts or sadness rather than rejuvenated new meaning and identity (ibid p. 193). There are many pitfalls in the study of themes. Basic terms must be defined. Because terms are used in many different ways, we need to define how we use them for research purposes in the video analysis.

Theme identification:

1. Statements that occur frequently or are repeated.
2. Statements that are marked in some way as being of great or central meaning to a person or persons.

"A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set (Braun and Clarke, 2006, p. 82). However, a theme is nothing that exists "out there" in its own right. My own judgement is necessary to make up what it is. In this context, bringing the themes from the video back to the participants in a second interview is crucial to approach validity and reach trustworthiness in this research.

Prevalence is often put forward as a point of reference in Thematic Analysis. When it comes to my looking for narratives which connect an interview with a video of a therapeutic session, prevalence is not always the most important and meaningful frame. Sometimes a subordinate clause might be the guide to deeper meaning and connections. My own curiosity is an important tool in working with the interviews, in which I seek to connect my knowledge from the first interview with the video.

The Single Case Study and Paradigm Cases

A paradigm case is according to Benner "… a clinical episode that alters one's way of understanding and perceiving future clinical situations. These cases stand out in the clinician's mind; they are reference points in their current clinical practice" (Benner, 1984, p. 296).

A paradigm case in this frame of reference consists of narratives that link personal development and clinical practice and that have been of great importance for the clinician's development and present practice. During the interviews, I asked participants for narratives that represented their points of reference in which they linked their personal life to clinical practice and explained the connection between them.

The concept of the paradigm case is closely linked to qualitative research and represents a… "nonexperimental qualitative sociological method that employs an exhaustive ex-

amination of cases… (Vidich and Lyman, 1998, p. 74). A paradigm case is a case that is based on experience and that is a part of the clinician's clinical competence. Some paradigm cases are simple and can be told as stories that students (and others) can incorporate in their knowledge to deepen and expand their practice. "However, many paradigm cases are too complex to be transmitted through case examples or simulations…" (Benner, 1984, p 9).

While the Grounded Theory analysis "pooled" the data to form concepts, hypotheses and categories, the case study model was intended to help look at each full participant in turn to pull out specific, illustrative examples of the narratives which connect.

Ethical Issues and Anonymity

The project plan for this research project was presented to the Research Ethics Committee at the Tavistock and Portman NHS Trust, and approved by them (Appendix 3). All of the participants have given me their permission to use their stories by signing a written consent (Appendix 2) and they have been given the opportunity to comment on my use of them and even withdraw if they are uncomfortable with the use in this thesis.

A letter describing my research program and requesting participation was sent to them after an initial oral enquiry from me. This letter emphasized that my sampling criteria will meet gender, multi-educational background, experience, age and systemic training. I encouraged potential participants to thoroughly discuss the ethical, the personal and the professional implications of participating before submitting to the research.

The audio tapes and the video tapes are stored and locked up in a safe at Diakonhjemmet University College according to the rules given by the Data Inspectorate (Datatilsynet) in Norway. Transcripts are also stored on my computer and here saved in a way that requires a password. All material that can be attached to a therapist or a client will be deleted when the project has finished.

This research concentrates on the family therapist's private and professional life. Their clients also play an important part in this research process. However, when the clients' stories appear they form a background or a connection for the therapist's stories. The client's stories are never in the forefront in this research. Nevertheless, the clients' anonymity is of great importance and is taken care of in this research.

Norway is a small country and the numbers of family therapists are relatively small. The participants in this research project have met me with generosity and an open mind and they have chosen to tell me many important private and personal stories. That means that it is

of the greatest importance that the participants keep their anonymity. In this thesis, I have done everything possible to cover my participants in a way that makes it impossible to recognise any of them by reading about their background and personal stories.

A research process that involves the participant's personal and private lives as well as their professional practice may influence them as well as the researcher in significant ways. This research process invites both the participants and myself as researcher to enter into reflections and documentations that demand respect and responsibility for the stories that are told and the clinical practice they let me be a part of. The analysis and the presentations of the participants' narratives will be treated as valuable material presented in a fashion that shows respect for each therapist's integrity and that does not cross their personal boundaries, as defined by them.

All participants were reminded that all narratives and all videos were to be considered as their property and that they had the right to withdraw at any time. They were also told that they would be shown how their material came to be analysed before the thesis was completed.

A research project and a research process has many ethical implications. It is, however, not possible to "fully identifying all the implications" (Wren, 2000, p. 84). For example, a research process may also be punctuated as interventions.

Self-reflexivity issues

The lack of interest in and work with the links between a family therapy students personal and private life and her or his process of becoming a family therapist is a main starting point for this research project.

My own ideas about the importance of understanding the connections of the patterns, which connects the therapist's personal and private lives with their clinical practice, appeared as a premise which I built on. Colleagues and friends also confirmed the idea that interesting connections between a psychotherapist's personal and private life and her or his clinical practice are important. However, I did not have any specific or particular ideas about special areas or topics of special importance or of special interest, and hence why I selected GT.

In the period when I was planning this research project, I went to the grocery store. There I met a researcher I knew a little beforehand. She asked me what I was doing for the time being, and I told her about my research proposal. She spontaneously said: "You have the right age and experience. You could not have done that twenty years ago." I had not considered that aspect of my project at that stage. However, I came to realize that a relationship of

trust and confidence was essential for the research process. One of the participants commented on this aspect after an interview by referring to another researcher that he felt tried to "pump him." That researcher did not get much from him, he said.

The Family Therapy community in Norway is fairly small and transparent. This makes these research issues very sensitive. I have been in the family therapy field for many years, both as a clinician and as a teacher. My background and competence will therefore be a part of what I observe and part of my analyses.

I decided not to include people I had as friends or students or clinicians I have been supervising. However, these guidelines should not exclude me from important contributions to my project. With one exception, I have followed these guidelines.

To further gain self-reflexivity I have also invited a colleague and doctoral student to interview me about my project plans and my own ideas and experience with patterns that connects a systemic family therapist personal and private life with hers or his professional life. I subjected this interview to theme analysis.

Research Flowchart

In Grounded Theory research, the sampling of material and the analytic process are closely linked. However, to help the reader to get hold of the process I have made two different diagrams to illustrate the research process. The first diagram illustrates the sampling process (The Research Flow Chart) and the second diagram illustrates the analyzing process (The Analyzing Flow Chart).

First, I will present the research flow chart that shows how the sampling process actually took place:

The Research Flow Chart: The process of theoretical sampling in Grounded Theory

Prepare interview, find 1st participant.

↓

Elisabeth, first interview.
Reflections from participant after interview
(Pilot)

↓

GT analysis of interview from Elisabeth

↓

Elisabeth, second interview.
Reflections from participant after interview

↓

Theme analysis of a video of a first session of FT from Elisabeth.

↓

Third interview, Elisabeth. GT analysis and reflections from participant after interview.

↓

Find 2nd participant, prepare interview

↓

Erik, first interview.

↓

Theme analysis of a video of a first session of FT from Erik. Prepare 2nd interview.

↓

Second interview, Erik. Find 3rd participant,

↓

Adam, first interview.
Reflections from participant after interview

↓

Theme analysis of a video of a first session of FT from Adam. Prepare 2nd interview

↓

Second interview, Adam. Reflections from participant after interview. Find 4th participant.

↓

Karen, first interview.
Reflections from participant after interview

↓

Theme analysis of a video of a first session of FT from Karen. Prepare 2nd interview

↓

Second interview, Karen. Reflections from participant after interview.

↓

Find participants with parallel connections to therapy.

↓

Interviewing Evelyn about being divorced when working with couples that consider divorce

↓

GT analysis of interview from Evelyn

↓

Interviewing Anne about working with people in crises when she was losing her husband in cancer.

↓

GT analysis of interview from Anne

↓

Interviewing Janne about working with families with problematic children while having serious problems with her own children

↓

GT analysis of interviews with Janne

↓

Questions about their thoughts today
(E-mail, fall 2006)

Putting together the whole material

Table 4. The research flow chart

Summary

First the design of the study and the methodology were clarified. Then I described the research process in this project. First the different elements in my research plan were presented. That included the design of the study, the material, the Grounded Theory procedures including the Thematic Analysis of the videos and the idea about making paradigm cases.

Then the Grounded Theory research process in this project was presented. The actual ideas behind recruitment and the actual research flow chart are presented. Examples of how I ask questions during the semi structured interviews and the transcribing procedures are documented.

4. Process of Analysis of the Material

Introduction

This chapter will describe the process of analysis of this research project. The analysing process is an ongoing process throughout an entire Grounded Theory project. I will here seek to give a complete overview of the analysis of the material that is the basis for the thesis. The process is divided into two main periods. The first period runs from the beginning of the theoretical sampling until the last interview is coded and analysed for the first time. This was the period of constant comparison where comparing the open coding and 1st level of categorisation of participant one's two interviews. On this basis the second participant is selected. The third participant is selected on basis of comparison between the first and the second participant, and so on.

The second period runs from the beginning of the analysis of all interviews in relation to each other and until writing the thesis. In this presentation, I will use this division. The second analytic phase started when all interviews were transcribed and the videos analysed for the second time.

The analyzing process

The analyzing processes have been perpetual in this research project. They started after the first interview, with the first participant, and went on until the thesis was finished. The Grounded Theory analyzing process and the Theme Analyses in this research are about comparing and contrasting, with the aim to construct and explore variation. The analyzing process can be illustrated as in this flow chart:

The Analyzing Flow Chart

GT open coding and analysis of first interview from Elisabeth. Pilot study. Writing memos.

↓

GT open coding and analysis of second interview from Elisabeth. Writing memos.

↓

Thematic analysis of video of a first FT session by Elisabeth. Writing memos.

↓

Comparing and contrasting first and second interview with the video of the first FT session. Preparing third interview. Writing memos.

↓

GT open coding and analyzing of third interview. Selecting the second participant.

↓

GT open coding and analysis of first interview from Erik. Writing memos.

↓

Thematic analysis of video of a first FT session by Erik.

↓

Comparing and contrasting first interview with the video of the first FT session. Preparing second interview with Erik. Writing memos.

↓

GT open coding and analyzing of second interview with Erik. Comparing and contrasting with Elisabeth. Selecting the third participant.

↓

GT open coding and analysis of first interview from Adam.

↓

Thematic analysis of video of a first FT session by Adam. Writing memos.

↓

GT comparing and contrasting first interview with the video of the first FT session. Preparing second interview with Adam.

↓

GT open coding and analyzing of second interview with Adam. Comparing and contrasting with Elisabeth and Erik. Selecting the fourth participant.

↓

GT open coding and analysis of first interview from Karen. Writing memos.

Thematic analysis of video of a first FT session by Karen.

↓

Comparing and contrasting first interview with the video of the first FT session. Preparing second interview with Karen.

↓

GT open coding and analyzing of second interview with Karen. Comparing and contrasting with Elisabeth, Erik and Adam. Selecting the participant for parallel connections. Writing memos.

↓

Selecting more participants for parallel connections.

↓

Open coding and analyzing of Evelyn's interview. Writing memos.

↓

Open coding and analyzing of Anne's interview. Writing memos.

↓

Open coding and analyzing of Janne's interview. Writing memos.

↓

Putting together the whole material
GT axial coding

↓

Bottom up analysis of all transcriptions from Elisabeth, Erik, Adam and Karen (nine interviews).

↓

Sorting open codes in piles with codes that are the same and that are closely related.

↓

Putting related piles into envelopes. Giving each envelope a long name that reflects the content.

↓

Categories and sub categories emerged. Writing memos.

↓

Top down analysis of transcripts from Evelyn, Anne and Janne (three interviews).

↓

New categories and several sub categories emerged. Writing memos.

↓

Constructing findings in thesis.

Table 5. The analyzing flow chart

The analysing process has been divided into two phases. The first analytic phase was closely connected to the process of recruiting participants and interviewing them. In addition, four videotaped therapy sessions were Theme Analysed and this analytic work established the background for each of the second interviews with the participants.

Theoretical sampling

"Theoretical sampling is important when exploring new or uncharted areas because it enables the researcher to choose those avenues of sampling that can bring about the greatest theoretical return" (Strauss and Corbin, 1998, p. 202). One criterion I have used in my sampling is ***variation***. Initially open coding offers many different persons to be interviewed because I initially do not have any concepts that have proven theoretical relevance. That means that I initially do not know where to look for variation. However, as an experienced family therapist, teacher, and supervisor I know the family therapy field quite well. That includes both different ways of conducting therapy and many family therapists in Norway.

According to the criteria for sampling, I am not trying to find a representative group, rather, I am trying to reach theoretical saturation. However, I have used both women and men preferably of different ages, trained and experienced in systemic family therapy. On the other hand, criteria such as religion and socio-economic background are among those criteria I will not use. The participants might therefore differ or be alike when it comes to these dimensions. Norway is a rather homogeneous country and the family therapy group is rather small. With such few participants in my project, these criteria probably do not contribute with important information. It can however, be an area for further research.

I have looked for participants with different family backgrounds and experiences according to the developing grounded theory analysis, that is, experiences from divorce, death, alcohol abuse, and so on. These are all areas commonly dealt with in family therapy practice. These are criteria that vary much among therapists and that may influence their practice dependant on how their own experience with these areas has affected them.

Participants have been sampled separately. This helped me to keep anonymity and avoid identification of participants in the same way that might happen when they are recruited from the same workplace. My research will focus on the patterns that connect therapists' own personal experience and life with their clinical family therapy practice. Discovery shall not only rest on videos and interview transcriptions but also on the Grounded Theory memos and participants' reflections that are produced as a part of the research process. To maintain this, I have written a research diary informed by my contact with the participants and my own re-

flections from the research process. The diary contain everything from who I met, where we met, when we met, how the interview came about, my reflections afterwards, further plans and so on.

Initially open coding offers many opportunities for different participants to be interviewed because I do not have any concepts yet that have proven theoretical relevance. That means that I will look for variation as a part of the theoretical sampling process.

Variation among Participants

All participants in the project are Norwegian family therapists. One is also an inhabitant of a Middle-East country. As mentioned, they are two men and five women with experience as family therapists that span six to thirty-three years of family therapy practice.

It is, however, different types of experiences connected to patterns that links their clinical practice to their personal and private experience that have been a major source when looking for variation. This aim has been reached through the analytic process in theoretical sampling and the method of constant comparison. When I knew about what and "who" I was looking for next, I used my own knowledge from the field of family therapy in Norway and my colleagues to look for the next participant. Only one that was asked to participate refused to be a part of the research. She used a week to decide, and she said "no" without any further explanations.

Writing memos

Through the process of interviewing participants and watching videos from their clinical practice, I have written memos. The memos are my interpretation and analysis and give direction and question for further data collection. This memo writing process is one of the frameworks for developing concepts and categories.

Writing memos represents the process in between analysing the material and writing the first draft. "Memos catch your thoughts, capture the comparisons and connections you make, and crystallize questions and directions for you to pursue (Charmaz, 2005, p. 72). Writing memos also became a way of storing ideas and possible connections between different parts of the material, for example between transcriptions and videos. Re-reading the memos in the process of writing a first draft was very fruitful and some of the memos represented pre-written reflections, case material and analysis of great value.

Memos are my contemporary interpretation and analysis of the ongoing research process and give direction and questions for further data collection. This process was the basis for

developing concepts and categories. Memos are made in between coding and form the framework for the thesis. The thesis is based on the developed categories and "…the categories reflect the interaction between the observer and the observed" (Charmaz, 1995, p. 32).

Open Coding for the Transcribed Interviews

Open coding consisted of line-by-line analysis of transcribed interviews and it constitutes the first stage in the analysis. Initial coding and analysing is a part of the theoretical sampling process. These processes are closely linked to writing memos and in that way developing the project on its way to saturation. In the analyzing process, the seven participants are treated in different ways. The four first (Elisabeth, Erik, Adam and Karen) participants contribute with nine transcribed interviews and four video sessions of a first therapy session. All the transcribed interviews are line-by-line coded and analyzed as a part of the theoretical sampling process. The videos are subject to theme analysis to make it possible for connections between participants' clinical work and personal and private life to appear. In this way, they are also a part of the theoretical sampling process.

The next three (Evelyn, Anne and Janne) participants participate with three interviews and the transcriptions are line-by-line coded in the same way. After analysis, these interviews are connected to expanding the categories that emerged during analyzing process.

The coding process gave initially many new ideas and was very helpful in developing the research to get variation and depth. The analysing process offered to the project new research categories that were not already included. This made me look for what could widen my project and find new family therapists as participants. In this period, I used my colleagues to get advice for who could be my next participant. I told them what I was looking for and they could give me ideas for whom to ask.

Analysis

Grounded Theory is well designed for developing theory in the topic under the investigation, and it is based on the idea of theoretical sampling. In addition, Grounded Theory appears to be a structured and well-suited approach to analyse huge amounts of information. It also has the advantage of being both descriptive and interpretative (Polkinghorne, 1989), and would therefore work well for my analysis. Analysis should come immediately after data collection. This means that analysis follow each interview or participant (Strauss and Corbin, 1998, p. 207).

According to Pidgeon and Henwood success in generating theory that is well grounded in data depends upon maintaining a balance between the full use of the researcher's own subjective understanding and the requirement of ´fit´ (Pidgeon and Henwood, 1996, p. 87). This means that the categories have to ´fit´ the data and that trustworthiness and subjectivity could emerge to a level of new meaning that can create intersubjectivity. Trustworthiness is in the eyes of the readers.

The material has been analysed in two steps. In the first step, I have used Theoretical Sampling from Grounded Theory to guide the selection of participants. Then I have used Grounded Theory coding to analyse the interviews and I used Theme Analysis of the videos as the main methods. Grounded Theory has been used to analyse my transcribed interviews. The relation between the interviews and the video has formed the basis for my theoretical sampling. I have been directed by looking for variation so in the analysing process I was always searching for new material and new stories.

In the second step in analysing my material, I have done ***axial coding***. Axial coding was the main process to create categories from the first and second interview.

Patterns between Narratives

Patterns between narratives that showed an important link between a therapist's private and personal experience and the therapist's clinical practice came forward already in the first interview with Elisabeth. All but one therapist could spontaneously tell stories from their own personal and private life and link some of them more or less directly to their own clinical practice. These stories are documented in this thesis.

Thematic analysis of videos

The aim of the thematic analysis of the videos was to look for links between what was going on in the therapy session and the knowledge I had about the therapist from the transcribed interviews. The videotapes were looked through several times.

The videos were coded according to themes that emerged in the sessions. The theme that came forward in this coding was compared with the transcribed and coded interviews. When any match between an interview and a video from the same therapist was found, these parts of the videos were transcribed too. Parts of the client's stories that the therapist did not give any specific attention are examples of what I did not transcribe.

The transcribed parts of the videos were then analysed and compared with the narratives that came forward in the interviews.

Patterns between Narratives and Videos

With the help of videotaped therapy sessions, observation as method was brought in to be a part of my material. After coding and analyzing first the transcript and then the video, the results were compared and contrasted in looking for patterns and narratives that could be connected. When connections between transcript and video were constructed, the construction was brought back to the participant in the next interview. In this interview my constructed relation between a story in the first interview and the video were presented. This new interview also worked as a validation procedure.

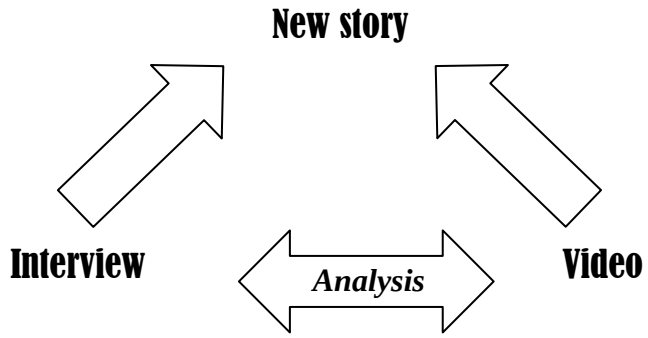

Table 6. The Creation of Patterns that Connects.

The Coding Procedure and Process, Bottom up and Top down

Bottom up coding was open coding of the nine first interviews. The categories that emerged through this process were used to "top down" analyse the remaining three last interviews. Several hundred codes emerged during the initial Grounded Theory analyzing processes (Appendix 5). At this stage, the whole material was analysed again, and this time with axial coding with the aim to develop categories.

After some considerations, I chose to do the analytic work manually. I used scissors and an empty floor and started to cut the more than 300 pages of transcriptions and sort them according to codes that were related. After the first rounds, it was possible to incorporate some of the piles and to move the work on to a large table.

When all interviews were coded and analysed as a part of the theoretical sampling process, the first nine were cut in pieces using scissors and spreading them out on the floor. I started to organize the small pieces of papers for each participant in piles after how they related to each other. These piles formed themes and some of the piles could after some time go together under a common theme. In the end, I put the piles for each participant into envelopes

and gave each envelope a name reflecting the content inside the envelope. The content of the envelopes for each participant helped me construct a diagram.

Open Codes and Research Categories

These open codes were sorted manually, as told before. At the same time, the videos were analysed with Thematic Analysis. After a long and demanding process the first categories slowly appeared. When they first appeared, the analyzing process came over into a "smoother water".

In the first rounds of analyzing the interview, the main idea was to use the result of the analysis to find the next participant. However, it became important to start writing memos already at this stage. These memos came to be the first theoretical constructions of my thesis. As mentioned, I manually cut all the interviews into pieces according to open codes and related codes and put them into piles. The first case was compared and contrasted with the second case. Then these two cases were compared and contrasted with the third. At last, these three cases were compared and contrasted with the fourth. I put all the piles into different envelopes and gave the envelopes names after the topics of what they contained.

Most of these names were long names like: "*Therapy, histories and experts that reflect with their blind spots".* Then I started to put these envelopes together according to how they were related to each other. The first categories came out of this sorting process. All together nine interviews were included in this process.

Top Down, Special Topics and the Representatives for these Topics

Already in the first round with coding interviews, the first category emerged. When I was analysing one of my cases I found some possible connections between my first interview and the video that was not clear, but that I wanted to explore further. In the video the therapist met with a couple. The woman in the couple said that she not could live with the man any more but since they had two children they needed help to communicate as parents. When the therapist was exploring what was the problem they told about several serious problems in the family. Two of the problems were that the man was a diabetic and that he was a heavy drinker. In the rest of the session, these two problems were the topics. The therapist asked some very qualified questions about his diabetes and she explored his drinking problem in detail. In the end of the session, the woman said that she had decided beforehand that she would not talk about her husband's drinking problem. She seemed astonished that that was all they were talking about.

In my analysis from the first interview I came to know that the therapist was a nurse and in one sentence she said: *"... and my husband is drinking too much"* (2, 23). Her interest for his diabetes could be connected to her background as a nurse but could it be a connection between her small comment on her own husband drinking too much and her focus on this drinking problem of the husband on the video? I decided to ask her both these questions in my next interview.

When I met her again, I presented my findings and when I asked for a possible connection between her focus on diabetes and alcohol abuse she said after some time of interviewing:

> *"This could have been me and my husband. He has diabetes and he is drinking too much. We have been going for couple's therapy for one and a half years with this problem" (3, 36).*

At this point I realised that sometimes there are "obvious connections" like this. However, these "obvious connections" are not always easy to discover or to act on. However, this made me interested in this aspect, and I immediately knew many stories like this from my own experience and from therapists I have met in the family therapy field. I named these kinds of obvious connections *parallel connections*.

Parallel Connections

Some connections between the therapist's own personal life and the client's experiences are based on special crises or dramatic events in the therapist's life. This can be connected to for example death or divorce. To understand these kinds of processes we have to consider time. Therefore, it is two kinds of connections that are obvious. First, there are connections that correspond in theme and time, and second, there are connections that are a part of the therapist's life history and that now are a present problem for the clients. For most therapists it is probably a difference between situations where the therapist and the clients have the same kind of problems at the same time, and situations where the clients' problems are a part of the therapist's life history, but not an active ongoing problem at the time being.

When the same kind of problems or difficult life situations occur simultaneously for the therapist and the family it can sometimes be impossible for the therapist to go on working with these families or as a family therapist at all.

When the same kind of problems or difficult life situations has been a part of the therapist life history it can be a very important source to a qualified therapy process. "Parallel connections" has got its own chapter in this thesis (see chapter 7).

Development of Categories and their Relationship

Pidgeon and Henwood (1996) note that Grounded Theory is more useful in helping the researcher *into* the maze of a fractured and multiseamed reality. It offers less in helping to find ways *out* of it. Categories emerged slowly from my material. However, categories emerged almost at all stages of the research process. The main body of categories came forward towards the end of the analysing process. "The first step in a grounded theory analysis is to begin to identify descriptive categories in the transcribed research interview as soon as data collection has begun" (Burck, 2005, p. 246). Appendix 7 gives an illustration on how one category connected to "Dynamics that show how that personal and moral values influence or not influence their therapeutic work" started to emerge.

An example of how the category called "Therapists that participate in parallel connections and that have to deal with the links between their own personal life and the client's problems" emerged is illustrated in this diagram:

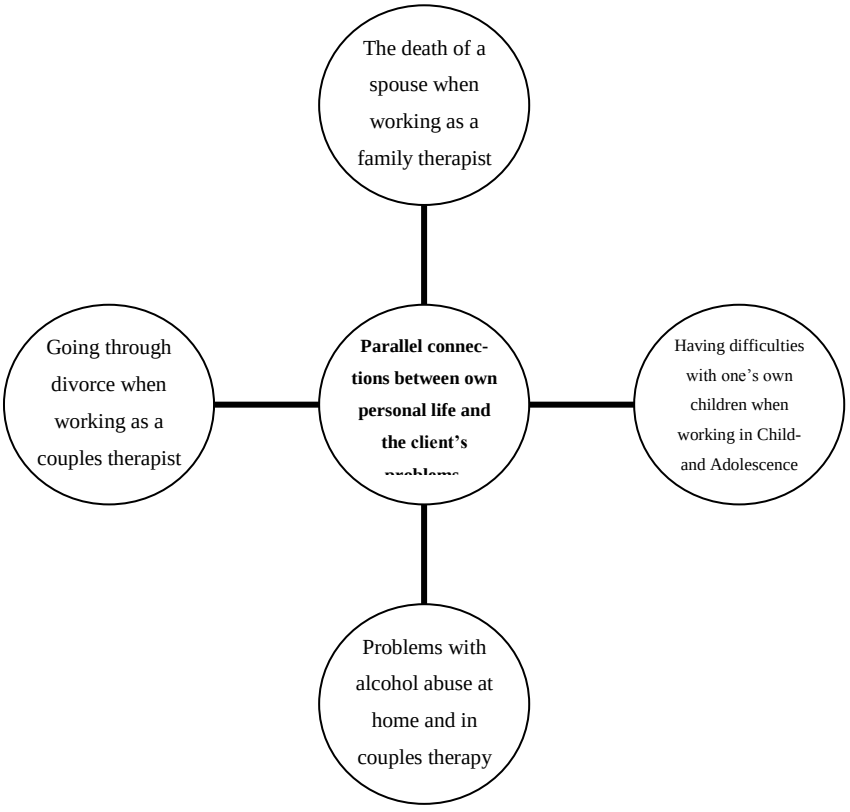

Table 7. The diagram illustrate how different research categories from the transcribed interviews form a category.

The relationship between categories emerged as the analytic work developed. Some paradigm cases could only be told and understood as a meeting point between different categories. Relationship between categories and between categories and sub categories are also documented in diagrams.

Patterns between Narratives, Videos and Literature

I have been looking for patterns that connect on three different levels. The first level represents patterns between narratives and stories participants could tell in interviews. The second level emerged in my comparison of the first interview and the video of a first therapy session. The third level represents a triangulation (see below) where narratives and videos encounter supervision literature, psychotherapy research and family therapy education.

The findings in this research project are viewed in a context of three main legs of a triangulation process. The first leg is the analysis of the transcribed interviews. The second leg is based on observation. The observations are videos and the analysis of the videos. The third leg is the literature review. With these three legs a triangulation strategy is formed.

Validation strategies

Use of a Second Rater of Coding Transcripts: Independent Audit

An assistant professor, working at a Teachers College at the University College of Oslo has reviewed one of the initial transcripts. General codes were identified and these were compared to the codes and categories developed by me. This was done to check the credibility of my own analysing work and to compare what comes forward when it is done by two different persons.

Triangulation

The most common definition of triangulation is that it is using different methods or sources of information in the study of the same phenomenon (Jick, 1979; Richardson, 1996; Robertson, 2002). There are different types of triangulation. We have data triangulation, observer triangulation and methodological triangulation. In this thesis I will, however, use *theory triangulation* (Robertson, 2002). The idea is to compare and contrast findings in this research project with similar and parallel topics in the literature review. In theory triangulation or theoretical triangulation (Jick, 1979) I will use different perspectives and theories from psychotherapy

research and supervision literature in analysing my material and extracting new theory from it. Triangulation can help me to be more confident of the results (Jick, 1979).

The way of triangulation used here can help "to counter all of the threats to validity" (Robertson, 2002, p. 175). If not all, to hopefully be an important step in that direction. My triangulation model looks like this:

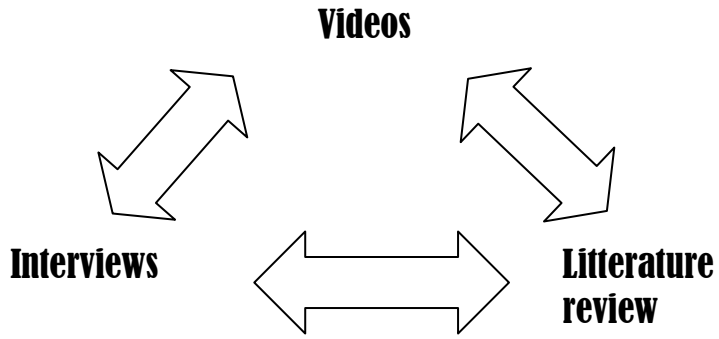

Table 8. The Triangulation Model

This model offers a context and an analytic view that gives possibilities for theorizing that also is related to established psychotherapy research and to some of the topics that are of special relevance for this research project.

Validity is closely linked to trustworthiness. Triangulation is a strategy for achieving trustworthiness and credibility in qualitative research. Credibility means that the theoretical framework generated is understood and that it is based on the data from this research. Validity is also connected to trustworthiness when it comes to the reader's assessment of a research text.

The Road to Saturation

This research process has been like entering into an unknown and exciting landscape. I had the feeling there was much to find there but I did not know if I would find anything in the track that I had planned to go. Would the therapists tell me their private and personal stories? Would they try to make links between their personal and private life and their clinical practice? Would I be able to find links between personal and private life and their clinical practice when I compared my interviews with the videos of their practice? Would my "findings" give meaning to their understanding of their clinical practice?

After the first interview, I found myself in a very optimistic mood. I felt I had received rich material with important stories that connected personal and private life with clinical practice. However, could this interview add any meaning to the video of her therapy session? In the following, connections of this kind were not that easy to discover or create, because they were hidden or blurred and they would not give meaning to my research before they were recognised or commented on by the participants.

In the second interview, I presented my understanding of possible links between the first interview and the video of their first therapy session with a family or a couple. In these interviews, we released new stories that gave meaning to an understanding of connections between personal and private life and their clinical practice.

The areas and topics that are relevant and interesting in this research field are close to endless (see Appendix 9). In this research project saturation also represents a situation where the project is able to document a varied and rich demonstration of meaningful stories about how we can understand the connections between family therapists personal and private life and their clinical practice (more about saturation, see p. 170).

The whole research process, with theoretical sampling, has partly been an analyzing process. After the comprehensive analyzing of the complete material to extract categories at the end of the research process ended with a realisation that my material was drained.

Summary

In this chapter the actual analytic process are accounted for. That includes how memos are used all through the entire research project. The coding procedures are shown with an example and the analysing flow chart illustrates the initial analytic process. This process is brought forward by the patterns that connect the transcripts with the videos and both of them with the literature review. This shows the way to saturation and the development of categories and the thesis.

Section B. Research Findings, Researcher Reflexivity, Discussion of the Thesis and Suggestions for Further Research

Orientation to chapters 5-9

The findings in this research project are divided into two main forms of presentation. One is the Grounded Theory categories with their subcategories. I will present the seven Grounded Theory categories with their sub-categories and sub sub-categories. The other form of presentation is the Paradigm Cases. The Paradigm Cases are used to illuminate topics from the research in terms of a "thicker" narrative derived from the GT analysis of the interviews with the participating family therapists, in order to offer a wider perspective on some of the GT categories presented. Both the Grounded Theory categories and the Paradigm Cases emerged through analysis of the interview transcripts and from thematic analysis of the videotapes of a first family therapy session.

In Chapter 5, the research findings are divided into parts A, B and C: Part A is a description of the participants' backgrounds and their contemporary lives. Throughout the thesis the participants will be presented by first (fictitious)name and with the number they were allocated in the research project. For example Elisabeth, who was the first participant, will be presented as "Elisabeth (1)," Erik as "Erik (2)" and so on. This will be done to help the reader keep an overview when reading.

In Part B. the seven Grounded Theory categories that emerged from the analysis will be presented along with their sub- and sub sub-categories. The categories are further organized into four main areas:

1. The first area concerns becoming a family therapist.

2. The second area is about personal and private values and attitudes.

3. The third area deals with therapists' dilemmas.

4. The fourth area concerns the influence of working as a family therapist on the therapist's personal and private life.

In Part C four main paradigm case topics are presented. Several sub-topics are presented as paradigm cases. In connection with topics under Parallel Cases, four major subtopics will emerge.

Chapter 6 deals with reflexivity and self-reflexivity. Professional and personal background to entering the research project and possible limitations of the methodology will be

presented. Ethical issues and the questions of validity and trustworthiness are also included here.

In Chapter 7, the discussion of the lack of research that includes the meaning of the therapist's personal and private life in psychotherapy research will be discussed. In addition, some of the main findings will be discussed linked to the psychotherapy research literature and to some extent the supervision literature connected to systemic family therapy.

In Chapter 8, a middle range theory will be presented based on the relations between the GT categories and paradigm cases. This theory will be discussed as a theory for understanding the influence of personal and private experiences on systemic family therapy practice.

Finally, in Chapter 9, I will give some thoughts and ideas about further research.

5. Narratives that Connect Family Therapists' Private and Personal Lives to their Clinical Practices, and Vice Versa

The Therapist's Background and the Grounded Theory Findings

The findings are divided into Parts A, B and C. In Part A, the participants' professional backgrounds and their experiences are presented. In Part B, the influence of private and personal experience on clinical practice and vice versa are presented. These findings are derived from the GT analysis and from GT categories with their sub-categories. All categories and sub-categories are documented with examples from the transcribed interviews. In Part C. the paradigm cases are presented.

Part A: The Therapist's Background and Experience

Introduction

The participants in this research project will be presented in such a way as to contextualise the research findings. The material presented here is drawn from the interviews and from later supplementary e-mails from the participants. All participants are Norwegian family therapists with different backgrounds in terms of gender, family of origin, education, experience, theoretical orientation and where they come from in Norway.

The participants' backgrounds and experience will be viewed in a professional context and their relevance for practice as family therapists discussed further on. First some elements from their family- and cultural backgrounds influencing their decision to train and work as family therapists will be illuminated to help the reader understand their background and who they are.

The family of origin forms one important context for understanding the family therapist's background. Alongside this aspect comes the therapists' political and cultural backgrounds, their social and economic settings and the religious commitments and values that have formed the therapists.

Family Background, Private and Professional Lives

The seven participants are between 40 and 59 years of age. Five are women and two are men. They originate from different parts of Norway and work currently as therapists in the southern and eastern parts of Norway. I have detailed the family backgrounds of the first four of the

participants but have not gone into detail about the final three. This is because the last three were brought in to provide some more specific narratives about parallel connections. I have similar information about all seven participants' personal lives and circumstances.

Family backgrounds

Six of the participants come from traditional Norwegian nuclear families. That means that they have grown up with a mother, a father (or a stepfather) and sisters and brothers. All of the participants have siblings. One of the participants was born abroad and grew up in Norway. Some members of her family still live abroad. One of the participants grew up in a stepfamily and one of the participants lost the father in her family of origin when she was young. The participants have working class or middle class backgrounds.

Private and Contemporary Lives

Six of the participants live with a man or a woman. One of the participants lives alone. Five of the participants are divorced one or more times and one has never been married. Two of the participants are in their first marriage. All of them have one or more children and two of them have children that still live at home.

Professional lives

The participants consist of two psychologists, three nurses and two social workers who all have family therapy training. There are two men and five women. When I interviewed them, they worked in adult psychiatry, in child- and adolescent psychiatry, Family Counselling Offices and in private practice. All except one family therapist asked to participate in this research project said "yes" to participation in and contribution to my research. I interviewed them in order of appearance (see p. 60)

There is insufficient information in my material to explain how and why the participants went from being professional health- and social workers to becoming family therapists. For example, I did ask all of them about these topics but I do not have enough material to include Evelyn (5), Anne (6) and Janne (7) in this section. For the four first participants, becoming a therapist is connected to early ideas and experiences in life. For the other participants it is more of a coincidence that they began training as therapists.

The Therapist's Experience and Expertise

The participants' years of experience as family therapists varies as mentioned earlier from six to 33 years. I have insufficient material to discuss differences between novices and expert therapists. It was, however, only the most experienced therapists who mentioned the ability to see two different views at the same time and ambivalence and that talked about these phenomena as assets in their therapeutic work.

Summary of the therapists' backgrounds and experience

The seven participants' family backgrounds are all Norwegian and they form a rather homogenous group when it comes to their socio-economic backgrounds. Some of them are able to point out how they became a therapist by telling stories from childhood and adolescence and some of them claim that their becoming a family therapist is more of a coincidence.

The researcher's personal reflections:

I have often wondered how important the therapist's background is when we shall explain what is going on in therapy. Will the social class the therapist stem from offer any advantages or any challenges when she or he meets someone with a similar or different background?

I am born into a big working class family where no one have any academic education, from my generation and backwards. I recognised this starting point as common for some of my participants. Other participants have a more middle class background and no one comes from a traditional upper class.

My own view of the world and ideas of how to live a life has been dramatically changed and widened since I started to work as a family therapist thirty years ago. I think about my journey as a family therapist as a great privilege. To learn to know this many different people and this many different ways of thinking and solving problems represent un irreplaceable aspect of my own life.

I felt that all my meetings with the participants represented strong and genuine meetings in an atmosphere of trust and openness. Did I choose participants of "my own kind"? Is that some of the foundation for my experience of an atmosphere of trust and openness? Should I also have looked for participants that represented variation not only when it came to the topics but also when it comes to me?

Part B: Grounded Theory Findings: Narratives that Connect Private and Personal Experience with Family Therapy Practice and Vice Versa[27]

Introduction

When we talk about a therapist's experience we most often refer to her or his training background and professional life. Her or his personal and private experiences are often left out or overlooked as parts of what is included in a professional context in the experience we consider a part of clinical competence. This is in line with some central ideas in evidence-based practice. In evidence-based practice the idea is mainly that it is the therapeutic intervention that works and interest for who the therapist is as a private person is limited, i.e. not thought to be relevant. However, in research interviews, the participants spoke about the connections between their own personal and private lives and their therapeutic practice. As this research will attempt to show, connections between personal and private life and therapeutic practice may be important in understanding family therapy.

Two of the research questions were: *"How does the therapist's own life history and personal and private experiences influence the way he/she understands and practises systemic family therapy?"* and *"What are the influences of being a systemic family therapist on the therapist's own life and how she/he thinks about the way she/he lives it?"* This chapter gives the Grounded Theory analysis of the interview transcripts and videotapes as they addressed the research questions.

When this research process started, I had no pre-made categories that I wanted to investigate. Neither did I have any coherent theory or hypotheses that connected family therapists' clinical practice to their personal and private lives. My starting point was my curiosity connected to these possible connections between family therapists' personal and private lives and their clinical practice and a hunch that this area was open for further research.

[27] Some of the findings are used in an article: "On Learning From Experience. Personal and private experiences as the context for psychotherapeutic practice." *Clinical Child Psychology and Psychiatry,* vol. 12 number 3, SAGE Publications

Grounded Theory categories with sub-categories presented in the findings[28]

The analysis of the interviews resulted in the development of seven GT categories. The seven categories are made up of sub-categories that offer a more nuanced and broader understanding of each main category. The seven categories with their sub-categories are:

1. The participants' personal experience
    a. The ability to "see" peoples' situations
    b. Interest in talking and listening to people
    c. Complexity of one's own family history
    d. The role as an intermediary in one's own family of origin
2. The influence on clinical practice of the therapist's experience of being in therapy themselves
    a. The obligation to let everyone be heard
    b. On becoming a better therapist
3. The participants' explicit personal values that influence practice
    a. Belief in change
    c. A nuanced understanding of clients lives
    d. Being careful and meeting clients with respect
4. Dynamics that show how personal and moral values influence or do not influence their therapeutic work connected to:
    a. Love life
    b. Raising children
    c. Alcohol abuse
    d. Religion and politics
    e. Relations between people
    f. Therapeutic process
        i. Creativity
        ii. Private strategies
        iii. The ability to see two different views at the same time
5. Therapists' acceptance and avoidance of how personal and moral values influence their therapeutic work

[28] See Appendix 8 for a map of categories.

    a. Never use personal background in therapy
    b. May use personal stories when it is meaningful
6. Therapists' personal and professional dilemmas when faced with clients' actions they approve or disapprove of
    a. Sexuality and love life
    b. Handling emotions in therapy:
        i. Compassion
        ii. Joy
        iii. Sadness
        iv. Anger
    c. Repetition and complaining
7. The influence of clinical practice on personal and private life
    a. When the therapist is using "family therapy techniques" on his or her own family
    b. Going through a divorce process
    c. Handling family and friends
    d. Professional practice does not affect private life directly

These seven categories have been further organised under four research headings. The first heading is "GT Findings about becoming a family therapist". The next heading is "GT findings on personal and private values and attitudes". Then we have "Therapists' Personal and Professional Dilemmas when Faced with Clients' Actions they Approve or Disapprove of" and "The influence of clinical practice on personal and private life". The two last headings are also GT categories.

GT Findings on "Becoming a Family Therapist"

Introduction

The GT findings on becoming a family therapist are made up of two GT categories with their subcategories. The first GT category is called "personal experience" and the subcategories are "the ability to "see" peoples' situations," "interest in talking and listening to people," "complexity of own family history" and "the role as an intermediary". The second GT category is "The influence on clinical practice of the therapist's experience of being in therapy for themselves" with the sub-categories "The obligation to let everyone be heard," and "On becoming a better therapist".

GT category 1: The participants' personal experience

Personal experience from one's own private life seems to be one type of narrative that family therapists find meaningful to use when they are asked to explain how they found their way into family therapy practice. This main category is supported by sub-categories derived from material from all four full participants Erik (2), Karen (4), Elisabeth (1) and Adam (3). I will bring one example from each one. As mentioned earlier, I do not have enough information from the final three participants to include them in this category.

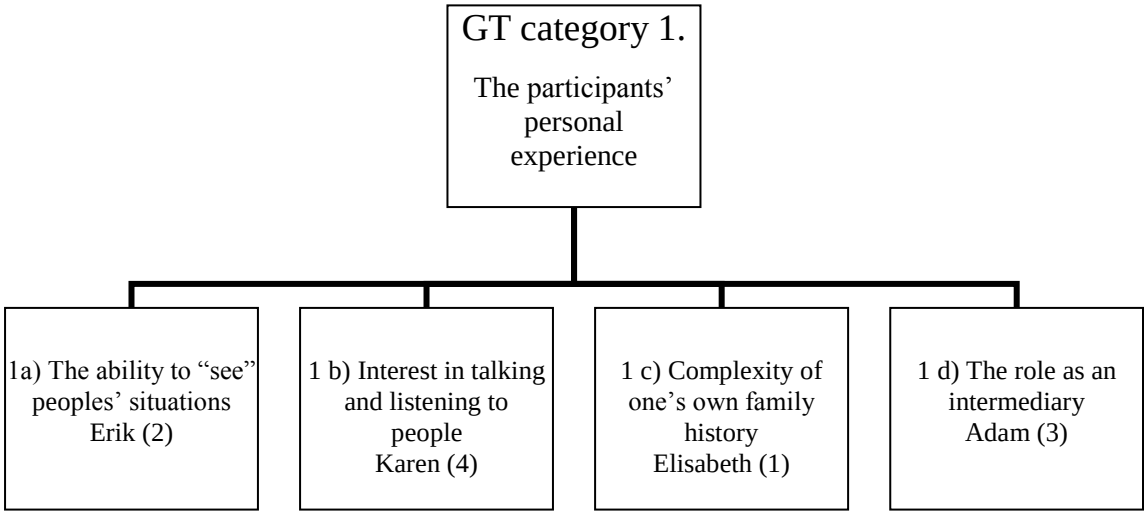

Table 9, GT category 1

1 a) The Boy with the ability to see peoples' situations

Erik (2) tells a story:

> *"...from the second year of occupational school where someone had an idea about how someone else was doing,...and I had a different idea about that because I thought I could see something...and that gave me in a way a platform, because there was something I understood about people which I didn't think other people did, ...but that was something that gave me a sort of building block, which was part of what drew me to what I've done, that is one of the elements..."* (4, 60).

He also remembers a story from his second year in lower secondary school. He disagreed with someone about another person's condition and he thought *"...I saw something...I have had confidence in being able to see something"* (4, 102). He understood something about people that others did not understand. That offered him a platform and was a building block on his way to becoming a psychologist and family therapist.

As we see, Erik (2) had the idea about his ability to "see" people long before he received any formal psychological or therapeutic education. With his working-class background

it was not expected of him to go to university to study psychology, but he was encouraged by a friend and took the step to enter university. However, he did not seem to be very interested in analysing this topic or taking a particular stand towards the question. He says:

> *"I don't think I can take any kind of permanent standpoint about that, I, because…I can go all the way back to my own treatment and that and I would have thought 'yes' that is meaningful and not least ideas connected to Alice Miller for example then, that are more psychoanalytic. If I go into that way of thinking, I would probably search sort of along these lines: why in the world should I, and for that matter my two siblings as well, be involved in very similar things?" (5, 5-6).*

1 b) Interest in talking and listening to people

On the other hand, Karen (4), had no idea whatsoever to become a therapist. She wanted to be an artist, but since she found that earning a living from art was too difficult, she went into the school of social work because, as she says; *"I like to talk to people and I like to hear their stories"* (8, 10). Through working in Child and Adolescent Psychiatry she slowly moved into more and more therapeutic situations and after a while started to think about herself as a therapist.

She met two family therapists who came to represent an alternative to the traditional hierarchy in Child- and Adolescent Psychiatry. She said that she did not understand much of what they said, but when she experienced their way of working, she understood what happened. *"It was a revolutionary way of thinking"* (8, 65) she says. She has worked as a family therapist for 25 years.

When I ask her what has made her stay for this number of years as a family therapist, she says:

> *"I feel that to work in therapy gives one so many sort of kicks, quite positive kicks, actually. The… moment, …where you suddenly know that something or other is connected in a certain way that makes it possible for people to get some new ideas about their lives. And that they make something out of that. I don't think there are many professions that have many of those sorts of moments"* (8, 21).

1 c) Complexity of one's own family history

Elisabeth (1) says that she got the idea of being a therapist when she was in the School of Nursing. She connects the development of this impulse to her own family background. She says:

> *"…because I…am from a mine-and-yours, I have the sort of, the sort of family that is modern today or that exists today, that's my family. My father has been married and divorced 3 times and I am the child of his…second marriage. He has a daughter from*

his first marriage, she's 12 years older than me and then he has a son from the third. And I am from the second and it was my mother's first marriage and there was a big age difference between them. My mother was 22 and he was 13 years older in 'Israel'.

And then my mother took me back to Norway when I was 2 ½ and they got divorced. Ehhh and then my mother met a new man when I was 5 and they got married when I was 10, and he had a daughter from before from a marriage where he had barely lived with her.

And then they've had a child together ehhh and then they had a project; we'll make a successful family. I was given his name then and from then on it was just us and I am quite stubborn about certain things and was quite stubborn about being an 'Israeli' citizen and that I had a father in 'Israel'. So we have sort of had two parallel histories, he tells colleagues and his work and everyone that I am his daughter and I say that he is my stepfather. We moved to 'Sarpsborg' when I was 17 because he'd then needed some practice as to become a lawyer.

Because I've always felt, or very early, that I was ungrateful because I didn't accept his love in the way he wished. And I didn't go along with their new project, right? I thought it was the wrong project. Like that my sister, half-sister, who was then born when I was 14 she was 8 years old before she knew that I was her half-sister and that 'Ann', her father's daughter from the previous marriage wasn't her cousin, but was her sister, because they were trying to protect her.

And I'm unbelievably against that also because there I've, it's one of those things; if one gets over…talk about a time you were taken by surprise and over-enthusiastic" (1, 39).

This story and her own understanding of her family background will be a key history when she later tells stories about parallel connections (see p. 106). Elisabeth (1) has been involved in different kinds of clinical work, mostly in the field of psychiatry. She has worked part-time as a family therapist and a couple's therapist for about 10 years, mostly as a substitute, and she is still looking for a job as a family therapist that will be suitable for her.

1 d) The role as an intermediary

The question of mediation as a competence area for family therapists emerged from the Grounded Theory analyses. Here it is connected to growing up as an intermediary in one's own family of origin.

When I ask Adam (3) if he has had any thoughts connected to the theme for this research interview he says that he has reflected on how he came to be a family therapist. And he says: *"I think it is connected to the family situation in which I grew up, to the part I played"* (6, 15). Further on he says: *"And some of it is connected to things I have read, especially*

when I was young… I particularly read Axel Sandemose. He was very preoccupied with his family" (6, 15).

When I ask if it was a particular novel he remembers he immediately mentions '*A refugee crosses his tracks'* by Sandemose." He points out that Sandemose was very negative about his family and how he in a way was oppressed by *"…all these ideas about how things should be"* (6, 19).

When I ask for more important references he mentions Marie Cardinal's autobiographical novel "*The Words to Say It."* The novel made an important impression, an impression that appealed to him. He was attracted by the idea that that it was possible to get into a healing process like this through talking. These ideas appealed to him tremendously, both the idea of going to a therapist and working as a therapist.

The influence from his family is connected to his role as *"... an intermediary or mediator… between us children and the grownups"* (6, 31). When he was a teenager he was a go-between for his parents and between his parents and grandparents and other relatives. He thinks this has formed him as a "helper". When I ask him how he experienced this role as a teenager he underlined that he liked it and that it was exciting. It gave him a particular position in the family as a whole. Adam (3) said that he was a kind of mediator in his family when he was a child and a young boy. This position as mediator gave him a particular status in the family, a position he liked and developed.

In his final year in the School of nursing, he had a practice in an outpatient clinic and got his own office and clients that came to therapy and returned every week. *"That was such great fun"* (6, 87) he says. From that point he knew clearly what he wanted and decided to be a therapist. That was twenty years ago.

GT category 2: The influence on clinical practice of the therapists' experience of being in therapy themselves

In Orlinsky and Rønnestad's (2005) research project about how psychotherapists develop, having engaged in personal therapy is rated as one of the most important single elements when research participants are asked what has been important for their own development as psychotherapists. The research shows that therapists who were currently in therapy showed the highest rate of progress and the lowest rate of stasis. On the other side, "Clinicians with no experience of personal therapy showed the lowest rate of felt progress and the highest rates of regress and stasis" (Orlinsky and Rønnestad, 2005, p. 121).

Six of the seven family therapists in this research have been in personal therapy. Their main reason for asking for therapy was their own personal and private problems in life. Some of them have been in therapy several times with different therapists. They have used different therapists with theoretical orientations different from their own. They have been in family therapy, couple's therapy, psychoanalytic therapy, individual therapy and so on. They have been in therapy before starting to work as therapists and have continued as therapists. We will look into the second GT category, which is made up of two GT sub-categories. The categories with sub-categories can be illustrated like this:

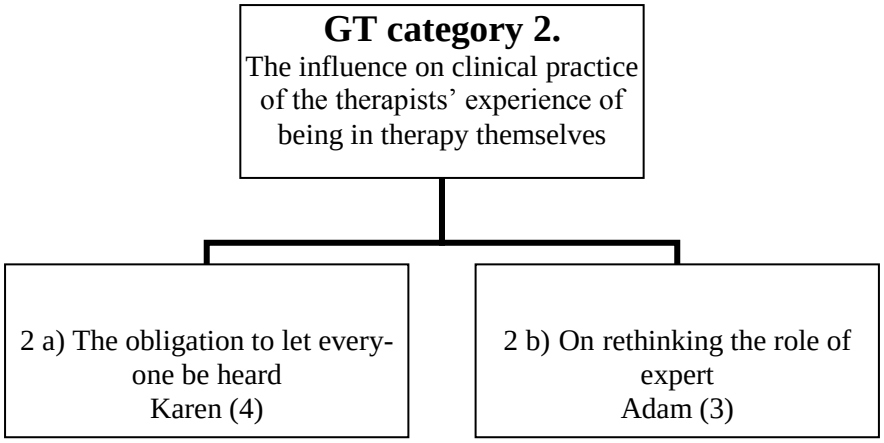

Table 10. The influence on clinical practice of the therapists' experience of being in therapy themselves

All participants did not tell in detail about their experience of personal therapy. However, some did and let us listen to Karen (4) and Adam (3). The sub-categories in their stories reflect each other in a way that suggests overlap.

2 a) The obligation to let everyone be heard

The participants in this research are all women and men with western and Norwegian background. Their experience and personal values as they came forward in my material are rather homogenous. However, the more experienced therapists emphasised some values and self characteristics that are in line with those discussed in some of the research literature on expert therapists (Skovholt and Jennings, 2004). I do not have enough material to include participants 5 – 7, Evelyn (5), Anne (6) and Janne (7) in this part.

Karen (4) has herself been in couple's therapy, and this has been a very important experience in her life. She was heard by the therapist and that came to be a central value for her in her own clinical practice. When I ask Karen (4) in which way it was important for her to be heard, she says:

> *"Yes, and that is…a guideline for me now, that people shall be heard. That even the damned shall be heard. And now and then there even comes one in who wants to blame another for something…So that voice is just as important, both, all voices are just as important. …it was actually that simple change there which led to my actually coming out of that. And afterwards I went into a long therapy process in order to "hang up" and all that"* (8, 331).

Karen's (4) experience from her own personal therapies initiated by crises in her own marriage has formed a part of her own clinical practice. All clients shall be heard and she denotes that as a guideline for her own practice. She also sometimes tell clients that she has used therapy to get the help to solve her own difficult problems connected to breaking up from relationships.

When I ask Karen (4) if there are any types of cases or something else that has made a special impression on her, she immediately mentions "breaking up."

> *"I think that the painful thing about when things break up… the existential loneliness we all have, we're all in the same boat. Finding oneself alone again…it is so …it is so hard, not having a framework, or that you feel the framework you have had and the expectations connected to it have… gone. And I recognise this very well from my own life"* (8, 121).
> *"I have told clients that are stuck in a breaking up situation that I myself had to go into therapy for a year to learn to shut the door and hang up the phone"* (8, 259) she says.

She has been in therapy herself in two periods in her life and one time the therapy started in a family counselling office. *"It was my salvation, in the sense that, there I too had a place to speak, myself"* (8, 329) she says, *"and that has been a guideline for me, that people shall be heard. Each voice has the same importance"* (8, 331). At the same time she knows that it is possible to get out of such situations because that is what she has experienced in her own life.

2 b) Rethinking the role of expert

Adam (3) went into therapy for four years. He finished just two years ago (6, 161). His background for asking for therapy was that he developed an intense fear in social situations. This was connected to stress in his workplace where it first appeared. It had come on suddenly and without any warning beforehand. When I ask him if his family was affected by this condition he says that at home his family could see that he was sadder and that he stayed more at home. This situation, however, did not last long (6, 183).

Adam (3) claims that although it can seem like a cliché it was a profitable experience to be a client himself (6, 165). He developed new perspectives from having to meet the therapist for an hour at a time. To be with the therapist was an example of a social situation he feared. He felt an intense repugnance. Although he knew he could walk away, he felt locked up for an hour. This experience also made him think about his role as *"an expert"* again. Although he theoretically had worked with the idea of *"the not-knowing position",* he got a new experience through being a client himself (6, 169).

Summary of GT categories about becoming a family therapist

The two main categories under this headline show that some family therapists' early life experiences have been part of their choice of profession. In addition some of them claim that inspirations from childhood and youth still add some meaning to their practice. Erik's (2) ability to "see" other people and Adam's (3) mediation skills are part of their comprehension of themselves. The therapists' expertise may also be connected to one of the participant's experience in their own family in early adolescence. Adam's (3) ability to act as an intermediary was developed during a period with conflicts in his own family of origin.

Almost all the participants have been in therapy themselves to help solve some personal problems. Some of them claim that this has provided some very important experiences that have added meaning to their own family therapy practice. When Karen (4) very strongly claims that everyone has an obligation to be heard it is first and foremost because of her experience with going into couple's therapy herself. It was also after going into therapy himself that the idea of "the not-knowing position" added a new experience to Adam's (3) conception of therapy.

The researcher's personal reflections:

Some time ago, I met a schoolmate from primary school in a shop in my hometown. I remembered that he himself had much trouble in school and that he was rather lonely and often bullied. When he recognised me, he immediately started to tell me about the successes for his two boys. One was educated an engineer and the other one was working on his PhD in USA. When he was about to go he looked at me and said: "But you were kind..."

When I grew up, I had never heard about a psychotherapist (not to talk about a scientific practitioner). However, in the same way as some of the participants in my research, I

think I am able to tell some stories all the way back from my childhood that adds meaning to my choice of occupation. I discovered early that some people liked to talk to me about their difficulties and I discovered that I liked to and was able to be in this position although I sometimes could feel a little bit lonely.

This personal experience is probably a background for me asking questions that give them the opportunity to tell stories that link their daily profession to stories from their childhood and from their youth. In one of my memos', I formulate one possible dilemma for a therapist when Elisabeth says: " From when I was a little girl I have known that if I am kind and pleasant and helpful, people will love me" (1, 41). Could this understanding of self represent some limitations and some hindering in her development as a family therapist?

My meeting with the participants was very much like meeting "old colleagues". Some of them I knew I little bit beforehand and some of them I had never seen before. However, our meetings had the character of a meeting between good colleagues. I was astonished by their generosity and openness with own personal and private stories. Stories from growing up and stories from own therapy gave me a rich material and I considered their stories as their gifts to me. I have to ask again; should I have been looking for variation also connected to myself? Had my material been even richer with more participants that could not connect to my concerns?

GT findings on "Personal and Private Values"

Introduction

It is a longstanding and central tradition in psychotherapy traditions like psychodynamic and systemic psychotherapy that the therapist's own personal and private values and preferred culture (politics, religion, ethnicity, gender etc) be separated from the therapeutic work and the therapeutic process. The therapist's personal values and cultural background should not influence the therapy, and this includes their ethical values. However, according to Len Jennings: "Making the best ethical decision can be extremely challenging for most therapists due to a multitude of complex ethical situations" (Jennings et al., 2004, p. 107).

In Norway, the Union of Family Therapists has not developed any ethical codes and there are no ethical codes that regulate psychotherapy in general in Norway. The professional

unions for psychologists, psychiatrists, nurses and social workers have their ethical codes but in many of them, psychotherapy and family therapy are not covered. This means that, for example, social workers and nurses do not have any specific ethical code to support them when they work as family therapists.

Jennings et al. (2004) claim that research shows that there is a discrepancy between what psychotherapists ought to do when an ethical dilemma occurs, and what they do. Researchers connect this behaviour with the extent to which the therapists are supported by ethical codes. When the therapist is supported by ethical codes, she or he tends to take a clear stand. "However, in situations that depended more on individual judgement, practitioners were less likely to 'do the right thing'" (Jennings et al., 2004, p. 107). In Norway, where many practitioners do not have any relevant ethical codes to lean on, this may have some important consequences for family therapy practice. Some could probably partly lean on ethical codes from their first discipline, but others could not.

Ethical values and culture are not only about dilemmas and difficulties. The therapist's professional and personal values may also guide the therapy process in a way that takes care of the clients in a necessary and important way. Some important examples are cases where children need protection, or where physical and psychological violence has occurred and where different kinds of abuse are part of the problem.

The participants' personal values seem to be an important element in the understanding of how personal and private life may influence their family therapy practice. Here are three GT categories that are closely connected to the participants' personal and private values. The first GT category is: *The Participants' Explicit Personal Values that Influence Practice.* The sub-categories are: *The Importance of Being Heard, Belief in Change, A Nuanced Understanding.* The next category with sub-categories is: *Dynamics that show how personal and moral values influence or do not influence their therapeutic work.* The sub-categories are: *Love life, Raising children, Alcohol abuse, Religion and Politics, Intimate Relationships and Therapeutic Process with Creativity, Private Strategies and The ability to see two different views at the same time.* The last category connected to personal values is: *Therapists' Acceptance and Avoidance of the idea that Personal and Moral Values Influence Their Therapeutic Work.*

GT category 3: The participants' explicit personal values that influence family therapy practice

This main category is supported by sub-categories from participants Erik (2), Karen (4) and Adam (3).

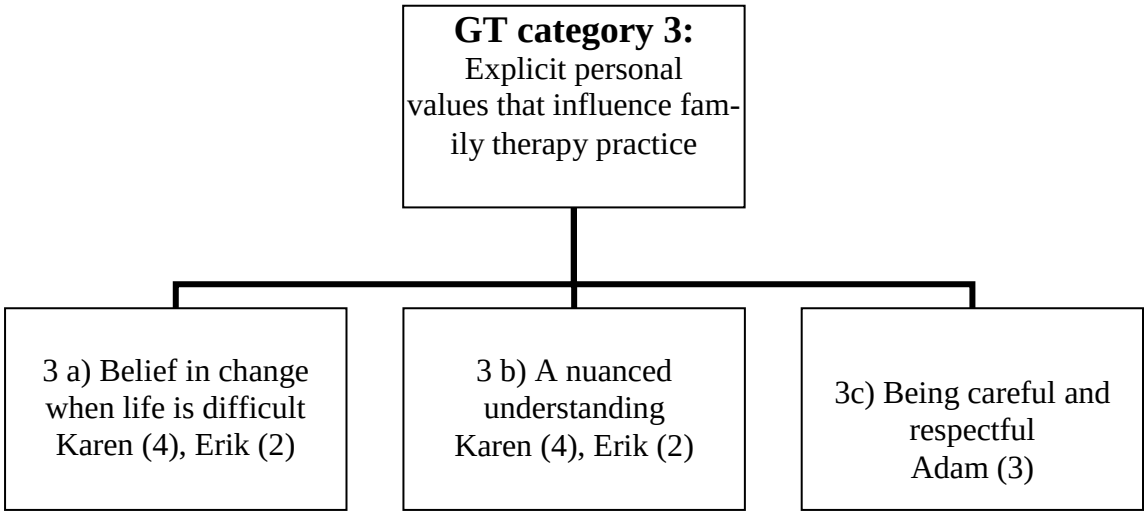

Table 11. Explicit personal values that influence family therapy practice

3 a) Belief in change when life is difficult

When I ask Karen (4) what has brought her to become a family therapist and what aspects of being a family therapist have influenced her personal and private life, she says:

> *"It has the effect that…you believe…in change, that is, change with the help of new ideas, …that change often happens in that way, that the first thing that forms is a new idea about something that can be thought about or done differently. And then one can change practice, …that's the way I work in any case as a therapist and it's also true of my life as well. And now and then I think when you have had something impossibly complicated it's almost as though the simplest thing can suddenly…click into place"* (8, 27).

For Karen (4), the belief in the idea of change is not only something that is connected to her practice as a family therapist but is also a part of how she views and understands her own personal life. This quotation also demonstrates her openness to change when she underlines how something that may seem to be "impossibly complicated" may "click into place."

Erik (2), who is the most experienced therapist with 33 years as a family therapist, states his view on change and therapeutic practice with these words:

"…I think that if you are to survive, then you must change as well. But how are you to preserve something at the same time? …And be aware of flexibility sort of, that if there is something in the wind it can be easy to slide over to that side and follow along, and everyone runs from the one line to the other, the one that is 'in' at the time…so I thought that both changing oneself and not allowing oneself to be moved too quickly, both of these are necessary,…to the extent to which you are present, then you will be changed, you can't avoid it…" (4, 146).

Erik (2) claims that change is a necessity in life. But he is also occupied with the idea of being in a situation in which something can be preserved. He talks about the necessity of finding a balance between change and preservation.

Karen (4) elaborates her angle on understanding change by drawing a line between being a therapist and being a client by saying:

"…when one comes as a client…stuck fast and with many elements, (one) can suddenly see things from another angle and something different, almost a little naïve sometimes…and then they can maybe get finished with something they've been struggling with…a break-up or something with children or that one has become stuck in the way things are this way or that way and I can't get out of my rut. That things can change, I believe that has gone…both ways" (8, 35).

Both clients and therapists get "stuck fast and with many elements" from time to time. This research shows that the observation that both clients and family therapists from time to time are in situations that seem to have many parallel elements, is typical for psychotherapeutic practice. This situation, that both clients and therapists experience the same kinds of problems in life, makes it much different from most other forms of clinical practice. As we hear, Karen (4) is well aware of this aspect of clinical practice and lives with these parallels as part of both her practice and of her own personal and private life. We will see later how she can use her own personal experiences as part of her family therapy practice.

After 33 years of clinical practice, Karen (4) sums up her ideas about therapy and change when she says:

"I am maybe a little more brave with that, and I also have, in a way, a stronger belief that you seldom do anything wrong even if you do a little too much. If it falls on deaf ears because you realise it didn't fit particularly well, then with a good heart and a lot of love for these people you haven't done anything wrong. It just doesn't get received, nothing worse than that happens. So that has made me more relaxed, in any case with censoring …Neutrality is a term I have been concerned with. Not to hold yourself back at any price, but rather to make sure that everyone is allowed to be included and all versions can be heard. I believe that I am probably …a little more clever about

checking with myself. …when people give versions that you react to, you immediately think I should never have done that, or terribly unethical and, so I check maybe a little better…" (9, 82).

3 b) The ability to see two different views at the same time and a nuanced understanding

The questions of living with the ability to see two different views at the same time and ambivalence are sub-categories from the Grounded Theory analyses. They are here connected to the ability to manage ambiguity in therapy as a part of working as a family therapist.

Karen (4) and Erik (2) talk about their own initiatives in relation to being unambiguous, to the ability to see two different views at the same time and to ambiguity. To make it clear what she means when we talk about ambiguity and contradictions, Karen (4) connects these to her own personal experience when she says:

"Ambivalence and living with contradictions – live with a "Yes" that is, receiving something, and sacrificing some things and losing some things and to manage to live with what can sometimes be both dominated by loss at times and painful while one nonetheless doesn't – I am very concerned about avoiding making radical choices which have big consequences for someone. In my life, I would sooner remain in a dilemma a long while before I did that" (9, 32).

Karen (4) claims that she always has been troubled with settings and organizations that demand clarity and an unambiguous stand, such as religious and political settings. Karen (4) comments:

"I have not joined in, I tried, disastrously for me, once to be a part of the Palestine Committee – which was supposed to be so active – and there I had exactly the same problem. I was completely in agreement with the issue, but that feeling that it all was so narrow-minded that it wasn't possible to – you know this about dilemmas that I like so much and ambivalence – I wasn't even able to be ambivalent or to have dilemmas. Not in the union, and not in political work, maybe a little…"
Per: "You are not cut out, so to speak, to be unambiguous and clear?"
Karen: "Unambiguous and clear I cannot go along with, it isn't possible…" (9. 142 – 143).

Karen (4) does not only connect a nuanced understanding with therapy, but also makes a close connection to attitudes towards her own life. Erik (2) claims something of the same attitude when he says: *"And I think it is important to discover the humane elements in what is inhumane"* (4, 136). To see different aspects of a topic and to create a nuanced understanding is something of an ideal for him. He calls this kind of view "the ability to see two different views at the same time". He claims that whatever a person has done, or whatever kinds of

lives people have lived, they will be in need of someone to care for them. He agrees that they are entitled to and in need of his concern (4, 137). He hopes he is able to hold many kinds of people. He connects this attitude to his practice as a therapist. When I ask him how he thinks about the ability to see two different views at the same time as a part of clinical practice, we have this dialogue:

> *Per: "You say that…if I heard you correctly you are saying that, that you view the ability to see two different views at the same time as an advantage in this type of practice…Is that a…or one can say…what other sort of word can we use other than 'the ability to see two different views at the same time '?"*
> *Erik: "Well…maybe one could use 'ambivalent', to use 'ambivalence' like that, makes the dilemmas clearer as well, I think, there lies a type of ambivalence in that word, I believe…"* (4, 133-134).

Erik (2) emphasizes his stand of the ability to see two different views at the same time as an advantage and he rephrases "the ability to see two different views at the same time " as "ambivalence". Although ambivalence has connotations that often point to situations and feelings that most people view as unwanted and that should be changed, Erik (2) claims that this is a concept he chooses to use to describe these situations.

Karen (4) takes this position a step further when she says:

> *"In contrast to most other people, I like to work with that sort of ambivalence. Lots of contradictions within the same pot. Ambivalence where many others think that: now they have to decide. But no, it isn't necessary to decide. All this can come up at the same time and if it isn't possible to choose, then it isn't possible to choose. So I like that"* (8,147).

Karen (4) emphasizes that she even *likes* to work with clients that are in ambivalent situations and have ambivalent feelings. She does not think it is necessary to take a decision and to choose as quickly as possible when you get into an ambivalent mood. Further on, Karen (4) fills in this position by saying:

> *"I recognise that so well that one can have so many things, so many contradictions and one can actually live with that. And this that one cannot actually make a choice before one can make a choice, simple as that. And to help people to live in an ambivalent situation, I believe I also have had and continue to take those kinds of cases"* (8, 149).

To sum up Karen's (4) position when it comes to ambivalence and living with ambiguity as a family therapist, Karen (4) says:

"The thing about ambivalence and what some feel is completely the pits, you know, is the feeling you're not getting anywhere. You turn and twist all this stuff around and why can't one just live with it? But of course, one can live with it" (8, 151).

3 c) Being careful and meeting clients with respect

In the second interview with Adam (3) we talk about his video and how he enters into the client's narrative in a very careful way. The client, a young man, tells that he has moved away from his wife and child because he has fallen in love with a new woman. Adam (3) moves slowly around in his story and avoids all provocative questions and giving any clear advice even when he is directly asked for it. I remark that he manages to create a reflective conversation with this way of doing it.

He says that: *"... according to his (the client's) experience, that he could use the contact with me in the right way and that I in a way show respect and there I am careful. I think that repeats itself in other conversations too and almost regardless of the theme"* (7, 122).

GT category 4: Dynamics that Show how Personal and Moral Values Influence Therapeutic Work

This main category is supported by sub-categories from the full participants, Adam (3), Elisabeth (1) and Erik (2).

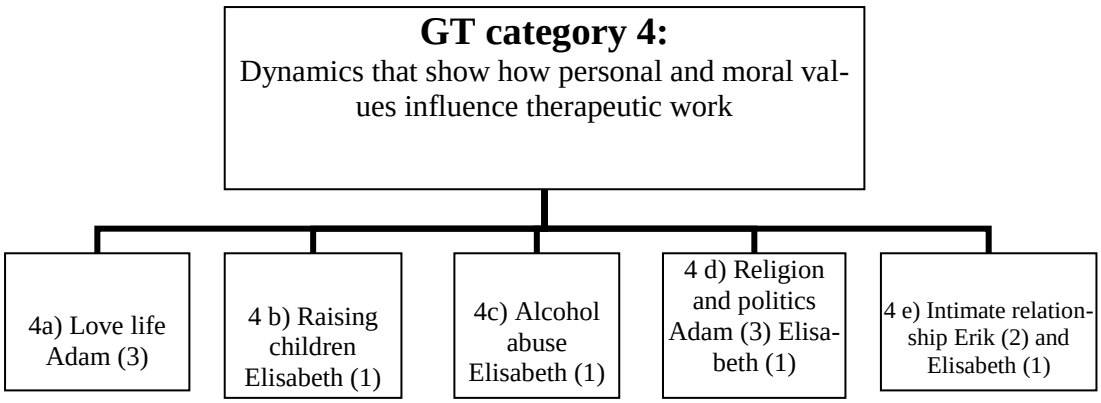

Table 12. Dynamics that show how personal and moral values influence or do not influence therapeutic work

4 a) Love life

> ”I think it’s only being in love that can make someone do something like this” Adam’s (3) client. (7, 95).

In the video session Adam (3) has provided for this research project, he is working with a man who has moved away from his wife and children because he has fallen in love with a new woman. Adam (3), however, claims that falling in love would not be something that would make it possible for him to move away from home.

> *“Yes, I for my part being in love wouldn’t have been legitimate…it wouldn’t have been enough for me in terms of being able to leave, it wouldn’t have. Not in relation to the situation I’m in now, in the sense that I have responsibility for children and…and that, but it just wouldn’t have. But I’m not going to say that it wouldn’t…given a different context, that it…could have affected that sort of break up, that is. I can’t rule that out, or say that, sort of that, that could never happen with me” (7, 104).*

When we are talking about the videoed therapy session I asked Adam (3) what he thinks about himself in the context of falling in love with a woman other than his wife. Referring to his own marriage and to the therapy session, he says:

> *“Of course, of course it could of course ram against, it wouldn’t stand on it’s own…that is the being in love wouldn’t stand completely free in relation to ehh…sort of that, it can’t be seen independently in relation to the relationship one is in then, or sort of what one is thinking and what one is experiencing around that, that is what one thinks around that, big things like what sort of values one has, but, but…I’m not a stranger to thinking that those sorts of infatuations can make one think differently about many things, then. Or that it can make one assess things, see things in a different light. But he also said something about how the infatuation had passed” (7, 108).*

These are Adam’s (3) personal values and ideas about his own family and love life. In the therapy session nothing of this was exposed. He did not even ask questions that gave his client the possibility of reflecting on how leaving his wife and children might influence his personal values. This could be seen as the opposite site of influence from the therapist’s personal and private values. The therapist did not even raise questions that are in line with his own values. The question could be asked about what therapists do when topics that are close to their own value systems occur. Do they enter into these topics? Do they avoid them? How do they influence topics like this? This is an area for further research.

4 b) Raising children

Childhood and looking after our own children are one of the fields that probably is most influenced by personal values and personal and private experiences. When it comes to children, my GT findings show that it is difficult to be aware of the difference between professional opinions and personal and private experiences also in the therapy room. These kinds of dilemmas can be illustrated by Elisabeth's story.

Elisabeth (1) is born in the Middle East and her mother came to Norway when Elisabeth (1) was five years old. Her father had one child from a former marriage and he did not follow them to Norway. Her mother re-married to a man that had one child from a former relationship and after some years Elisabeth (1) got a new half-brother. Her mother and stepfather insisted that they should "forget" the past and that Elisabeth (1) should act as her stepfather's "real" daughter. His former child should be called a cousin and the new sister should not be told anything.

Elisabeth (1) did not agree with this "project" and this way of hiding the truth from children. *"I am extremely against it"* (1, 39) she claims, and supports the idea of openness. She claimed to her mother and stepfather that she would keep her citizenship of the land she was born in and that her father was in the Middle East.

Some years ago she worked as a co-therapist and she and the other therapist met a family with two children aged five and seven. The father suffered from depression. He had been married before and had two children, aged thirteen and fifteen. This situation was connected to his depression. When the two children from the former marriage visited him and his new family, they were presented as cousins to his two new children. *"At that moment I saw red, I really saw red"* (1, 51) she says.

She said that they had tried to make them tell the children by talking and asking questions connected to the topic, but they did not get anywhere. *"At the end I arranged with the therapist that I should give them "the punch". I should tell the parents my personal history and tell them how it is to pretend to be with your uncle when you visit father and pretend that it is your uncle the whole weekend or all through Christmas"* (1, 51). They had much doubt but in the end they decided to tell the children.

The next day she met the man who was *"white as chalk"* (1, 51) and told her *"that he would never see me again and that I had destroyed his entire family. He was furious"* (1, 51). The wife and children were glad and showed her pictures of the new siblings. But one of the children had asked the mother: *"But is he my daddy, mommy?"* (1, 53). The father "panicked"

when he heard this, a doubt had been sown and the father was afraid the children would never trust him again. They continued working with the family and in the end everyone was happy about the openness. *"I think I did them a great favour"* (1, 55) she added.

In this GT analysis the resonance between the clinical practice and a therapist's personal and private experience from their own life history is obvious. It is also Elisabeth's arguments from her private history that are the main arguments for the therapeutic intervention.

Elisabeth (1) thinks she did them a great favour. This is a possibility, but it is also possible that her actions gave them some new problems and a more difficult life. We do not know, but we know there is always the exception that proves the rule. Elisabeth's starting point in this history was that she "saw red". This emotion formatted her context and guided her to suggest an intervention. This intervention forced a new knowledge into the family and included the children in this knowledge about their father's earlier marriage and children.

4 c) Alcohol abuse

"I think that it is a gift to be intuitive and to be sensitive and to get in deep contact with people, but it is also a cross to bear and a burden" (2, 41) Elisabeth (1) says. In her home with mother and stepfather, alcohol was not a topic at all.

Elisabeth (1) mentions however that her father was an alcoholic and she also adds that she thinks that her husband drinks too much. When she visited her father when she was nineteen she found a lonely alcoholic wreck. When I ask her for stories that can illustrate how she thinks about her own experience she tells the story of a well-versed fifty-year-old male patient with serious depression and alcohol problems. However, *"He is more like you and me"* (2, 23) she says. This is a man that has tried to commit suicide several times. After a period with a much better life he stopped drinking and quit smoking. *"And then came the emptiness. The great emptiness"* (2, 19) she tells. She explains that it was impossible to find a good programme for him and he started to drink again. He started to plan his funeral in detail. She concludes *"And then I was standing there alone and thinking that I had maybe gotten too close, or that I get too open"* (2, 25).

She claims that this man has moved her deeply and that she has not understood why. As a comment about her strong engagement in this case she says:

> *"And that I closed my eyes at home to the fact that, that my husband also drinks too much, so I feel that the moment there was a hole put in that blister in relation to my home situation, that I put my foot down at home, and in a way I managed to clear him up a bit also"* (2, 23).

Her thoughts are that she has a husband who fades out and does not see the children, and she has been blind to the situation. She thinks that meeting this man has helped her to see that she does not want to live like this, and this has made her take action at home.

> *"But I think that it is also strengthened because my father really died the same way, I mean he committed slow suicide in the same way"* (2, 43) *"But I still do not understand why he has got under my skin"* (2, 48).

In this example the resonances (Elkaïm, 1997) are both clear and diffuse. Elisabeth (1) recognises some topics from her own life, and she can understand that these topics give her some possibilities for contract. On the other hand, the alcohol theme does not sufficiently explain her engagement. This can perhaps illustrate that the discovery of resonance is not always made in a framework sufficient to help us understand this type of interaction.

4 d) Religion and politics

It is a firm tradition in Norway to separate religion and politics from professional practice. In the field of psychiatry we have a tradition about not entering into conversation around these topics with patients. To some extent, religion has also been viewed as something that both causes and adds difficulty to psychiatric illness. However, there is also a long-held tradition of tolerance and respect for clients' religious ideas and practice as a part of their private lives. It is more of an exception when a professional interferes in clients' religious lives or enters into discussions of political topics with them.

None of the participants had a dedicated political engagement and they located themselves in the middle or to the left on the political scale. Only Adam (3) told that he had been a member of a political party as a young man.

When Elisabeth (1) was a young woman, she was for some years a member of a religious charismatic group. Today she feels that she has moved far away from these types of religious groups. She says that she has a problem *"…when you talk about belonging or religious or the like… (I), I can't handle the type of religious contexts that I have been into earlier"* (2, 81). When I ask about her experience with patients with this kind of connection she says that she is one of the few *"…that dare to say that I wish that (a charismatic group) would be taken away from patients*" (2, 83). When Elisabeth (1) "dares to" speak up about these charismatic religious groups she does not first refer to any professional explanations but to her own personal experience with being a member of such groups.

4 e) Intimate relationship

Family therapists use their own personal and private life experiences in different ways in psychotherapy. One tradition is to keep private life and professional practice apart. On the other hand, some therapists tell stories from their own life and share personal feelings with the aim of establishing contact with clients. Erik (2) and Elisabeth (1) are examples of two therapists with different practices in this area.

My first question to Erik (2) is if he has had any special thoughts connected to this interview since he was invited to participate in this research. He answers:

> *"Well, you could say that it is a bit peculiar that I lived for many years in a non-residential intimate partnership. And I have lived pretty unconventionally when it comes to family, really, with a daughter I have never had any married status in relation to and almost none as cohabitant, and quite opposite to the way I was brought up, in many ways quite a conventional family life and a Christian pietistic milieu. I have probably moved far away from that, so in a way it is a sort of discrepancy, maybe. Discrepancy, yes…"* (4, 2).

When I ask him to define more precisely what he means when he says "discrepancy" he adds:

> *"Well, in a way I think that the Family Counselling Office has a framework, family and relationships ehhh… and I have not lived that, particularly conventionally… It was actually after my parents died… that I for the first time went into a longer lasting, steady relationship"* (4, 4 and 4, 6).

When I ask what consequences this has had or how his way of living his life influences his work, he says that it does not influence his work directly but that it should be obvious that he does not think that there are fixed, particular ways people should live their lives.

Working in a family counselling office as a therapist means working with families and couples with problems similar to those in the therapist's own life. When I ask if he sees any connection between the many years of his life he lived in a non-residential intimate partnership and his work in a family counselling office, he says that he never has reflected on any possible connection whatsoever. It is not often he *"...brings cases home"* (4, 116). But when he does he needs to talk to someone. When he gets into this mood he *"... gets night work"* (4, 116), meaning that if it is something that bothers him, it comes back to him at night.

Elisabeth (1) says that:*"From when I was a little girl I have known that if I am kind and pleasant and helpful, people will love me"* (1, 41). She tells that she was the teacher's helper and the helper in kindergarten; she was a leader because she cared for everyone. *"If*

there was a problem it was always me who should put things right." (1, 41), a position she maintained throughout her schooling.

For a period of time Elisabeth (1) was working in a psychiatric hospital. She worked with a pleasant, agreeable man who was also very depressed. Elisabeth (1) recognised the pleasing aspect of this man as a side of her own personality. He was, however, difficult to get a hold on, she says. She tells that when this man feels he is not understood by anyone, he beats his wife. Elisabeth (1) wondered if a more personal approach could get him into communication. She says that it is difficult to introduce this idea because it is not good etiquette and protocol to use one's own experience in this way.

> *"What I brought forward was that I myself understand that conflict between wanting to, uhm…wanting, I certainly wanted for many of my teenage years, I wanted for people to see that I felt bad, but I did everything so that they wouldn't see it."*
> *"I have, I certainly have some belief that therapy is somewhat mutual, in a way"* (1,93)

Elisabeth (1) found that it was, in a way, necessary to tell him a part of her story first, to get into a deeper communication with him. Men are more like that than women, she claims.

GT category 5: Therapists' acceptance and avoidance of the idea that personal and moral values influence their therapeutic work

All therapists interviewed in this research project seem to agree that it is the client's stories that are the focus in therapeutic sessions. Nevertheless, in relation to how they viewed their own personal stories as a part of a therapeutic process, they had different views. Erik (2), Karen (4) and Evelyn (5) represent two sub-categories.

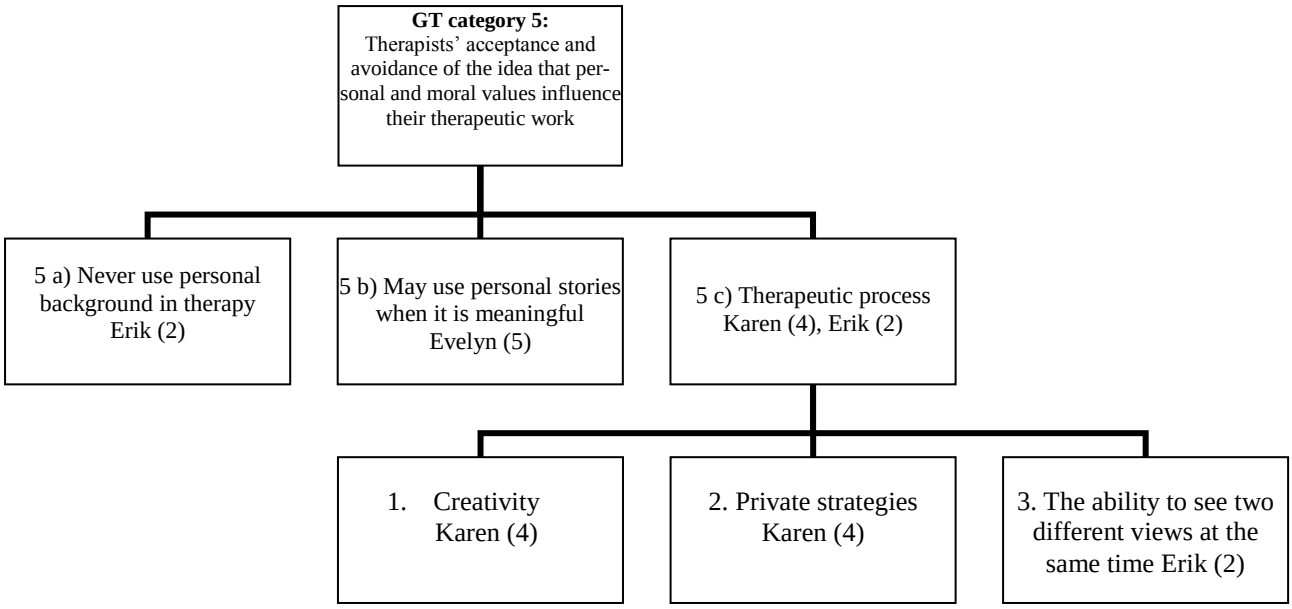

Table 13. Therapists' acceptance and avoidance of the idea that personal and moral values influence their therapeutic work

5 a) Never use personal background in therapy

Erik (2) says that he has never used his own background and own moral values directly in therapy. However, he says that from time to time it has been profitable for example to know something about the pietistic religious milieu that is a part of his own background. Erik (2) claims with great emphasis that: "…I obviously do not hold any particular ideas about how there are set ways to live one's life" (4, 22). When I ask him what he does when he is confronted with people who have carried out physical violence and sexual assaults he resists entering into a "yes" or "no" position. Instead, he tells a story about an encounter with a violent father who came from jail to therapy with his family. In commenting on this situation, he says: *"And I think it is important to discover the humane elements in what is inhumane"* (4, 136). When I ask him if he in a way "holds" many different kinds of people, he reply: "I certainly wish it was like that…" (4, 154).

5 b) May use personal stories when it is meaningful

Evelyn (5) takes a slightly different stand. She agrees that the client's stories are the objective in a therapeutic process. She emphasises however that she has never worried about being touched by clients' stories. It was never a point for her not to be moved by their stories. However, it was important that her own personal story should not regulate what should be talked about. It is essential for her to emphasise that she does not know the meaning of the client's experience although it might seem to have an echo in her own life.

She says: *"If I think I know how they are feeling, because it is similar in a way to my story, then I begin to ask questions with a starting point in my experiences and my thoughts and my guilt and shame and all these kinds of powerful, sad struggles,"* (11, 13).

On the other hand she emphasizes that:

"I was never afraid of being touched by others' stories, because they often moved me. I can get a lump in my throat and I can get the tears running and that's just how I am. To avoid getting moved was never the point in itself, but it was a point for me that my own story shouldn't determine what they could speak about" (11, 11).

She points out that she does not know their story although the story they tell may seem to be similar to her story. They are *"actually in another place"* (11, 13) she says. She stresses that she aims to meet them in their arena. Within this framework she thinks it sometimes is meaningful to tell personal and private stories as part of the therapeutic process. For example, when she works with families with children, she sometimes tells stories from her own child-hood.

5 c) The therapeutic process

This analysis shows that the therapeutic process is in different ways influenced by the family therapist's personal and private values. Dynamics that show how personal and moral values do or do not influence their therapeutic work are documented here through three sub-categories. The three sub sub-categories are creativity, personal strategies and the ability to see two different views at the same time.

1. Creativity

When Karen (4) is asked what is of greatest importance for her from her own life history, she immediately mentions creativity. She links creativity to her artistic interest. This interest is still active and alive for her and she pursues some creative activities in her spare time. When I ask how this comes forward in the therapy room she mentions language. She likes to look at topics from many angles, use metaphors and find new perspectives.

2. Private strategies

"My first impulse when something is difficult is to run away" (8, 285). Karen (4) says. That is how her own experience from life appears. When I ask her what she does when she meets

clients who use the same "method" she says that she tries to keep them in the room. She agrees that it is better to stay than to run away (8, 294). This has changed in her life, she says. She can still run away, but nowadays she returns to talk about what happened privately.

3. The ability to see two different views at the same time

Erik (2) emphasized several times that the ability to see two different views at the same time is an important part of his fundamental attitude to life. *"I believe in the ability to see two different views at the same time"* (4, 90) he says. When I ask him to elaborate the concept of the ability to see two different views at the same time he says:

> *"Also…maybe one could use ambivalent, to use ambivalence that way, also clarify the dilemmas, also, I think. In that there also lies a kind of double vision I would think…*
> *Per: Mmm…maybe in double vision there lies as well the capacity to encompass many points of view, many ways of living, many forms…*
> *Erik: Preferably that as well…And I believe it is important to locate the humane things in the inhumane, to an extent, as well…"* (4, 134-136).

Erik (2) emphasized that this is about including as many people as possible in the therapeutic process. He strives for an openness in which he is able to contain very different kinds of clients with different life experiences and a diversity of life histories.

Summary of GT categories on values

The first GT category called "*The Participants' Explicit Personal Values that Influence Practice"* contains four sub-categories that could be seen to describe professional values. The sub-categories are: "*The ability to "see" peoples' situations", "Interest in talking and listening to people", "Complexity of one's own family history*" and "*The role as an intermediary in one's own family of origin".*

The second category is called *"The influence on clinical practice of the therapist's experience of being in therapy themselves".* The sub-categories "*The Obligation to let Everyone be Heard,"* and "*Becoming a better therapist*". These participants also describe their personal and private experience, and how these inform their practice now.

The third category is: *"The participants' explicit personal values that influence practice"* with sub-categories: *"Belief in Change", "A Nuanced Understanding"* and *"Being careful and meeting clients with respect".* The next GT category is "*Dynamics that show how personal and moral values influence or do not influence therapeutic work".* It is made up of the sub-categories "*Love life," "Raising children," "Alcohol abuse," "Religion and Poli-*

tics," "Relations between People" and "Therapeutic Process". These are all topics from everyday life that most therapists share with their clients. This shows that family therapy deals with themes and topics that therapists and clients have in common.

The last GT category connected to personal values is "*Therapists' Acceptance and Avoidance of the idea that Personal and Moral Values Influence Their Therapeutic Work".* This category shows some important differences among the participants. On one side is Erik (2) who claims that he avoids letting his own personal and private experience influence his clinical practice. On the other side is Evelyn (5) who takes a stand in the middle by emphasizing that she does not have special insight even though her personal and private experience parallels that of her clients. She also is able to use some of her experience from personal and private life in her clinical practice.

These GT categories about personal values are very much in line with some research findings about the development of psychotherapists. Openness to change and comfort with ambiguity are examples of values they share and that are emphasised in the research literature (Skovholt and Jennings, 2004).

The researcher's personal reflections:

I know one thing for sure; it was not I that introduced the concept "value" as a framework for describing and understanding their therapeutic practice. I have a long history as a critic of this concept. As a young man I experiences a rather narrow world view governed by pastor's and the congregations values connected to rules. Meeting the field of psychotherapy contributed to open up my world view.

I have tended to say that the concept "value" is best when it is used to describe the price on sausages or used to describe an amount of money. I have been looking for more humanistic concepts when we talk about worldview, view of human life, ethics, religion and ideology.

However, in my memos, the concept "value" appears already after the first interview with Elisabeth (1). One of the research codes that appears are "moral and values". As I go on interviewing my participants this concept appear over and over again. It is time for me to re-examine my relation to the concept and establish it as a word I can use in communication with the participants. From this point, I am ready to use "values" as something I ask for. Al-

ready when I meet Erik (2) in the first interview, I ask him: "Do you remember a situation where your values/ideology has governed your communication with the family?"

On the other side, I have grown up in a religious context and I work in a college connected to the Norwegian church. My preoccupation on "worldview, view of human life, ethics, religion and ideology" may after all be a part of my own biases that I introduce as an "important" topic for all participants. When I look back, this seems to be the most likely explanation.

When it comes to the final GT analysis of the transcripts categories connected to values appear over and over again and I have to admit that this concept communicate in a fruitful way when it comes to the participants self-understanding and descriptions of their practices. I have been forced to re-examine and redefine the concept of values.

GT Findings on "Therapists' Dilemmas"

Introduction

The next major area of research findings is the GT category with three sub-categories dealing with the dilemmas that form connections between the therapist's personal and private life and clients' actions of which they approve or disapprove. The sub-categories are sexuality and love life, emotions such as compassion, joy, sadness and anger, and repetition and complaining.

GT category 6: Therapists' personal and professional dilemmas when faced with clients' actions of which they approve or disapprove

This main category is supported by sub-categories and sub sub-categories from all four full participants Adam (3), Elisabeth (1), Erik (2) and Karen (4).

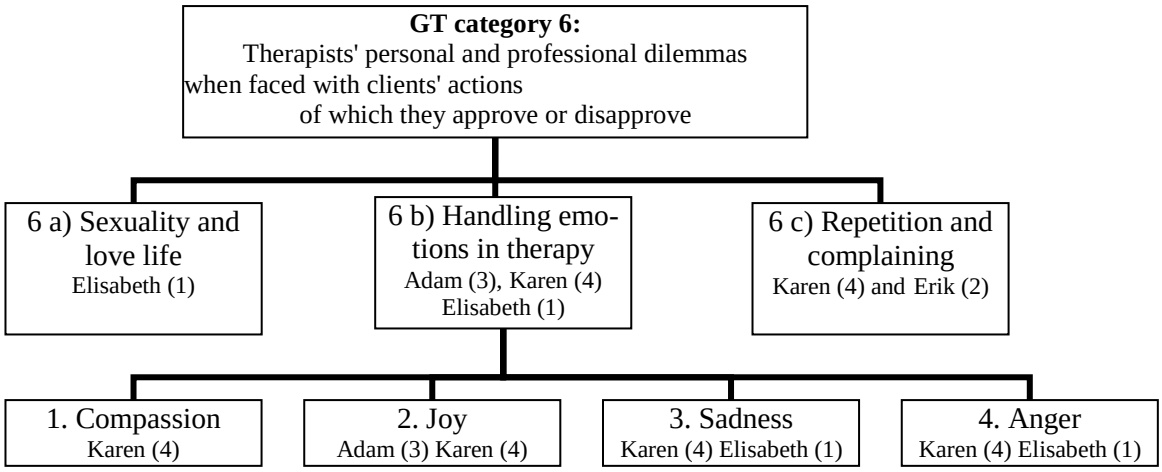

Table 14. Therapists' personal and professional dilemmas when faced with clients' actions of which they approve or disapprove, with sub categories.

6 a) Sexuality and love life

Elisabeth (1) is a psychiatric nurse and she is working in an outpatient unit and in a Family Counselling Office. In my first interview with her she opens up by saying:

> *"I am now in a specific situation with a client where I think that I act differently than if I had not had my own experience as background. It is a very personal experience and I have not told any of it to the client. But, in a way, it is lying there in my manner of asking and in my attitude towards her*" (1, 5).

The personal experience she refers to here is her own time in therapy at the end of the 1990's. She was married, but about to be divorced at that time. She fell in love with her therapist and he returned her feelings. They ended the therapeutic relationship and when she contacted him after about two months, they embarked on a romantic relationship. *"It took me two and a half years to get out of it"* (1, 13) she says.

The "specific situation" she refers to is a client she has taken over from a nurse who has taken a leave of absence. The client is a female teacher who has lost her job. She lives alone and has a weight problem. In her history, she had a father who abused her sexually. In their first meeting, in the very beginning of their conversation, the client tells her that she also is in therapy with another therapist, and has been for many years. This therapist is in private practice so she has to pay him. He is married and has children. The client and this therapist have a sexual relationship. In the beginning of one session Elisabeth (1) chooses not to comment on this topic. They talk about everything else and at the end of the conversation, Elisabeth (1) says apropos of nothing in particular:

"Do you often think of him?" And the client answers:
"Yes, every day" she says, *"almost all the time"* (1, 15).

Elisabeth (1) says that without her own experience she could not have had this type of conversation. She claims that she made an immediate contact with the client on this topic. As indicative of this kind of contact she tells a story about the client telling her that she wanted to go back to the therapist because her cat had died and she was completely crushed. The client said: *"I know you don't like it"* (1, 17) before Elisabeth thought she had made any comment.

The client has told some of her friends about the sexual relationship with the therapist and some of them have left her because she continues to go to see him. Elisabeth (1) said that the same happened to her when she told her friends about the relationship with her former therapist. Elisabeth (1) recommended her client a novel by Irving Yalom, "Lying on the Couch." The client read the book in three days' time and Elisabeth (1) hoped it could form a background for their conversations. She hoped she could start asking some questions and find out "what's in it for her".

6 b) Handling emotions in therapy like "compassion," "joy," "sadness" and "anger"

When emotions like compassion, joy, sadness and anger become a topic most therapists in my material have a reflective and active approach to how they handle their own and client's emotions. Most of them say they show clients if they are moved and do not hide their emotionality when dealing with their clients' stories and lives. For example, Adam (3) says:

"…I find it quite easy to laugh. So…I don't try to hold back, …be sorry…I show it…it can happen that I show it…not much, but it certainly does happen. Not that I cry or anything, but I can say that something touches me and so on, I can" *(7, 177).*

There is, however, a difference between joy and sadness on the one hand and anger or aggression on the other hand. Whereas they share both joy and sadness with clients, it is more difficult for most of them to express anger and aggression. Some of them have a more complicated relation to anger and aggression and they refer to their own personal background to explain this situation. Karen (4) formulates it this way when I ask her what she thinks is most difficult: *"I think it's the ones, where there is a great deal of animosity and anger"* (8, 167). This is elaborated when she says:

"Yes, I really don't like those, those bitter enemies, we get them a lot of course in connection with mediation and also in connection with, similar cases to mediation where there is, where I feel that my room for manoeuvring becomes very small. Because they sort of, they

are so angry with each other so there is just that sort of, and then comes my, those qualities that I don't have so much, namely, keeping structure and order where people absolutely won't sort themselves out, actually, where it gets important to do that, to keep people in place and to structure…I don't think I'm so good at that" (8, 163).

The GT analysis suggests how the research participants connect their own compassion, joyfulness, sadness and anger to their clinical practice.

1. Compassion

When Karen (4) talks about compassion, she does it in two different ways. First she talks about it as a feeling that she shares with her clients. However, she also talks about it in a more pragmatic manner. Compassion is something she can show to try to regulate the therapy session. In this sense she uses signs of compassion to help clients to *"…stop being so argumentative, so nasty to each other"* (9, 113).

"But I can show…compassion. More like quiet compassion when people are suffering, when people cry and so forth. And I can also say things like…'this is terrible,' and, 'oh it's so awful to see you, that you're having such a hard time' and…'yes I see how painful it is', and that sort of thing. And sometimes I do it purely and simply because it's tactical, so that people will stop being so argumentative, so nasty to each other. Then I can stop and say that I don't think you deserve things to be like this, I feel sorry for you both, that you are in this situation, I can see that it's very painful for you both" (9, 113).

Skovholt and Jennings describe master therapists as "…kind-hearted, compassionate people. The compassion is expressed within self-developed limits that function to keep the compassion genuine; this is not 'quid pro quo[29]' giving" (Skovholt and Jennings, 2005, p. 137). In this sense compassion appears as a genuine description of a relationship and not as a "tool" or "tactic".

2. Joy

When I ask Karen (4) if she could characterise herself she says:

"Karen: Yes, it is maybe the creative.
Per: OK, yes.
Karen: …with good humour, in a way, I believe…" (8, 79-81)

When I ask Adam (3) how eager he is to show his own emotions, he immediately replies: *"Yes, I hope that I'm ahead in that area"* (7, 172) and he adds: *"I think I probably*

[29] A favour or advantage granted in return for something.

show quite a lot of sort of joy and laughter, I do" (7, 174). And he adds: : *"...I laugh easily. So that… I try not to hold that back"* (7, 177).

When Karen (4) is asked about emotions in the therapy room, her first thought is: *"Yes, now we share lots of feelings of good humour, beginning to laugh at something, not unusual"* (9, 103).

This is in line with one of the conclusions that Skovholt and Jennings (2004) draw in their research on master therapists. Descriptions like fun, zesty, pleasure and humour are often used. Some therapists bring their joy and laughter into the therapy room. "Master therapists seems to be healthy, happy people" (p. 137), they claim.

3. Sadness

When therapists talk about empathy they often mention sadness and misery as emotions they are able to participate in or get into when they hear clients tell their story. Elisabeth (1) tells one story about an elderly woman who tells a terrible story about a life-long misery. It is a story that the woman has not told with coherence before. The story moves Elisabeth (1) and she remarks:

> *"Ehhhm… and there, there is…some of that massive loneliness of having borne it alone ehhhh…which made…and the tears ran, it was not in a way, one had to simply…and she told about it like…you know how you tell about something when you are…she was in a way not too close to her story, right? She was quite sort of sober and realistic…"* (1, 163).

Karen (4) has a different experience and attitude when it comes to sheer sadness and sentimental emotions. I ask her:

> *"When you think of what you yourself can show in terms of feelings, your own attitudes and values and the like in the therapy room – what do you think about that – is there any of that that you in a way think you can come forward with-or whatever-that you can share? Take feelings for example.*
>
> *Karen: Yes, now we share lots of feelings of good humour, beginning to laugh at something, not unusual.*
> *Per: Weeping then?*
> *Karen: I don't cry - not with anyone*
> *Per: No matter what moving stories they might tell?*
> *Karen: Don't cry no*
> *Per: Never done it either?*
> *Karen: No, I don't even have the Kleenex handy"* (9, 102 – 109).

Although it may seem as Elisabeth (1) and Karen (4) have different ways of showing participation, this does not necessarily reflect their ability to be empathic with their clients. These different attitudes may also reflect difference in experience as family therapists and different ways of handling own emotions.

4. Anger

Several of my informants mention aggression and anger when they are asked to point out a difficult area or something that represents a particular challenge for them. When I ask Adam (3) if he becomes angry with anyone in therapy he says that it is very rare. He underlines that this does not mean that he never gets angry, because he does get angry. And he adds:

> *"But, aggression is of course ehh…I mean I think of course it's a harder feeling to show in such a way that…that like I think, then that (it) can be something useful, then. Or sort of can be used. I think laughter, being sad and the like that's easier to share something around that. But to say to someone and show to someone that I get really angry or irritated or…"* (7, 185).

Elisabeth (1) formulates what she strives towards in this way:

> *"I have a couple that I feel I'm struggling with, and there is a lot of sort of animosity, where they just want the other one to change. There I'm lucky to have my student with me…we have had many good conversations in that, where I can feel that I've been too strict or something or other…"* (3, 58).
>
> *"Per: …does it remind you about something in your own life or from your own experience?*
> *Elisabeth: …my stepfather. I wouldn't say that it exactly fits this couple, but there is certainly something, I certainly have a problem with this where the facade is lovely, but where one pokes terribly in underneath, right, I probably feel that my stepfather is that type. He is this sort of lawyer and truly…if I had had someone who, then I'd really have had to work hard"* (3, 61 – 62).

Anger may also come to the surface on behalf of clients. For example Elisabeth (1) formulates her own anger about our own society's attitude towards psychiatric patients:

> *"I think I have a type of anger which is directed at, in relation to stigmatising, this about the demands of society, that we should all be so active that whole thing. I feel for periods of time that I get, I get really poorly from it. That we to such a great extent are to hide ourselves and to pretend as though we're something other than we are or that we don't have problems or…You can't of course say that; 'And no, you understand that, here in Norway we feel that having been in a psychiatric ward that's just an expansion of one's lifeworld,' right…on the acute ward one can lie there because it's sort of a somatic hospital at the end of a somatic, so no one needs to know any-*

thing different, right…yes, no, I better become a member of Mental Health…" (2, 203).

Handling anger is one of the topics Karen (4) experiences as a difficult task from time to time. Handling anger is a topic all therapists have as a personal and private experience and that they may handle differently at home and as a therapist. Let's hear how Karen (4) talks about the way she handles anger:

> *"Per: I remember you said that when clients get angry, is part of what you don't like?*
> *Karen: I just have the desire to conclude it, I just want to conclude the situation. If they don't manage to stop it in that sort of way, then I feel that – it takes a lot for me to get angry – then it's more that I stop it by saying that this isn't getting us anywhere"* (9, 121 – 122).
> *"Per: I was thinking more about if you yourself get angry because you get provoked by someone – by something someone says or is doing.*
> *Karen: They tell me that you aren't a very good therapist in a way, but I don't really get angry very much now. I get angry inside probably, but I say more like: OK in this office and in this country there's free choice of therapist. So it might happen that we don't manage it, the chemistry isn't there between all people. I can probably feel angry. I would probably have an argument if it were a private situation, or begin to defend myself, I think. To say that listen here, but I can certainly say that when you say that then I get annoyed or upset.*
> *Per: Can you say that sort of thing?*
> *Karen: Yes, I don't know that I get so terribly upset, but I say it now, because when they begin in that way then I get a bit speechless. Not that I get so angry maybe the first time around, I start a sort of panic-stricken searching after what do I do now. And what I can say is that if you don't think I have any ideas, then I won't be able to find any either. In this situation I can't think up anything. But I have never thrown anyone out no"* (9, 123 – 128).

When I ask her how she will describe her development as a therapist when it comes to handling anger as a part of her clinical practice, she says:

> *"And then I can tolerate anger a bit better, …and aggression, a little better, I tolerate it better now. I don't say so easily: 'Oh my God, get yourselves out that door'"* (8, 281- 283).

6 c) Repetition and complaining

Some clients act and behave in a manner that some therapists find hard to handle. It may seem that it is the therapist's emotional reaction that formats the main context in these situations. Two typical topics that trigger some therapists emotionally are clients that tell the same story over and over again or repeat the same theme over and over again. Another topic is complain-

ing, including clients that complain without making any move to change or who act demanding to gain advantages. Both Karen (4) and Erik (2) cite examples that support this subcategory. Karen (4) starts by telling this story:

> *" ...I can feel that it's difficult with a sort of broken, sort of broken record about these things. I mean, they're never finished, they come back and back and back and back every time, you think you've rolled the stone up so far and next time they're exactly in the same place again. They talk about that terrible man and how awful he was and what he's done to me and also…I can certainly feel, that I'm fed up about this.*
> *…*
> *Per: Your experience is that when they get stuck in that way after a break-up it's then also connected to other stories from their own lives?*
> *Karen: Yes, yes*
> *Per: Have you any idea about what kinds of stories these are?*
> *Karen: They're often sort of old abandonment stories, not least as children, or neglect, neglect stories by carers"* (8, 137-143).

Erik (2) needed to reflect for a while before he came up with some answers to a question about what he experiences as difficult to deal with or types of people he thinks it is hard to handle. He tells this story connected to this topic:

> *"Per: Look back…Is there anything you know you don't deal well with? Among the types of stories, the types of people who come in here…*
> *Erik: No, not in terms of types, but…Well yes, also some that are very demanding also, I have a little trouble with demanding and whining people also…*
> *Per: Complainers?*
> *Erik: Complainers…ehh…and…complainers and those that demand and want lots of things also, because then I can be too strict also…Then I can close myself off, and I can get terribly obstinate and sort of "don't even think about it"…And, I was about to say, that I don't develop trust that it won't make me rigid, that I get obstinate, if I don't jump through the hoops. That's not what I think the benefit of therapy is among other things, that it is actually possible to be stubborn, and stick to your own, and still be able to be flexible as well…"* (4, 147 – 150).

Clients who tell their stories over and over again and clients that are understood as complainers seem to be hard to handle for Karen (4) and Erik (2). When I ask Karen (4) what she actually does when she meets this phenomenon in the therapy room she says that she tends to put up the next appointment a little bit further on than she normally would have done.

Summary of GT findings on therapists' dilemmas

The three subcategories under this GT category are "*Sexuality and Love Life," "Handling emotions in therapy"* with sub sub-categories such as *"compassion, joy, sadness and anger,"* and *"Repetition and Complaining".* All these sub-categories tend to influence the therapists' feelings. These influences seem to range from compassion to a sort of irritation. These emotions seem to be one important element in understanding the therapeutic context. Some of these categories also invite to ethical reflections. Ethical reflections should be raised both concerning Elisabeth's (1) story about her patient that are in a sexual relationship with her therapist and how Karen (4) and Erik (2) handles with clients that are complaining.

The researcher's personal reflections:

"Do you have a partner for the time being?" My therapist looked at me and I felt confusion for some seconds. This was my twelfth session with him. I had told him about my former girlfriends, my wife and my newborn son, and he asked me if I had a partner for the time being. I suddenly understood that my therapist did not have the slightest idea about who I was. I answered him polite, and I knew that this was my last session with him. Was he brought into a dilemma when he asked me if I had a partner for the time being? I did not know. I felt disappointed and hurt.

I have often wondered about if there are any connections between the choice of therapeutic orientation or field for therapeutic work, and how the therapist's show interest for and emphasise feelings. However, when it comes to therapists' dilemmas it seems like the feelings that appear between the therapist and the clients to some extent govern the therapeutic process.

I think that this experience with my own therapist is one of the key experiences that have formed my occupation with and interest for the significance of the therapeutic relationship and how feelings may decide the continuation and the outcome of therapy. This is without doubt some of the background for my interest for feelings and dilemmas in the therapy room.

GT Findings on "Influence on Personal and Private Life"

"You are the one, you play all the roles" (8, 249) Karen (4)

"I don't often bring cases home with me" (4, 116) Erik (2)

Introduction

In this section I present the GT analysis of what can happen when personal and private lives are influenced by the participant's clinical practice. Sometimes the experience from practice as a family therapist may engage the therapist in such a way that it is impossible to go home and leave a special case at the office. On the other hand, in this thesis we find that sometimes the whole work situation affects the therapist in such a way that she or he feels exhausted or burned out. In these situations clinical practice affects the therapist's personal and private life and sometimes her or his job and loved ones. The connection between p**r**ofessional life and a family therapist's personal and private life have sometimes this kind of impact.

However, the participants in this research project had far fewer stories to tell about these kinds of connections. Most of the participants could tell about how their professional life has influenced their attitude and behaviour, their world view and understanding and their emotions. The professional practice adds meaning to the participant's personal and private life. The participants also made connections between their professional practice and their personal and private lives.

GT category 7: The influence of clinical practice on personal and private life

This main category is supported by sub-categories from three full participants, Karen (4), Adam (3), and Erik (2), and Evelyn (5), one of the three "parallel connections" participants. The GT categories and sub-categories that emerged from their material are summarised in this diagram:

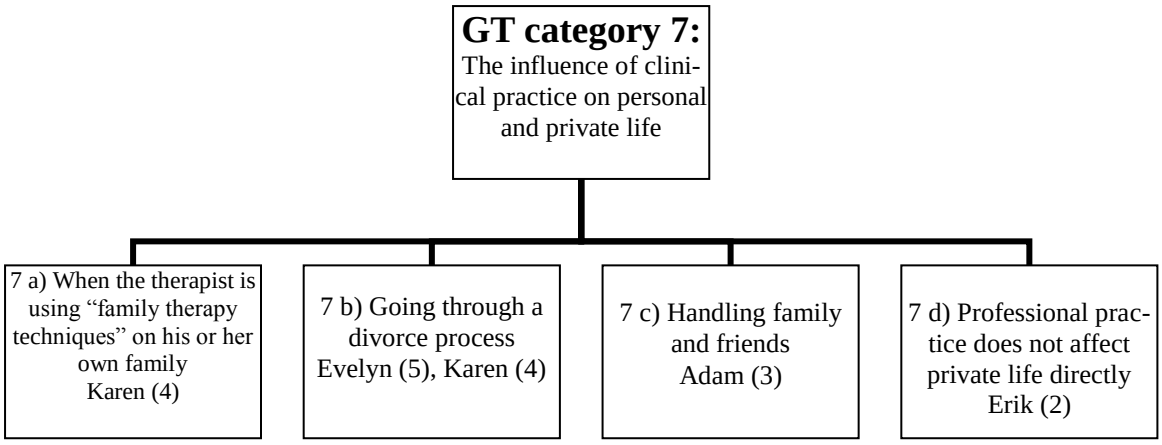

Table 15. The influence from clinical practice on personal and private life with sub categories

When we look at the topic of connections, it is even more difficult to find research and professional engagement with how the experience as therapist influences our personal and private lives. Nevertheless, according to my research material, we have some connections here too. These parallel connections are to situations where therapists reach an "experience of despair, fatigue and burnout" (White, 1997, p. vi) and when the family therapist uses methods or techniques from clinical practice in their own family.

None of the family therapists in this material drew strong connections between their clinical practice and their private lives in the sense that they used methods or family therapy techniques from their clinical practice in interaction with their own family. But some of them had examples where they had tried some family therapy methods on their children, especially when they were young children. Some also told stories about their own divorce and how they derive help from their clinical practice in their private lives.

7 a) Using family therapy techniques with our own children

Karen (4) told me that she used *"the theory of opposites"* (8, 37) in a period when one of her children hesitated when she wanted to give him a hug. She says:

> *"…when one had children, small children, yes small or big, but where people very easily come into such conflicts, such power struggles, and then I think, it made the idea whether it came from therapy first or home first I don't know. But…do the opposite, the theory about the opposite. If you're used to speaking loudly, for goodness' sake speak softly or, I remember for example my son …where he wasn't to have any hugs. I thought, damn it, I want to give him a hug, how shall I do it? Of course, I can surprise him, stand behind a door and fall suddenly over him. (laughs) Get the giggles you know. Yes and back to that it's possible to do the opposite of what I've done. Of course I didn't want to lose physical contact with him just yet. It maybe wasn't such a big problem then but, the idea of the opposite… which you often try as a therapist,*

*also, you explore alternatives all the time. My ideology is of course not to go in the direction of what people have done, but to…find the pockets of things that haven't been thought and haven't been tried, then. And I believe that that is what I try out in my private life… (*8, 37-39).

It is not only the therapists themselves who explain some of what is going on in their family lives with their professional background. Adam's (3) son once told him that a friend of his had complained that he quarrelled a lot with his siblings. Adam's (3) son remarked that the explanation for why he did not quarrel much with his siblings was that his father was a family therapist.

7 b) Going through a divorce process

A couple's therapist in private practice and with huge problems in her own marriage said to me: "How should I be able to go on working as a couple's therapist if my private problems influence my clinical practice? I would go bust in a few months." This ability to separate private experiences from professional practice may be seen and handled differently. Evelyn (5) and Karen (4) are two examples.

When Evelyn (5) decided to separate from her husband of many years, they still had two younger children. She worked in a family counselling office at that time and she says:

"I got something of a flying start with my own divorce by having encountered many questions concerning second marriage and stepchildren and one's own children's relationship with stepfathers. That whole arena there, to have encountered that at work before I was there myself, gave me a bit of a flying start…" (11, 65) she remarks.

We will look more carefully into this example in Chapter 5, part C, concerning "paradigm cases". However, this example also illustrates that her experience as a family therapist seem meaningful and useful in personal and private life.

Karen (4) claims that working as a therapist has made her believe in change, change connected to a process in which new ideas take root in your life.

"Change happens often that way, where first a new idea forms about something that can be thought about or done differently. And then one can change practice, like I find at work, that it is, like, the way I work as a therapist I think it concerns my life as well.. The idea could be about… something that could be done differently or be thought differently about… That is how I work as a therapist and that is how it is in my life too" (8, 27).

When I ask if she is able to refer directly from her experience as a clinician to her private life, she immediately comes up with two stories about relationship break-up. She connects the fact that she has been able to walk out of two relationships to her competence as a therapist. She claims that this is connected to a process where *"...I have struggled with something for a long time and suddenly…the alternative or opportunity to choose suddenly seems simple"* (8, 33).

That is also her experience from therapy, that clients are able to act differently when they are able to see their life from a new angle or when they get some new ideas or understanding of their problems. These can be problems connected to relationship break-down, children or young people or other difficulties in life. Her idea is not to concentrate on what clients have done, but to look for pockets of ideas that have not been explored or things that have not been tried.

7 c) Handling family and friends

From time to time friends want Adam (3) to be an expert, to tell them what to do in difficult situations. Women ask him to explain men and men to explain women. He says that his contribution to questions like this is to encourage the one asking to go home and learn to know their man or woman. He says that is better than reading tons of books about such topics. He thinks it is more difficult to be a parent than to be a therapist. However he hopes that his family has felt that he uses his time in conversations with them. *"It has something to do with, how shall I put it, something to do with tuning in to each other"* (6, 191), he says. But he thinks he is an ordinary person at home and he has not deliberately used methods from family therapy at home. No one would discover that he is a family therapist if they saw him at home, he says.

Elisabeth's thoughts are that she has a husband who fades out and does not see the children, and she has been blind to the situation. She thinks that meeting this man on the psychiatric ward (see p. 107) has helped her to see that she does not want to live like this, and this has made her take action at home. *"But I think that it is also strengthened because my father really died the same way, I mean he committed slow suicide in the same way"* (2, 43) *"But I still do not understand why he has got under my skin"* (2, 48).

Karen (4) says that one of her private strategies is to run away (see p 110). However, this has changed in her life, she says. She can still run away, but nowadays she returns to talk about what happened privately. When I ask her what she does when she meets clients who use the same "method" she says that she tries to keep them in the room.

7 d) Professional practice does not affect private life directly

One of the participants could not tell any stories to illustrate how working as a family therapist has influenced his personal and private life in a direct way. Erik's (2) story is an illustration of this position. He has worked as a psychotherapist for 33 years and for the past 22 he has worked in a family consultation office. Erik (2) has never been married or lived with a woman. 24 years ago his girlfriend was pregnant and he decided not to marry her. For the last ten years he has had a steady girlfriend. They are together every weekend and every other Wednesday. However, they have never lived together.

When I ask him if this way of organising his private life may seem to have some advantages in his work with couples in crisis every day he says: *"I have absolutely never reflected on that possibility because… and so usually so…it isn't very often that I take things home with me"* (4, 116).

This reflection may illustrate a lack of awareness among the participants when it comes to creating meaningful links between family therapy practice and personal and private life. However, Erik (2) tells several stories from his clinical practice that have affected his life in a way that has kept him awake at night and worried him during the day. These are for examples stories about clients who have committed suicide and heavily traumatised clients.

Summary of GT Findings on Influence on Personal and Private Life

The GT categories with emergent sub-categories are connected to the participant's own children, the participant's divorce and to the participant's friends. Some ideas from family therapy methodology come forward (doing the opposite) and some ideas from a basic understanding of relations (not to draw parallels from literature to a specific case). The resonance occurs for example when Karen (4) looks for ways to go on hugging her son without forcing it on him and when Adam (3) is looking for proper answers when some of his friends generalise about gender or other group characteristics. On the other side, Adam's (2) position represents an important voice when he underlines the lack of direct connections between his family therapy practice and his own personal and private life.

However, it seems as though these examples are few in this research compared to the categories that emerged when we looked at how experiences from personal and private life can influence family therapy practice.

The researcher's personal reflections:

The first time someone came to me, after what I considered a normal conversation, and said: "It is easy to hear that you are a therapist," I was taken by surprise. I have never thought that I should use any therapeutic ways of asking questions or try out any family therapy methodology with my friends or my family. I have never had the idea that I may bring my therapeutic skills or knowledge home, to help me and us, to get a better life. I have never believed it is possible or meaningful in a direct way. On the other side, my professional competence and skills is a part of my personality and way of life. In that sense, my personal and private life has been formed by my professional life.

I do not know where this scepticism or avoidance of therapeutic knowledge comes from or how I have been able to establish this opinion of therapy. It is probably connected to my avoidance of belief in a rationalistic basis for living my life.

Surprisingly, my participants also reported few attempts to use their therapeutic skills at home or with their friends. One exception is therapists' children. Some of them had tried some methods on their children.

However, some of them refer to attitudes and behaviour that they think stem from their clinical practice. I think this refers to my own experiences when someone point out some links between what they see me do in private settings and my professional work.

This would be even more distinct when it comes to worldview and how to understand how I participate in a private communication on relations between friends and even how to explain social and political affairs.

Summaries of GT findings and Conclusions

> I am more preoccupied with what people think and feel than with which enzyme affects which other enzyme (1, 45). Elisabeth (1)

The GT categories 3, 4 and 5 format the centre of the findings and concerns how the therapist' personal and private values influence their therapeutic practice. In category 1, some of the participant's personal experiences from life also enlightening some personal values that the therapists underline as abilities to "see" people's situations, interests for people and interme-

diary skills. Rethinking the expert role and always let everybody be heard format foundations for therapists. The influence from category 2, being in therapy for themselves, in this way support the centre of the GT findings. Explicit value systems and strong beliefs naturally point to dilemmas (category 6) that challenge the therapists in their clinical practice.

In this research project, looking for the influence of personal and private lives on family therapy practice has been a major task. This research project documents several categories that have emerged through the GT analytic work, which might be used to explain and give meaning to aspects of the practice of the participating therapists. In some areas, the influence of the therapist's own values and life experiences seems to form the context for some family therapy sessions.

For example both Karen's (4) experience of being heard when she attended her own therapy and Elisabeth's interventions in the family that was hiding the fact that the father had two children from a former marriage stand out as very important histories. I view this as an extremely important finding that give evidence of the need for us to revisit such topics repeatedly, both as a part of clinical practice, and as a part of family therapy education and supervision.

Personal and private values as context for clinical practice

Feather (Furnham, 1997, p. 262) has claimed that value systems "are systematically linked to culture of origin, religion, chosen university discipline, political persuasion, generations within a family, age, sex, personality and educational background". These value systems are organized in such a way that they also may guide both beliefs and behaviour in many situations, also at work. The participant's personal and private values seem to influence aspects of their therapeutic work. Categories 3 (*Participants' explicit personal values that influence family therapy practice*), 4 (*Dynamics that show how personal and moral values influence their therapeutic work*) and 5 (*Therapists' acceptance and avoidance that personal and moral values influence their therapeutic work*) deal in one way or another with how the therapist's personal and private values influence her or his clinical practice.

When the relation between values and behaviour is assessed it is important to distinguish values that are espoused from those that are in use. Values are often socially and professionally desirable and that makes them important to express for many professionals. However, that does not necessarily mean that they are in use or show up in practice.

> "Therefore, when an individual's values are different from those that are prevalent in his or her environment (e.g., unit, organization), the values of the social environment

> may influence what the individual says, but they may not predict how he or she will actually behave" (Meglino and Ravlin, 1998, p 356).

From time to time there is a lack of consistency between what is said and what is done. Erik (2) is very clear when he points out the difference between his own personal and private life and his clinical practice. Erik (2) says that he has never used his own background and moral values directly in therapy (see category 5a, p. 112). He claims: "…obviously, I don't have any particular ideas about how one should live one's life" (4, 22). He points out that there has been a "discrepancy" between his childhood and his life history as an adult (see category 4e, p. 109).

How therapists develop

Research on the development of therapists and how therapists with different gender, ethnicity, age and experience develop is extensive (Protinsky and Coward, 2001; Rønnestad and Skovholt, 2001; Rønnestad and Skovholt, 2003; Beutler et al., 2004; Skovholt and Jennings, 2004; Orlinsky and Rønnestad, 2005). However, the interest in therapists' characteristics has decreased over the past twenty years due to the focus on manual-driven treatment and randomized clinical trials. Psychotherapeutic treatments are often evaluated as entities independent of the therapists who deliver them. Eventual effects of the therapist as a person are often viewed merely as a "…source of error" (Beutler et al., 2004, p. 227).

It is interesting however to investigate how professionals have found their way to becoming family therapists. It is even more interesting to try to understand what has made them stay therapists for many years. Jennings et al (2003) claim that there is evidence that expert therapists share some characteristics:

> "These features include: experience, highly developed characteristics of master therapists, openness to change, cultural competence, and comfort with ambiguity. We believe that these factors characterize expert counseling and therapy practitioners and make an important difference in the quality of the counseling and therapy experience" (Jennings et al., 2003, p. 62).

Of the characteristics mentioned here, topics such as openness to change and comfort with ambiguity are confirmed and commented upon by therapists in my material.

Openness to change

The link between therapy and change is probably one of the most common ideas in the field of psychotherapy. Arguably, most psychotherapists will agree that change is one major goal in

clinical psychotherapeutic work with clients. In the field of family therapy a discussion of how change occurs, what is needed to make change occur and how we may understand the phenomenon of change, came to be an important discussion after the publishing of "Change" by Watzlawick, Weakland and Fisch in 1974. These ideas suggest connections with the discussion of how to understand change and balance, and the differences between concepts like steady state, homeostasis and homeodynamics (Watzlawick et al., 1967; Rogers 1970).

Karen (4) claims that her experiences with change from private life have played an important role in understanding what is going on in therapy (see category 3a, p. 100). She draws a direct line from personal and private life to her clinical practice when she comments "*…that's the way I work in any case as a therapist and it's also true of my life as well"* (8, 27).

Erik (2) takes an even more radical stand when he says (see category 3a, p. 100): *"…I think that if you're to survive, then you have to change as well* (4, 146). This view of change, as a part of life and of living, influences therapeutic work in a way that raises the question simultaneously of stability or preservation. Erik (2) claims that it may also be necessary to not move too quickly. However, change is something " *you can't avoid…"* (4, 146).

When change is used as a concept both to describe what is going on in life in general and to understand how we move psychologically it is essential to understand that we operate on different levels. At one level we may perceive that all living creatures are part of an ongoing process of change. However, as human beings we are not capable of being conscious of all constantly ongoing changing processes. In our minds, a certain kind of stability or equilibrium is maintained during periods of our lives. Some phenomena, persons and structures seem the same over a period of time. Both first order change and second order change might be included in this kind of equilibrium for periods of time. However, because the process of change is ongoing, this equilibrium will be challenged and this will end in crisis and change from time to time. Thus changes might be viewed in terms of both first and second order change. This point of view also gives meaning to the understanding of therapeutic processes.

Comfort with ambiguity

The research on the importance of the therapist's experience is very much spread out (Hubble, Duncan, Miller, (eds) 1999; Wampold, 2001; Skovholt and Jennings, 2004; Orlinsky and Rønnestad, 2005). However, according to Christensen and Jacobson "the evidence for the value of accruing professional experience is weak at best. Interest has also waned in the areas of therapist race/ethnicity, age, and sex" (Beutler et al., 2004, p. 239). This may partly be un-

derstood in the context of evidence-based practice. When one believes it is the psychotherapeutic techniques that work, variables such as experience, age, ethnicity and sex do not seems to be very important in the understanding of what works in psychotherapy. The understanding of the therapist's expertise has in the same way been out of focus in psychotherapy research. Although therapists often claim that they are much more professional as seasoned practitioners than they were as novices this is seldom supported by research: "…empirical research supporting this idea has been slow to accumulate though there has been more work in recent years" (Skovholt et al., 2004, 24).

Therapists and counsellors need to go through many of the same types of processes to develop their practical and clinical skills. According to Skovholt and Jennings there are four signposts on the novice to master counsellor path (Skovholt and Jennings, 2005, p. 1). These are that:

1. It takes Time;
2. The essentials include extensive experience in the Domain, will to grow, an open work environment and reflection;
3. That novices (a beginner) stay with the big picture (uncertainty) while doing the small picture (certainty); and
4. That professional life stages are like personal life stages.

These four points emphasize that it takes time to be a good clinician and that clients are the therapist's primary teacher. It is also clear here that the novice needs structure and that "faced with the heat of the ambiguous complexity of human life, needs help in doing counselling" (Skovholt and Jennings, 2005, p. 1). Finally, these authors compare the stages of professional life with the stages of personal life. In terms of comfort with uncertainty and ambiguity, Jennings claims that

> "Tolerance for the elusive—ambiguity, anxiety, disorder, conflict, ambivalence, and paradox seems essential for expertise in the helping professions" (Jennings et al., 2003, p. 68).

Both Erik (2) and Karen (4) comment on these topics (see category 3b, p. 102). Karen (4) even claims that she has never been able to cope with a setting or an organization that demands clarity. Erik (2) takes something of the same stand when saying: *"And I think it is important to discover the humane elements in what is inhumane"* (4, 136). Erik (2) connects this the ability to see two different views at the same time to ambivalence (see p. 103). Karen (4)

makes this point even more strongly by claiming that she likes to work with ambivalent clients (see p. 103).

The ability to handle ambiguity is a central part of these kinds of developments. "The counselor's job is to understand one of hundreds of strains of this complex ambiguity as expressed in the life of one person at one time and then to offer assistance to that person. It takes lots of time to get good at this" (Skovholt and Jennings, 2005, 1). Ambiguity is often presented as a special challenge. To meet ambiguity and live with ambiguity as a part of your daily work can for some therapists be tiring and draining. This could, for example, be the case when clients and the therapist come from different contexts. Jennings remarks:

> "Related to working effectively with clients who are culturally different is an inherent comfort with ambiguity. The complex ambiguity of the helping professions can sometimes appear to be so daunting as to make the process of acquiring competence an impossible task. This does not have to be the case. Instead, complex ambiguity can be an asset" (Jennings et al., 2003, p. 67).

As we have seen, ambiguity is an asset for some therapists. Karen and Erik comment on ambiguity and how to handle equivocal situations in different ways. These involve processes that are characterized by unclear understanding and ambivalent feelings.

Living with ambiguity as a therapist is often described as an important characteristic and a special ability that is essential to becoming a psychotherapist (Skovholt et al., 2004). The systemic understanding that analogue communication is equivocal is basic to the understanding of human communication. This means that a "translation" from analogue communication to a digital message never will be able to replace or capture the full meaning of the analogue "messages". According to Bateson, this understanding of communication as equivocal and paradoxical promotes the development of communication; "…without these paradoxes the evolution of communication would be at an end. Life would then be an endless interchange of stylized messages, a game with rigid rules, unrelieved change or humor" (Bateson 1972, p. 193). We will never fully understand, but we are in the process of understanding.

Inexperienced therapists often try to solve their own frustration in therapy sessions by looking for simplistic solutions and frames of reference through which to view clients in such a way that enables them to avoid being overwhelmed emotionally. This might lead to "premature closure" in therapy sessions. Premature closure is defined as the "tendency to offer only a single solution to any problem that, because of insufficient or ambiguous information, logically permits more than one solution" (Skovholt et al., 2004, 20). With their attitude to ambi-

guity, Erik and Karen are unlikely to get into situations where premature closure emerges as a problem or a limitation in the therapeutic process.

The influences on a family therapist's own personal and private life of practicing psychotherapy are also many. It was however easier for most participants to tell general stories (as under GT category 7) of how being a therapist has been a part of forming their personalities as open, listening and tolerant. One special situation where connections between private and personal life occur is when the therapist's own personal crises and problems in life are of the same kind as the client and may even occur at the same time. I have called this GT category *parallel connections.* I have chosen to depict and discuss this issue in the following chapter called "paradigm cases". In an effort to develop these findings further and make it possible to widen the reflections both on systemic family therapy practice and family therapy training, I will in chapter 8. develop a middle range theory that include these findings and that offers some new concepts that might be useful.

The researcher's personal reflections:

I am overwhelmed! In addition, I am worried.

When I started this project I was prepared to accept that very little would come forward in this project. Just by examining my own history as a clinician, I knew that I was not able to tell many stories about direct links between my own personal and private experiences and my clinical practice. It thought it would be more indirect, like links between personal values and practice.

The amount of stories from the therapists' personal and private lives and their therapeutic practices both surprised me and worried me. How could I and we as educators of family therapists' in Norway avoid all these topics in our education programs? What should we do next? I was in the middle of making a proposal for the first Masters degree in Family Therapy and Systemic Practice in Norway. I decided to write in 100 PPD sessions to the proposal although I did not know what it should contain.

Part C: Paradigm Cases

The Structure and the Content of the Paradigm Cases

A paradigm case stands out in the clinician's mind and is a description of a clinical episode that alters one's way of understanding and perceiving future clinical situations. It is a reference point in current clinical practice (Benner, 1984). Paradigm cases in this research project consist of narratives that link personal development and clinical practice. As mentioned earlier, I asked participants for narratives that represented their points of reference in which they linked their personal life to clinical practice and explained the connection between the two.

The paradigm cases were identified starting with "parallel connections". Elisabeth was the first research participant. One of the GT open codes that emerged from the analysis of both her interviews and her videotape was "obvious connections". At this very early stage of the analysis it seemed as though this code had potential to describe what had happened in the videotape of the therapy session. The GT analysis of the next three participants' data found "parallel connections" to emerge as a Grounded Theory category, in which the links between therapists' values and life experience one the one hand, and their practice on the other, became evident.

As a result of the process of constant comparison between GT open codes and categorisation of codes from the data collected from the first four participants, the GT code "parallel connections" seemed to hold explanatory potential. For this reason, the last three participants (Evelyn (5), Anne (6) and Janne (7)) were asked to reflect on the idea of parallel connections in their research interviews, and asked to give examples of how and whether these "connections" were evident to them in their therapeutic practice. Benner's (Benner and Wrubel, 1989) work on 'paradigm cases' was used as a framework to form the stories told by the last three participants of these "parallel connections". This section describes the further analysis of the final three participants. In addition Elisabeth's (1) narrative about parallel connections is included.

Four paradigm cases are presented. The first one is Anne (6) who shares her narrative about working with clients in crisis when she is in crisis herself. The next one is Evelyn (5) that tells about being in a process of divorce when working as a couple therapist. The third narrative deals with the difficulties that occurred when Janne (7) worked in Child- and adolescent psychiatry as a family therapist when she was having difficulties with her own children. Finally, in the section on parallel connections Elisabeth (1) shares her narrative about

working with a couple in which the husband had a serious drinking problem when Elisabeth's (1) own husband was also dealing with similar problems.

The next three paradigm cases are constructed around three main topics. These paradigm cases come from different participants. They deal with how private and personal values may influence clinical practice (told by Karen (4)); how therapists accept or avoid the idea that private and personal values may influence clinical practice (three cases from narratives of Karen (4), Adam (3), Evelyn (5) and Erik (2)); and finally how interaction between private and personal background, parallel connections and moral values may influence clinical practice (told by Adam (3)).

Paradigm cases with sub-topics

The paradigm cases are presented as narratives to illustrate the GT categories and to illuminate parallel connections between each participant's own private and personal life and his or her clinical practice. The paradigm cases presented in this chapter are:

1. Paradigm cases concerning parallel connections
    a. Death of a spouse when working with clients in crisis
    b. Divorce when working as a couples therapist
    c. Difficulties with one's own children when working in Child- and Adolescent Psychiatry
    d. Alcohol abuse at home and in couples therapy
2. Paradigm cases concerning how private and personal values influence clinical practice
    a. The therapeutic process
    b. About children
    c. About family relations
    d. My new spouse or my child?
3. Paradigm cases concerning how interaction between private and personal background, parallel connections and moral values may influence clinical practice
    a. Mediation in therapy

Paradigm Cases concerning "Parallel Connections"

Introduction

It is important to discuss and be aware of the dynamic between therapist and clients when the same type of life crisis the clients are expressing closely affects the therapist. When the thera-

pist is in the middle of a personal crisis of the same type as the client or years afterwards has a resonance experience emanating from such a crisis, we need to be aware of what is happening in these therapy sessions. When resonance like this occurs it may influence a therapy session or even the therapeutic process.

It is a special and complex situation when a family therapist's private and personal life forms a parallel connection to her or his clinical practice. It is, however, very important to keep in mind that two situations with different people never are the same and that they do not carry any inherent, fixed meaning. What I here call "parallel connections" does not mean therapists merely sharing similar experiences as clients but to ***"related situations"***. The concepts of context and resonance help to describe these processes. These concepts will be discussed later in the discussion.

The meanings therapists make of such related situations or parallel experience is diverse. The experience of a parallel connection will affect different therapists in different ways. One participant, Evelyn (5), commented, when she was asked about parallel connections: *"From all the grand words in social constructionism about how my world is different from yours even though we have experienced something that is apparently similar or is based on something that is apparently similar, the differences can be just as great as the similarities"* (11, 10). What is then added to the therapy process is not fixed but differs from therapist to therapist and situation to situation. In this research, I will highlight some examples that illustrate different kinds of influence. In some of them the parallel connection has major significance for the therapy process while in others the connection is of minor importance for therapy but of major importance for the therapist.

In this chapter, I will present some findings from this research concerning issues from therapists' family lives identified by participants as difficult and as having parallel connections to their clinical practice. Four of these stories (Elisabeth (1), Evelyn (5), Anne (6) and Janne (7)) will be presented in the thesis as paradigm cases illustrating parallel connections. These cases are general and should be recognisable to most family therapists and are important cases for family therapy students. They are general and recognisable in the sense that phenomena such as death, divorce, alcohol abuse and psychiatric illness also are part of many family therapists' lives. These and similar phenomena occur throughout therapists' life cycles. Family therapy students should reflect on and work with this as a part of their training because such encounters will be a part of their clinical practice from time to time.

These themes and events can at times affect and involve the therapist's personal life in a way that fills most of his or her attention and emotional life. These events can be connected to developmental changes in the family life cycle or to personal crises concerning breaking up intimate relations, psychiatric disorders, or any kind of abuse. When personal and private events like this correspond with what clients bring to therapy, this connection will probably influence the therapeutic process. When we investigate the influence of private and personal life on professional practice and the influence of professional practice on private and personal life we must not, of course, view these influences in a linear perspective. It is not a question of cause and effect. In this study, our perspective is based on a circular and dynamic understanding (Watzlawick et al, 1967; Bateson, 1972).

Background

These questions about parallel connections did not occur until this research had been underway for some time. These perspectives arose when the first participant, Elisabeth (1), in a second interview conducted after I had analysed the first interview following the first therapy session said: *"...It isn't more than one or two years ago that I sat in a family consultation office and said 'I'm leaving if this doesn't get sorted out'"* (3, 36). She and her husband had asked for help from the family care office because she found it difficult to live in a relationship dominated by her husband's drinking. She was aware that she was in a parallel situation to the couple she was working with: both her husband and the husband in the couple coming for therapy had a drinking problem, and she saw the parallel between her private life and this couple's situation.

I have chosen to call this area "parallel connections". It seems to me that most family therapists I have talked to acknowledge these connections as important. Many of them are able to tell stories from their clinical practice in which they describe having met a parallel to their own personal and private situation through clients in the therapy room. They can tell stories about painful and overwhelming meetings with clients where their own private situation has been brought to life in the therapy room. They can also reflect upon how these special instances have affected their clinical practice both during and afterwards. There is also the question of how they will anticipate such occurrences in the future. In chapter 7, I will discuss why this is important for family therapy training practice.

The therapist's personal life in psychotherapy research

On the other hand, when we look into psychotherapy research and the literature on family therapy training there is little on such topics as "parallel connections," though there has been some attention paid to this connection in the literature on supervision of family therapists. In psychotherapy research there is some work on self-disclosure and how seasoned family therapists use their private and personal experience in clinical work (Høglend, 1999; Hurst, 2001; Protinsky and Coward, 2001; Roberts, 2005). However, this research is not connected directly to my research question connected to the situation in which the psychotherapist experiences parallel stories between themselves and their clients.

In Orlinsky and Rønnestad's research project about how psychotherapists develop (systemic family therapists are included in this research) there is one question connected to the influence (positive and/or negative) current experiences in personal life have had on their current development as a therapist. As mentioned before, experiences in personal life have had a positive influence on their development and just a few say they have had a negative influence (Orlinsky and Rønnestad, 2005, p. 128). When Orlinsky and Rønnestad asked how experiences from personal life have influenced the therapist's career development, about the same pictures comes forward (ibid p. 137).

However, Orlinsky and Rønnestad do not say anything about what it is in the therapist's personal life that influenced development as a psychotherapist or how this influence has been felt besides being categorisable as either "positive" or "negative". In the chapter on further research, under the headline "Additional variables" (ibid p. 205), they say: "A sequel to the present report will focus on the therapists' lives and personalities and relate those to the currently reported findings on therapeutic work and professional development." This research is in process.

In the research reported here, we need to discuss more carefully what is needed in the way of empathy and connectedness to be able to conduct family therapy at all. The answers to these questions are not at all obvious. According to the evidence-based concept of psychotherapy, empathy and connectedness are not the main areas discussed in relation to understanding the psychotherapeutic process.

Similarly, the literature on personal and professional development (PPD) does not discuss the connections between personal and private life and clinical practice in a direct way. When mention is made of these connections, it is often in the context of another issue and in general terms (Hildebrand, 1998; Cox, Faris and Hardy, 2005).

As I have shown in the literature review, the connection between personal and private life and clinical practice is more often discussed in the literature on clinical supervision (Framo, 1976; Lieberman, 1987; McGoldrick, 1992; Hardy and Laszloffy, 1995; White, 1997; Halevy, 1998). Joyce Scaife and Sue Walsh (2001) emphasise how feelings experienced towards people outside work may "occur just as readily towards clients" (p. 37). In the same way, clinical practice may be influenced by events outside work. They mention events like bereavements, health problems, formation and breaking of relationship, births and other important incidents from the therapist's personal and private life (p. 38). They call attention to how personal life history, values, beliefs and personal characteristics such as temperament and humour may influence clinical work (p. 39). Events like these may constitute parallel connections between the therapist's life and the client's life. Such influence may also be reversed when experience from clinical practice influences personal and private life.

Examples of parallel connections

The topic I formulated was: *Therapists sometimes participate in parallel connections and have to deal with the links between own personal life and the client's problems.* In this research project this main topic is illustrated by four examples (for more examples, see Appendix 9).

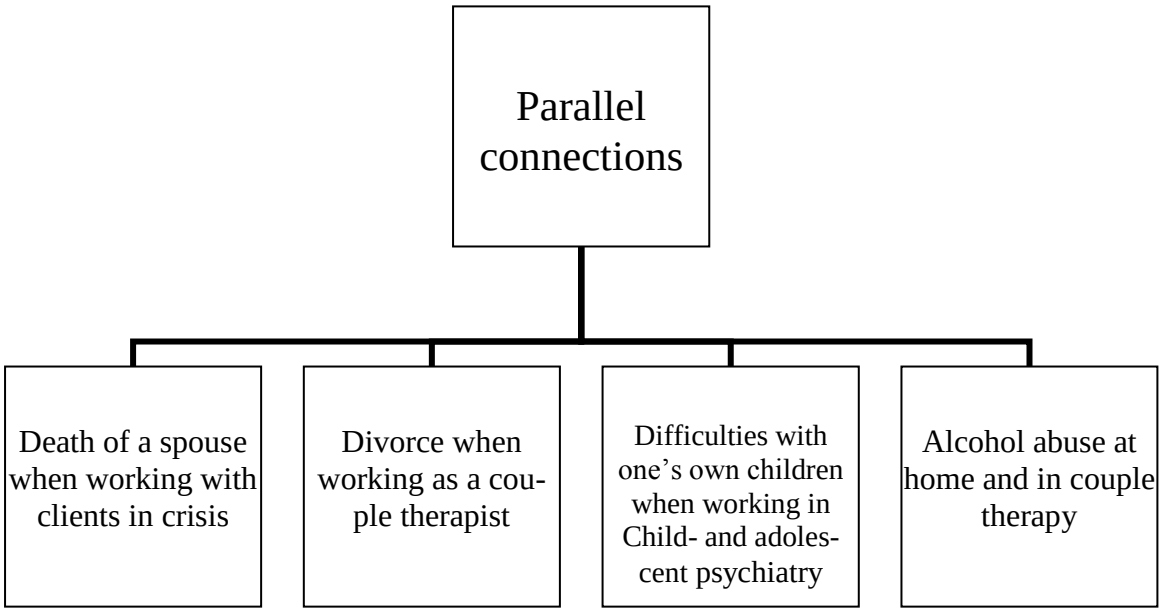

Table 16. Parallel connections with examples

The last three family therapist participants were invited specially to talk about parallel connections as a result of the emergent GT analysis. They are Anne (6), Evelyn (5) and Janne (7). Anne (6) lost her husband when she worked with couples in a Family Counselling Office.

Evelyn (5) was in the middle of her own divorce when she worked in a Family Counselling Office. Janne (7) was struggling with her own children when she worked as a family therapist in child- and adolescence psychiatry. In addition, Elisabeth (1) was in a situation where her private life came to influence on a therapy session. In the following, we are consequently going to look closer at these four areas. That is topics connected to death, divorce, problems with children and alcohol abuse. These four topics are presented as the first paradigm cases.

"Death of a spouse when working with clients in crisis"

Anne (6) is an experienced social worker who has worked as a family therapist in a Family Counselling Office for four years. One year ago, her husband died from a chronic illness he had suffered from for about one year. Anne's (6) story is about working with other peoples' crises when you are in the middle of your own personal crisis. This situation is the main parallel connection in this paradigm case, but it also reflects parallel connections connected to death and losing someone close to you.

Anne (6) tells that she worked part time after her husband became ill. During that period, an older woman who had a sick husband came for therapy. The woman was rather frustrated because of her husband and the extra burden of his illness. She lived in a difficult relationship, she claimed. She was the one who was healthy and she would continue living with this sick man for a long time. Anne (6) says that she recognised aspects of the woman's story. Anne (6) knew that from the day her husband was diagnosed they had started two different "projects". He would prepare for dying and she would handle the impending loss of her husband. However, Anne (6) was also to take part in her husband's "project" to get the best out of the rest of his life. She had several "projects" of which he was not a part.

When Anne (6) listened to the older woman's story, she recognised much of her own situation, but nevertheless made several contributions and comments about her predicament. Towards the end of the session, Anne (6) thought it would be a mistake to continue without commenting on her own situation. Without being too explicit she said: *"I have to say this to you because it would be wrong not to say it, I have been through similar things in my life. And it affects me and it makes it so that I think that you should go to another therapist,"* (10,10). The result was that the woman chose to go to another therapist and not long after the encounter, Anne (6) had to take sick leave herself.

Anne (6) claims that this was partially about being in control. In the meeting with the woman she told about, she felt she was about to lose control and that would have been a mis-

take. It is a different situation when one has distance from one's own experiences. Nevertheless it is dangerous to:

> *"…convince oneself that one has understood something about the other because I have…experienced this myself. And that thought is very dangerous. I haven't understood anything else than my own. Even though it is similar, there might be completely different things that lie there and which aren't captured and which make it so that my thoughts and associations can lead us down the wrong road. Because then we lose the other's path. Because it wasn't like that after all"* (10, 18) she says.

When Anne (6) and I meet for an interview, she is still on sick leave from work. After her husband died almost one year ago her physician encouraged her to go back to work and she tried to do so for a while. However, she did not manage to stay with other peoples' crises, and she says: *"I am still a little reluctant about going too much into other peoples' lives…But I don't know how quickly I can get going again. It is a crossroads in a way"* (10, 29). She says she will work for about one year outside the therapy field to get the necessary distance to continue with and function in clinical processes.

Comments

A personal crisis has both an emotional dimension and a dimension connected to content or ultimate meaning. This first paradigm case illustrates that parallel connections do not have to be parallel in terms of the content of the experiences. The therapist wanted the best from the remainder of her life together with her husband while the client wanted to complain about her dying husband. In this case, the main parallel is that of being in a deep personal crisis when you are working with clients that also are in deep personal crises.

This therapist viewed herself as a strong and reflective person. She is a very experienced social worker, but had only worked as a family therapist for four years. It could be interesting to hear from more family therapists to see whether experience and other factors can help the therapist handle this situation in other ways even very close to the loss of a spouse.

"Divorce when working as a couple therapist"

> *"I got something of a flying start with my own divorce by having encountered many questions concerning second marriage and stepchildren and one's own children's relationship with stepfathers. That whole arena there, to have encountered that at work before I was there myself, gave me a bit of a flying start. It really is a second-order change to be about to marry all over again and to suddenly get stepchildren. It is something you've never done before, but the problems, the dilemmas, the possibilities and the limitations and danger signals you've talked about and worked with quite a lot*

beforehand. So you aren't as blank as one would have been without having worked with this as a therapist" (11, 65) Evelyn (5) tells.

Evelyn (5) is a very experienced clinical psychologist and family therapist. Some years ago, she decided to separate from her husband of many years. At that time, they had two younger children. Evelyn (5) was at that time working as a couples therapist in a Family Counselling Office in a small town in northern Norway. She had been working in the Family Counselling Office for several years. Her troubled family life had been difficult for a long time and one autumn she decided to leave. She got a separation from her husband and moved to a new apartment.

When I asked her what consequences her separation had had for her clinical practice, she said: *"It had enough of an impact that I chose to leave"* (11, 31). After some months, she left the Family Counselling Office and got a new occupation outside the field of couple's therapy. She tells that her problems, doubts and worry about her children and husband had lasted much longer and were bound up in questions about her own values and choice. She says that she was continually aware that she brought her own stories with her. She says:

> *"The value of being so aware is that I, I think I had quite a strict censoring of which questions I posed and which I left alone and didn't ask about. So that was good. But at the same time the drawback was that the censoring could be so powerful that I chose not to ask questions that probably would have been useful. And that was because I thought that it was mine, now I'm putting my experiences and my feelings, my dilemmas in to them. So therefore, I can't ask. But other times I think because of my own experience I could ask both him and her certain questions that I don't think another person who hadn't been in that situation could ask,"* (11, 8).

When I ask her if this situation had become *"unbearable"* or *"too heavy to carry on with"* or *"to stay in?"* (11, 19) she said that it was not like this though it was *"very exhausting"* (11, 22). And on bad days she wondered if it was right of her to continue to work as a therapist when she was able to inflict such pain on other people. Was she able to contribute something good for other people? *"On those days (the) question of whether I could continue to work popped up"* (11, 31) she says. The answer to the question about whether she should continue as a therapist came first and foremost from her clients. They confirmed that it was *"alright to talk to me"* (11, 3) she says. "*The restorative energy to continue was derived from the clients"* (11, 33) she says.

When I asked her how she thinks about her experiences today when she is back working in the Family Counselling Office she says that her fight to keep her self-esteem and her

intrinsic value was a terrible one. *"I think that my own experience makes it so that I am very seldom easygoing in meetings with women or men who show signs of distress connected to self respect, connected to 'what about my children'"* (11, 37) she says.

When I ask her if she shares some of her own experience from her divorce with her clients today she says "no". There is one exception, however, and that is when she is a part of a reflecting team. In this situation, she can use her experience because she will be able to leave the room soon afterwards and does not have the follow-up. When I ask if she does not tell personal stories when she works as a therapist on principle she remarks that she often tells personal stories, but that these stories are connected to topics that are general in a sense that "everybody" agrees on a common goal. As an example, she talks about a child who is wetting his or her pants. When she talks with a child with such problems she can tell the child that she had the same problem. But it is different when it comes to telling divorcing adults about her own divorce, *"…by giving a personal experience to a couple you will most often through your personal history support one and not the other. There is such an obvious difference,"* (11, 52) she says. Going through a divorce when you are working as a couples therapist creates, as we have seen, several parallel connections between the therapist's own personal and private life and her or his clinical practice. This example shows however that these experiences can both create difficulties for the therapist and a level of sensitivity that can be a very important part of the therapist's development.

Another participant, Karen (4), when talking about her belief in change, is reminded about one important period of change in her own life, one of her own separations. She is reminded of how this particular separation process affected her clinical work in the Family counselling office.

> *"I remember for example when I was in a separation process with my partner …it occurred in such a very rotten way. Then I realised about myself that when I was a therapist here, I realised that I'd become very cynical for awhile. People told me about themselves – and I thought, 'Oh God how trivial, if you only knew, you know, what I have to deal with?'…I couldn't bear to get into it, I assessed so many such trivialities. Why should they get so upset over these trivial things about habits, bad habits, one thought about a possible affair that had probably never happened, and those sorts of things. Then I thought, what are we doing at this office? Is it sort of treatment of pimples on the tiny backsides of the bourgeois, I almost doubted the goals of this place. These aren't big enough problems. Then I realised that, because in relation to what you yourself are going through,…and then I knew how I'd found it difficult before, difficult to go properly into…big or little problems"* (9, 82).

Comment

Parallel connections emerged from the GT analysis, with some powerful illustrative examples presented here as paradigm cases. It may seem obvious to say that clinical practice sometimes is influenced by the therapist's private and personal life in a way that shapes their family therapy practice or sequences of family therapy practice. Family therapists are expected to go through the same expected and unexpected life cycle transitions and crises as their clients.

Working in a Family Counselling Office offers many opportunities to meet clients who present problems close to the experience and the situation of the therapist. Being in a divorce situation illustrates this kind of parallel connection in a way that is close to many therapists' experience. Evelyn (5) chose to change her workplace during such a period but not because she felt this move was absolutely necessary. It might, however, be interesting to look at how different Family Counselling Offices handle the situation when these kinds of parallel experiences occur. However, family therapy curricula do not formally address the issue of parallel connections nor directly equip trainees with strategies for managing such connections.

Difficulties with one's own children when working in Child- and adolescent psychiatry

Janne has four children aged 21 to 27 years. Two of them have had problems of a kind that has made it necessary to get help both from pedagogical and psychological services, alternative schools and from Child- and Adolescent Psychiatry. Her family also attended family therapy. Janne was educated as a family therapist eight years ago. She has not worked as a therapist continuously during these years but has been in other types of clinical practice much of the time. Her paradigm stories about parallel connections are about having had difficulties with her own children and meeting some parallel stories when she was working as a family therapist in Child- and adolescent psychiatry. Her stories about parallel connections are also about being divorced when she was working as a family therapist in Child- and Adolescent Psychiatry. She was divorced 1 ½ years ago.

She tells that during the period when she divorced her husband, she was on a sick leave for 14 days because she *"... couldn't manage to get involved in the problems of others"* (12, 6). "*I now have a new understanding of what is happening when someone leaves their partner*" she remarks. She says that she thinks she has become a more sensible therapist, but at the same time that it is important not to get into something that is not her own.

She was in the middle of some of these problems with her children when she attended family therapy training. She says that the family therapy education program helped her to be wiser and stronger and it contributed to helping her develop more confidence in her own judgement regarding care for her children. *"I got more secure with what was normal and not normal and what I couldn't accept"* (12, 27) she says. Family therapy training also meant that she had new possibilities to meet new people. However, she did not tell anyone about the problems she had with her children, choosing instead to disclose a little about the problems in her marriage.

When I ask how her experience with being a mother to two troubled children became visible when she worked as a family therapist in Child- and adolescent psychiatry, she connects her answer to a story about her son. His saving grace proved to be his talent for music and he was engaged by a black metal band playing satanic music. The band became a very famous black metal band. She tells a story about a family with a troubled young girl.

> *"There was one I remember in particular, there was a young girl of about 13-14 years who came in with her parents and they were divorced and she was dressed completely in black with her hair hanging down and she wouldn't speak, wouldn't say one word, was depressive, was self-harming. It was very difficult. I remember being in conversation with them and trying to make contact with her and I commented a bit on her clothes and asked what music she liked. 'That's none of your business, you don't know anything about it,' she said. 'Try me then,' I said, 'I have a son who plays in a black metal band so I've heard a little of that type of music.' It was completely obvious that she was a black metal girl. So then she couldn't be bothered but suddenly she woke up and asked which band it was. And when I said '(*The band's name*)' she got terribly interested"* (12, 42) she relates.

This connection between her son playing in a black metal band and the young girl opened up for communication between them and they started to listen to music together and the girl started to send her own written short stories that dealt with suicide and her longing for death. *"I think…that my experience with my son made it so that I managed to take it up with her, actually, because I'd had exactly the same kinds of conversations with him"* (12, 46) she says.

Comment

This paradigm case illustrates how parallel connections may help the therapist connect in a situation where contact could be very crucial and very important. By telling about her own child she established contact with a girl who was hard for parents and professionals alike to

connect with. Janne used this information deliberately to establish contact and she also underscores that she recognized that the communication with the girl was similar to that with her own son. On the other hand, this kind of communication seems to strike a balance between being private and professional. When Janne told this girl about her son, she was communicating at the same time that she knew and had some interest in black metal music. This was the appropriate door-opener and Janne made use of this possibility to establish contact.

Alcohol abuse at home and in couples therapy

The video of this first therapy session shows Elisabeth (1) with a couple articulating a quite clear and distinct request for help. The woman opens by saying that they have decided to divorce but since they have two children they need help in communicating with one another. At present their communication results in quarrelling all the time.

Initially Elisabeth (1) asks about the family as a whole and the couple relate many severe problems for both the children and themselves. Both parents and children have for many years struggled with both somatic and social- and psychological problems. The husband's alcohol abuse is among these problems. However, after these opening questions and answers, they use almost the whole session to talk about the husband's alcohol abuse.

At the end of the therapy session they decide to meet with Elisabeth (1) again. When they rise to leave the woman remarks that there is something odd about this therapy session. She says that the only topic they had decided beforehand not to mention at all was her husband's alcohol abuse and yet they had ended up using most of the session to talk about this very subject. Elisabeth (1) seems to become a bit hurried at this point and says that she is aware that it was their communication problems they had requested help with. She looks around for some pamphlets about good communication and hands them over to the couple. The couple leave with a decision to meet again with Elisabeth (1) after two weeks.

I was slightly surprised about Elisabeth's main interest in the husband's drinking problem. They had asked for help with their communication and they presented with many very serious problems. I decided to try to understand how Elisabeth (1) had ended up concentrating most of the time on the husband's alcohol abuse.

When I analysed the first interviews with Elisabeth (1) there were few links to alcohol abuse. The only links to alcohol were to her father (with whom she had only lived as a small child) and a remark she made on one occasion that her husband "…was drinking too much." I decided in my next interview with Elisabeth (1) to ask more explicitly for an explanation

about her choice to concentrate almost entirely on the husband's drinking problem in her first therapy session with the couple.

When I return to Elisabeth (1) for the next interview I ask her: *"How do you think about your entering… that alcohol emerged as it did and that you followed that thread among all the possible threads?"* (3, 23) First, she says that she wanted to get out of it and then she says that he needed to talk about it but she does not give me any explanation. Therefore, I remain curious and after a while, I ask her if she thinks I overdo the topic of alcohol and if I ask too much about it. Then she says: *"…It isn't more than one or two years ago that I sat in a Family Consultation Office and said 'I'm leaving if this doesn't get sorted out'"* (3, 36). She then says that she thinks her husband drinks too much and *"…he's just angry, angry, angry"* (3, 38) she says. They have attended couples therapy because of this situation. I ask her if she was aware of this parallel when she conducted the session. She says yes and that when she came home she told her husband that she had had a challenge at work that was somewhat like their relationship.

The couple has continued to come to therapy and Elisabeth (1) feels she has a dilemma about whether she should go on working with the drinking problem or if she should refer them to other specialists. From the first session, she really felt she made good contact with them and they have been eager to come for more therapy. She also discloses that this is the first time this husband has told a professional (Elisabeth) about his drinking problem. When I ask her how she compares her parallel life situation with the couple's life situation, she says that although there is a parallel connected to the drinking problem, there are huge differences in all other areas and she feels she manages this parallel connection in such a way that makes it meaningful to go on working with the couple.

Comment

Resonance is a kind of dynamic that could be used to understand both Adam's (3) and Erik's (2) paradigm cases. When we use the concept of resonance to shed light on Elisabeth's paradigm case it should be quite clear how a therapy session is influenced by the therapist's present private life (more about resonance in chapter 8). In the above example, there is not the mere appearance of the ideal or sense of resonance but its domination for most of the therapy session. This paradigm case illustrates how a personal and private situation may form and structure a therapy session. This illustrates how a therapist may lose her curiosity and openness and let her own private situation govern the therapy session. The therapist's personal and

private situation also gives her a particular understanding of this couple's situation and may give her a special ability to connect with them.

The researcher's personal reflections:

"Now you have developed your competence as a family therapist," he said. I had worked less than one year as a family therapist and I had married last Saturday. This was how the chief physician greeted me. First, I thought he was joking, but "no" he claimed to be serious. He was an experienced psychiatrist and I found his comment both interesting and puzzling. At that time, I was working with a family that was in trouble at many levels. One of the problems was that the couple was unsure that wanted to go on as a couple.

A few weeks later, they decided to split up. A colleague and I agree to be with them in their home when they told their two children about this decision. It was a girl age 17 and a boy age 14. When they announced their decision, the boy turned completely insane, started screaming and locked himself into his room. We were not able to get in contact with him the rest of that day.

Working with this family, in the middle of their divorce, shortly after I had married myself came to fill me with anxiety. When I "discovered" the connection between my own private situation (just married) and my professional work (working with traumatic divorce), my anxiety got new meaning and my understanding of family therapy was widened. Connections between private and personal life and clinical practice seemed important and obvious.

Parallel connections tended to be the most obvious links between personal and private lives and clinical practice. I am a little bit ashamed to say that this aspect came forward as a part of this project first after the first interview with Elisabeth (1). I had to revise my research questions and rethink my design.

In a memo, (see Appendix 9) I wrote down 40 topics and sub topics that might represent parallel connections for a family therapist in clinical practice. This was overwhelming and I had to choose just a few of them to be represented in this research project. The three parallel cases I selected in addition to Elisabeth's was picked mostly on behalf of my own knowledge from colleagues in the field (Evelyn (5) and Janne (7)) and after getting a recommendation from a colleague (Anne 6).

Paradigm Cases about How Private and Personal Values Influence Clinical Practice

We will look at three short paradigm cases that illustrate GT category 3 dealing with how the family therapist's personal and private values may influence her or his clinical practice. First we will look at Karen (4) and Adam (3) who show us how the therapeutic process may be influenced by personal experience.

Then we will look into Evelyn and her experience from personal and professional life taking care of children. Finally Erik (2) shows us how values from his own family of origin may be understood as background for a sequence from his therapeutic practice with a couple.

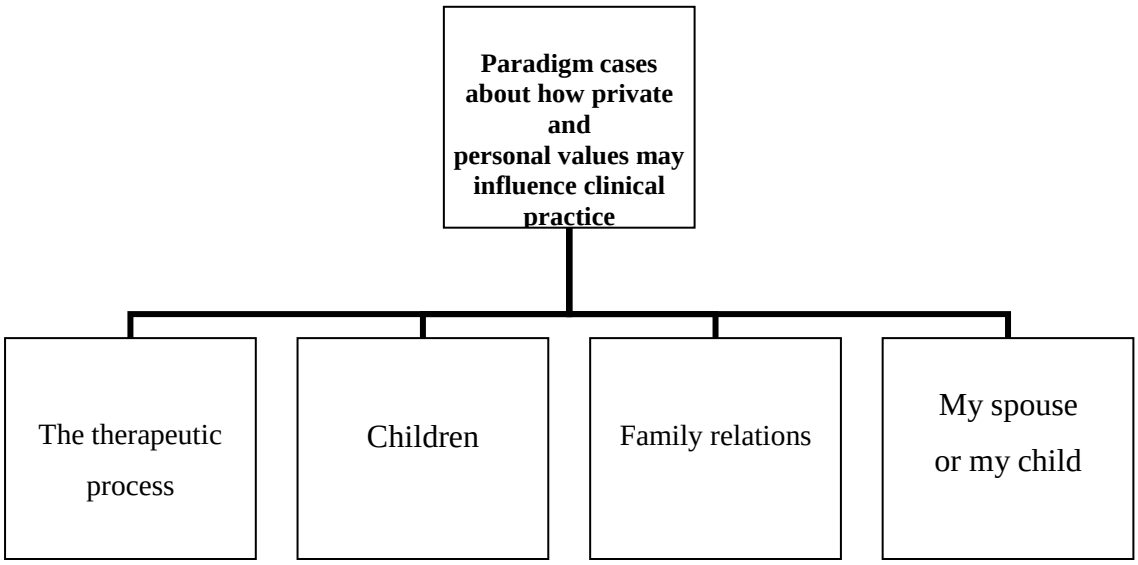

Table 17. Paradigm cases about how private and personal values may influence clinical practice

The therapeutic process

Patience and impatience

"I have learned to be patient" Karen (4) says. When she started to work as a therapist she was fairly impatient and had not experienced much difficulty in life. But after experiencing difficulties in her own life she discovered what was needed in terms of time to *"…work towards changing behaviour. And so become more patient"* (8, 45). She says this was something she learned the first time she wanted to break out of a marriage. She had tried with *"…dialogue and kindness and friendliness to solve the problem" (8, 49).* It was through going into therapy herself that she learned *"…such simple things as hanging up the phone, shutting*

the door and going my own way…" (8, 49). She needed help to change her own practice. *"I developed respect for slower processes"* (8, 53) she says.

In relation to her own children she has used the idea of "doing the opposite". *"If you are used to speaking loudly, speak by all means in a quiet tone"* (8, 37). This is about exploring alternatives, she says. She has often told stories from her own family life about "doing the opposite" to clients.

Using mediation skills

Adam (3) is an active member of a congregation. However, he feels somewhat outside the church in relation to topics such as sex and homosexuality. He claims that he has *"… a critical attitude to doctrines and dogmas"* (6, 125). He is critical about truth with a capital T. He does not think that belonging to a congregation plays a part in his professional life. However, sometimes in his private practice clients are referred to him by pastors because they know his background.

Sometimes clients ask directly about his beliefs. He tells a story about a couple where the husband had something to tell, but did not want to do it because he believed that only a fellow Christian would be able to understand it. His wife encouraged him to do it, but he needed to know about Adam's beliefs (3). After a round with discussion of the therapist's own beliefs, the client felt he could tell his story. Adam (3) claims this was an important and necessary discussion.

He emphasizes that his experience as a mediator when he was a teenager has helped him to be able to keep information from different people in mind without reacting to it immediately. He is able to keep an expectant position. As an example of how he uses his mediator skills he tells a story about a family with a young boy who have caused much discussion among professionals. The family was referred to them by a psychologist who had treated the boy for several years. The parents were stuck in a situation in which they had to decide if the boy should continue in therapy with the psychologist or start using Ritalin. The boy met the criteria for a diagnosis of ADHD. The parents wanted to choose the psychologist but other professionals offered the boy drugs. The situation became the basis of a bitter discussion among professionals. Some of them claimed that the boy needed to be examined more carefully and some said the boy had not been offered what he had a right to. But the parents were very satisfied with the psychologist and the boy was making good progress. When the family came to the Family Ward some of the same divisions became apparent. Adam (3) managed to maintain balance and to listen to everyone, and after many therapy sessions with the parents

they calmed down and were able to see the son as more than a boy with problems connected to his childhood.

Telling a personal story

Karen (4) tells a story about a couple where the husband accused his wife of remaining silent when meeting people she did not know. In that way, she did nothing to help guests to feel good, he claimed. The wife said that she felt insecure and shy and did not know what to do. At this point in the therapy session, Karen (4) told the couple a story from her first year in The School of Social Work. She had come from a small place on the South coast of Norway with no prior experience whatsoever with intellectual work or academic language. She told the couple that she had tried to find another person who seemed to be lost in the same way, and had used this first year to "learn the language." Until you *"…crack the code"* (8, 255) *you can look for someone to join in the quietness*" Karen (4) told them. *"And that was meaningful there… in that situation"* (8, 255) she said.

Children

Evelyn tells that the most difficult aspect for her of her own divorce process was what she might inflict on their children by divorcing their father. The children had to live in a situation in which their mother and father lived separately. The ideal of the family she has brought with her from her own childhood is that it contains a mother, father and children. This was a strong picture of the family where everybody lived together. *"Should I then rob my children of this? Are they to have him torn away by me?"* she asks (11, 15).

When I ask her for an example of where these topics were difficult for her to tackle in her practice she comes up with particular kinds of situations. These situations are connected to couples who discussed divorce and who had children they had to take care of. When these couples were worried about what was happening to their children and saw this as an important problem connected to the question of whether or not to divorce, she would join them in that topic, and help them develop their concern. *"There was maybe some self-therapy in it as well"* (11, 15) she says. On the other hand, when the couple did not seem to be worried about the children in their separation process she almost *"forced them into it"* (11, 15) to discuss the children's situation, because she thought they ought to. *"Then it was suddenly not their dilemma, but it was my focus and not theirs"* (11, 15) she says.

On one occasion, she literally exploded in front of a man she thought did not care about his children but was preoccupied by his dispute with his wife. *"I stood up and dressed*

him down" Evelyn says, *"I haven't done it either before or since. It was connected to…my own struggle and that way of thinking around children, that I didn't manage to be curious about his project, what it was that got him to act the way he did"* (11, 29). In this sense her personal and private situation affected some couples therapy sessions.

Family relations

Erik (2) is a very experienced family therapist. He is also the therapist who most clearly made his point about not using private and personal stories as part of his clinical work. Erik (2) is eager to tell me that he does not know how people should live their lives and he would never try to give anyone advice about how to organize their lives. He says he never would *"promote"* any of his own ways of living either as a therapist or in general terms (4, 40). When I interviewed him for the first time he very generously shared his personal and private history with me, well aware of how I would use it.

In his video of a first therapy session, he meets with a young couple who have come because they wonder whether or not they should remain married. When he asks what has brought them to the Family Counselling Office the wife says: *"It's not supposed to be too easy when one has children, to turn your back on each other"* (13, 5). At one point in the therapy session they talk about who, if anyone, knows they have problems in their marriage. The husband says that he has not told anyone, including his parents and friends. The wife relates that she is an identical twin and that she tells her sister everything. She has not told anyone else, including her parents and friends.

With my first interview with Erik (2) as background and knowledge of his avoidance of giving advice, I was surprised when in the video he asks the couple what they feel about telling their parents, and then says the following:

> *"One could say of course to parents and acquaintances, to family and friends that one is going to family counselling, so that they will understand that this isn't something one has done with a light heart, for example"* (14, 44).

At first, I did not understand his reasoning for giving this near-advice to the couple. But then I remembered one of his own private stories from his time as a young student. His girlfriend became pregnant and he decided not to marry her. She would keep the child and that meant that he would be a father. That also meant that his father and mother would be grandparents and his siblings would be uncle and aunt. He knew he had to go home to his pietistic parents and the rest of the family and explain that would be a new member of the

family and that he would not marry the child's mother. In the early 1970's this was a difficult message to give a Christian, pietistic environment in eastern Norway. They "had to" include a new member in the family born outside marriage. In many families it was viewed as terrible to make a girl pregnant out of wedlock. However, his family included the child as one of their own. They managed to be real grandparents to the child. In his home *"... it was possible to have an open dialogue about most topics"* he says (4, 26).

I decided in my second research interview with Erik (2) to link this good, early experience from his private life to his intervention when he had "advised" the couple to go home and tell their parents. When I met him I was prepared for him to reject this interpretation or to ignore it, or even that he could be angry with me for trying to pin this kind of unprofessional clinical behaviour on him. I presented my idea about this connection for him and said:

> *"You said that you thought it might have been an idea for them to tell their family and maybe their friends. And then I thought that that was something Erik (2) also did when something dramatic happened with him and in his family. The first thing he did was to go home to his mother and father, his family, to say that there is actually a grandchild on the way"* (5, 35).

When he heard this, he was stunned and obviously moved, with tears in his eyes, and he remarked: *"I can feel that I'm moved"* (5, 38). He confirms that to him these kinds of stories represent an important value in his own understanding of being in a family in his own context. At the same time, he was surprised that he really had said what he said or had given that advice. To do so is contrary to his ideas about therapy. He said he would never do that again.

My new spouse or my child?

> "I believe that…through ideas and a bit of extra energy one can find the…aids one needs to manage, even in truly awful weather" (8, 81). Karen (4)

In this paradigm case three GT categories are used to illustrate how therapists accept or avoid the idea that private and personal values may influence clinical practice. The examples concern difficulties and problems that occur in families when children are involved in a family conflict or when the child is seen as the main problem. They may also reflect what may happen when a stepmother or a stepfather is involved in such a situation. In addition to "Parallel

connections" the two other GT categories that are identified here are category 4 and category 5:

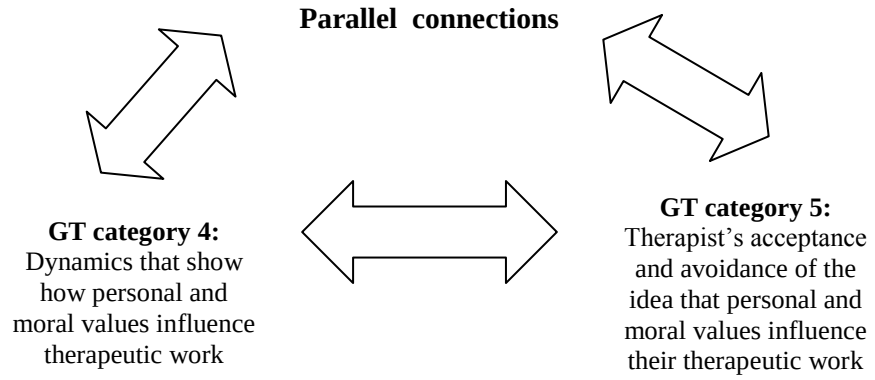

Table 18. How one paradigm case includes two GT categories.

Karen (4) has been married three times and has also had a live-in partner. She has been working in a family counselling office for 15 years. This means that she has worked with break-up situations professionally for many years and that she has had several breaking up experiences in her own personal life. I ask her:

> *Per "…What is it about such cases that makes the biggest impression on you?*
> *Karen (4): Probably the painful aspects of it.*
> *Per: The painful, yes…*
> *Karen (4): …and what I recognise so well…*
> *Per: …yes…*
> *Karen (4): …at the same time as I have some hope that it's possible to come out of it, because I've experienced that myself in my life, that it's possible to come out of it…*
> *Per: Yes, so you have experienced both the painful and that it…*
> *Karen (4): …yes, yes and that the painful aspects for me in my life have been much more painful than I had thought beforehand.*
> *Per: Yes, yes*
> *Karen (4): Because I'd never have believed that about myself, I've thought that I'm a person who can adapt rather well, and I have in many situations as well. But that this in particular should take such a major hold, that was actually surprising.*
> *Per: Does that affect you, do you think, in any particular way in your encounters with people who are in that situation?*
> *Karen (4): Yes, I believe it affects me such that we connect well about it and then I don't get impatient. I can be creative in the sense of finding survival strategies and getting-further strategies and the like. But at the same time with the recognition that this is painful. So I can have quite a lot of patience, but that doesn't mean that I work myself to death for people because of that"* (8, 122 – 133).

In the video of her first therapy session she meets with a couple who married a few years ago. The husband has been married before and has two children from that marriage. In connection with the break-up of that marriage he and his first wife had some help from the family counselling office. The new couple have one child together and the husband's 17-year-old son from the first marriage lives in their apartment with them. They have come to ask for therapy because the new wife has great difficulty living with her husband's son from his first marriage. She says that she and her husband are unable to communicate about his son and when they try, a war breaks out (16, 6). The new wife says that she wants to see the husband's son as rarely as possible and that she does not want to vacation with him.

Karen (4) asks them repeatedly if they think it is possible to *"stand together and have a common policy"* (16, 56) towards the child. She mainly addresses the husband through the entire session and offers much advice about living with an adolescent in the house. They decide to meet again to work on how to develop a *"league"* and to find out how to live with an adolescent in the house (16, 72). When Karen (4) comments on this therapy session in my next interview with her she says that it is *"an almost impossible choice…"* (9, 14). She is referring to making a choice between one's own child and a new spouse. When I ask her if she recognises this kind of choice and dilemma from her own private life, she says: *"From the man's side – and it's clear I remember that I had some antipathy towards that lady"* (7, 16) and *"…and then I think I certainly thought that she was a bit sort of bitchy, I think I thought that"* (7, 20).

To illustrate her feelings and this situation she tells a story from a period in her own private life. After a divorce she lived with her son alone in an apartment. After some time she entered into a new relationship with a man. She decided not to move in with him or let him move in with her, but continued to live with her son separately from her new man. In this way she did not need to deal with this dilemma and it also worked as a "test" of the strength of the new relationship. *"…I made a different choice then, than this man here had"* (9, 26). I ask her if or how her own private experience influenced the meeting with the couple I saw on the video, and she says:

> *"I probably feel that I struggle a bit with judgmentalism also there. If I hadn't been a therapist or the like, just a neighbour, I'd have said: 'Good God honey, this isn't right! You can't relate to this boy like that. You're an adult and he's a child.' I think so"* (9, 34).

Karen (4) agrees that this attitude is not useful for a therapist. With an approach like this, *"I would probably lose one of them"* she says (9, 36).

Comment

What is the *highest* context in these stories? The therapist's own ideas about what governs her or his therapeutic practice are often a main source of understanding of what is going on in a therapy session. These professional ideas may, however, from time to time be overruled by other aspects than those considered to be a part of professional practice. When a therapist claims that she or he is governed by her or his professional background and experience, she or he is claiming that professional considerations form the *context* for her or his clinical work. According to Bateson (1972) context is defined as the mental and psychological frameworks that offer meaning to a phenomenon. This means that there may be different contexts and these contexts may offer different meaning to the same situation. This means that we often have different possible contexts in which to include a phenomenon. The phenomenon may change meaning dependent of the context that is given priority. The contexts that are given priority are here called *the highest context*. When the highest context offers meaning to practice and guides practice it may provide a framework for understanding what is going on in a psychotherapeutic session. A scientific practitioner would probably claim that professional practice and perhaps manual-based methods will decide the context.

The following examples have shown that even for an experienced therapist clinical practice may be influenced by personal and private values that she or he normally would try to keep outside of the arena of professional work. When in a sequence the highest context seems to be the therapist's personal and private values, the therapy session may be structured by these values.

The paradigm case called "The spouse or my child" is used to show how the therapist is affected emotionally by a client who she thinks is acting in an inappropriate way. This response can be understood as resonating with her own experience from her private life. When she found herself in a parallel situation some years ago, she decided not to invite a new man into the home with her son. In this way she managed to take care both of the relation to her son and the new relationship. In meeting this couple, in which the woman wants to see her new husband's son *"...as rarely as possible"* (9, 5) despite the fact that she lives with him. Karen (4) experiences strong feelings of antipathy towards the woman. However, her role as a therapist does not permit her to show her feelings. They would probably not have returned if she had done that.

In this paradigm case the therapist's personal and private experience clearly influences the therapist's experience and her understanding of the case, but her difficult feelings about the woman's attitude do not determine the highest context in the therapy session. Karen's (4) project is to invite them to form a common "league" and find their way together as a new family.

The researcher's personal reflections:

I find it very difficult as a family therapist (and also as a family therapy educator) to handle my own feelings when I meet a client in the therapy room whom I dislike or whom I have mixed feelings. What does it mean to "dislike" or "have mixed feelings"? These are categories that should be developed and brought into the therapist's relations to own experiences and own history.

My own experiences from the therapy room are partly the background for my interest for this aspect of being a therapist. I have never found a satisfying way to handle these situations. The general advice to change therapist is easier said than done. To bring such cases up in supervision is probably the best advice.

However, many Norwegian family therapists do not attend supervision regularly. When the compulsory amount of supervision are achieved from an education program or a clinical training program, some therapists' stop using supervision as a part of their practice. Should we consider saying that a certain amount of therapeutic practice should be supervised?

Paradigm Cases about how Private and Personal Background, Parallel Connections and Moral Values Influence Clinical Practice

Paradigm cases are meant to teach us something that is more general than the content of the single case. They are cases that show lines of interpretation that sometimes are invisible or hidden from ordinary perspective. In this paradigm case Adam (3) shows us how he developed his abilities as a mediator as a young boy and illustrates how this competence is useful in his current work as a therapist.

It is Part A (p. 87), "Family background, private lives" and category 3, "The participants' explicit values that influence therapeutic work" that are connected to "Parallel connections". These are parallel connections concerning how private and personal background influences clinical practice, including dynamics that show how personal and moral values influence therapeutic work.

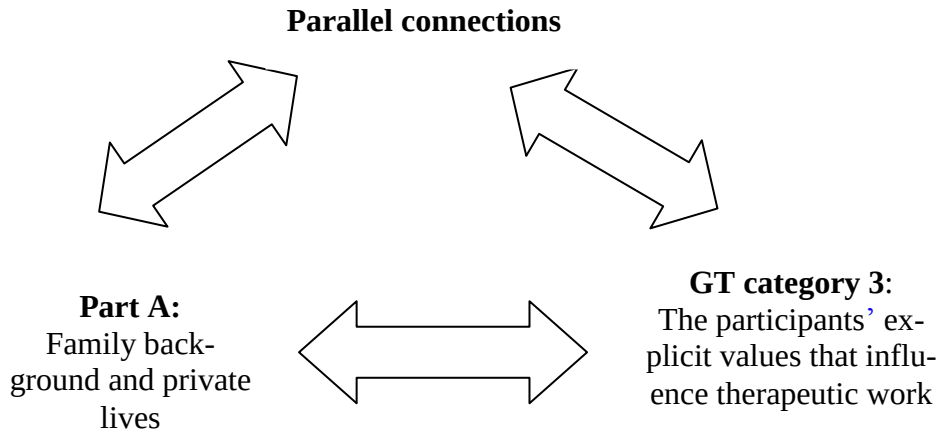

Table 19. Relations between GT categories and parallel connections formatting a paradigm case.

Mediation in therapy

When Adam (3) grew up he was the middle child and only boy of three siblings. When I ask Adam (3) what his background and his upbringing have meant for him as a context for becoming a therapist, he points out two areas. He says: *"I believe some of it is connected to the family situation I've grown up in…sort of (to) the role I had there. Then some of it is connected to things that I've actually just read"* (6, 15). The period he refers to is when he was between 14 and 17 years of age and when I ask what he has read, he points as mentioned earlier to his reading of fiction during his adolescence.

When he starts talking about his background in his family of origin, the picture of his function as a mediator soon emerges. His personal history contains an important sequence where, for a long period, his family of origin was in a kind of a fight with the rest of the family. Actually he cannot say what it was all about, but he is sure *"…it was a situation where there was a frustrating break between our family and my parents, there on the one side and the rest of the family"* (6, 37). He also clearly remembers his own role in it.

He had the function as mediator between his family of origin and the rest of the family for periods of time during his growing up. This function gave him a particular position and a special status in his family. He says: *"I had a role where I got a bit like a middleman or me-*

diator sort of also between…also between us children and the adults" (6, 31). To elaborate what this involved he says:

> *"For periods of time there was little conflict at home like between my parents and then…then I probably had a sort of dampening effect on them, or what can I say one, one who…brought…things further or…in a way one who kept the conversation going, I think. Kept sort of the connection going. Both sort of inside the family and like outside to the extended family, relatives and the like, grandparents and that"* (6, 33).

In the video of his first session, he meets with a man who is in the middle of a "frustrating break-up" from his wife. They have been married for 15 years and have two children aged 11 and 14 years old. He has fallen in love with a new woman and he has moved away from home to a new apartment where he lives alone. He is not sure what to do and he is afraid to end up in the situation of having a broken heart in ten years' time. When he asks Adam (3) about his experience with breaking up like this, the mediator in him seems to appear when he answers: *"I have experience with both those who have regretted it and those who feel it has been a good thing"* (15, 23).

The client shows a lot of doubt about what to do and he is very concerned about his children and about their growing up with divorced parents. Adam (3) follows up and shows a particular interest in this aspect, returning to the children's situation repeatedly. Adam (3) underlines the situation when he says: *"It is hard to choose in stressful situations. It isn't for nothing that one practices what one will do in stressful situations"* (15, 53). Through the entire session, Adam (3) goes slowly and introduces different questions and topics for the client to investigate. Along with his obliging attitude and kind manner, he guides the client into several important questions without suggesting any answers.

When I, in the next interview, ask him if it was his mediating skills I saw on the video he says:

> *"Yes, yes, mmm, I believe I'm more concerned with sort of taking in his story then and taking…maybe taking in his experience around it and in that maybe think…also be a bit sort of what should I say, small steps or maybe not to bring in too big, what should I say, contrasts into the conversation. If that has to do with being a mediator, yes, that is maybe the case. Because a mediator, some of that is about maintaining a position, then…also maintaining a position in relation to him. In order to preserve the contact and then certainly I'm relatively careful with introducing sort of the big, big leaps…"* (7, 42).

When I ask him what he thinks about giving advice when a client like this asks for it he says that he never would offer any advice when clients are struggling with existential questions like this (7, 58). He could perhaps give advice if the client asked what to do to keep the contact with his children or how he should handle his wife, but never about whether or not it is right to leave or stay in the marriage.

Comment

In the Norwegian educational tradition, we have a long history of making a distinction between the place where knowledge is applied and the place where knowledge is picked up. The distance between university on one side and working life on the other are growing. The kind of knowledge we can only acquire through practical work has little or no space in the academy today. This has moved us towards a narrow definition of knowledge. At the same time this process has led to a rise in the status many educational programmes and professions.

Practical knowledge may here be seen as the kind of knowledge that has lost priority or that has never established its own domain. Michael Polanyi named this ***personal knowledge***, and he called for the search for an epistemology of personal knowledge (Polanyi, 1958). Jeff Faris argues that: "The relationship between the personal epistemology embodied in therapists' practice and the discourses of espoused theory about therapy seems central to this process" (Faris, 2002, p 92). He claims that it is important to examine this relationship rather than allow it to "silently" influence practice.

The researcher's personal reflections:

When I was a young man, I used much of my time to listen to my friends' problems and troubles with girlfriends and boyfriends and family and meaning with life and... I did not tell much myself. I was much more interested in listening to my friends' stories than telling stories by myself.

May some of the fundaments for a family therapist be found in her or his own personal and family history? In the memo after the first interview with Adam (3), I consider his ability to mediate as a part of his personal history. Adam (3) agrees that he has ability as a mediator and that it is a strong element in his clinical practice. Adam (3) tells that he developed this ability during his youth, when his family went through a period with internal conflicts. For me it seems obvious that this ability represent an advantage for him as a family

therapist. When I watched his video, this ability as mediator came forward even though it was a single client with him in the therapy room.

On the other side, when one has developed a certain speciality, this may also represent some difficulties and hindering. It might represent an avoidance of alternative approaches when a useful approach is developed. However, I do not have any empirical data to support this possibility when it comes to Adam (3).

Summary

As we have seen, parallel connections may sometimes have a high relevance in understanding clinical work. We have here documented what happened when four family therapists with different experience, different workplaces and in different stages of life experienced parallel connections in the therapy room. We have documented what went on with Anne (6) following the death of a spouse when she was working as a family therapist; to Evelyn (5) going through a divorce when working as a couples therapist; to Janne (7) having difficulties with her own children when working in Child- and Adolescent Psychiatry; and Elisabeth (1) dealing with her partner's alcohol abuse while working as a couples therapist. For example, Elisabeth's stories about alcohol abuse in her own family and her consultation with the couple in which the husband was a heavy drinker seems to be a very important type of story that should have consequences both for our understanding of family therapy practice and for our training programmes.

Six of the seven participants could tell important stories of how their personal and private experiences in life have influenced their clinical practice. In addition, the three that were invited on behalf of telling stories about their experiences with experiencing a parallel connection with their clients, told additional stories of how their personal and private life has influenced their clinical practice.

Working as a systemic family therapist also, to some extent, influences the therapist's personal and private life. All together, this research project shows the relevance of including the therapist's personal and private life in the understanding of systemic family therapeutic practice. This may have some consequences for how we organize family therapy education and what we include in the education programmes in the future. This understanding may also have some consequences for how we understand systemic family therapy in the future.

All the therapists tell stories about how their personal and private experience played an important role in how they conducted some of their clinical practice. Together, the Grounded Theory categories with their subcategories organised into illustrative Paradigm Cases, form the findings in this research project.

6. The Researcher and the Research Process: Reflexivity and Self-reflexivity

Introduction

The last of my four research questions is: "How will the researcher and the research process influence the participant and vice versa and create meaning for the relationship between his or her personal life and clinical practice?" This chapter seeks to address these questions.

Reflexivity and self-reflexivity are necessary and compulsory parts of a qualitative research project. Reflexivity seeks to include the researcher as a part of her or his research, (Dallos and Vetere, 2005). For a research project that builds on constructivist and constructionist worldviews the reflexive stance is a part of developing trustworthiness in the research project findings:

> "…if researchers and scholars are to take seriously principles of constructionism, these very same principles must be applied by researchers to themselves and to their research. That is, the research process itself must be seen as a socially constructed world or worlds, with the researchers included in, rather than outside, the body of their own research" (Steier, 1991, p. 1 – 2).

Reflexivity in research involves putting the complete research project up for a new critical overview. In this qualitative research project it is not possible to lean on an idea of objectivity or refer to the researcher's neutral and observing position. I look upon myself as a participant in the sense that I have influenced the research process at all stages. Wren comments on this stance when she claims:

> "To research reflexively is to make the research study itself an object of sustained reflection. It involves acknowledging unexplored levels of meaning and managing an awareness of other possible interpretations of the research material. This is inevitably an uncomfortable stance as it means going beyond the conventional degree of self-challenge to one's 'findings', to take up a position of more radical doubt" (Wren, 2000, p. 257).

Professional and Personal Background for Entering into the Research Process

I have been involved in family therapy training programmes in Norway since 1983. The question of the necessity of students going into their own therapy as a part of the family therapy education program was a topic from the very beginning of my engagement on the board of the

program. During the 1970s and 1980s this family therapy education program made students' own therapy compulsory. However, only 20 hours of personal therapy was offered to these family therapy students. Psychodynamic therapists often did this kind of work. The main idea was to enable the students to experience sitting in the client's position and working with material from their own personal lives. For some of the students, working within this narrow framework gave meagre profits. For example, psychodynamically and psychoanalytically oriented therapy traditionally uses a far greater number of hours, even years, to conduct this kind of process (Kringlen, 1972, p. 418).

Many suggestions were made to change this portion of the family therapy education programme. Some students and trainers believed that we needed to find therapists who employed techniques that were better suited to the programme. Others believed that the students needed to bring members of their family into the therapy room, and some felt that more time and effort in the programme should be devoted to their personal therapy.

Nevertheless, most students and teachers believed that this portion of the programme should be discontinued, and that ordinary clinical supervision should cover this field. Their main argument was that personal therapy was based on psychodynamic theory, and that this element of the educational programme contradicted and even undermined the rest of the programme. The result was that personal therapy was removed from the programme, and has not been a part of family therapy education in Norway since the late 1980s.[30] As a member of the board of this education program, I supported this decision, mainly because of the psychoanalytic profile of the individual therapists.

My question in the years to come was whether we had thrown out the baby with the bathwater. When psychotherapists are asked what is most important in their development they point to their own therapy as a main source (Orlinsky and Rønnestad, 2005). In addition, the whole area of reflection on links between one's own personal and private life connected to family therapy practice was removed from the Norwegian family therapy education program in the 1980's.

The Construction of a Research Question

From the first, I wanted to do a research project about the narratives that connect a family therapist's personal and private life to the therapist's clinical practice, as I have seen narrative

[30] The board of Family Therapy Education under the Norwegian Church Family Guidance Service decided at its February 1989 meeting to discontinue using personal therapy as a part of the programme. I was a member of that board.

as part of the process through which such links appeared. Immediately, people started to tell me stories that linked the family therapist's personal and private life to the therapist's clinical practice and to reflect on the implications of such connections. With this experience as background it is important to hold onto the idea that the project is a constructivist project. That means, among other things that I am not out to expose hidden links between family therapists' personal and private lives and their clinical practice such as it is in the "real world". My aim is to be part of a process that develops these topics in conversation with the participants, my supervisors, with literature, with theory and colleagues. This thesis should be seen as a result of these conversations.

The research questions and the results of the research project should be seen as part of a constructivist process that nurtures and encourages participants, myself, supervisors and others to develop the research questions and other aspects of understanding of how a family therapist's personal and private life might be seen as linked to the therapist's clinical practice.

Reflexivity at different stages in the research process

When I began thinking about conducting a research project in connection with the interaction between the therapist's own personal and private life history and his or her clinical practice, I discussed my ideas with many people in Norway – family therapist colleagues, friends and relatives. The immediate response from many of them was, *"That's a good idea!"* Some of my friends from outside the family therapy field said, *"Is there anything else to do research on? Hasn't it all been done already?"* Some colleagues from within the family therapy field said, *"It's about time, because not very much has been done in that area. In fact, I am not aware of anything of the sort having been done before."* It seemed that everyone I spoke to agreed that this was a relevant and important topic, and that it held promise as an interesting research project. It also seemed as though everybody I talked to during this period viewed this as part of clinical practice. It was thus not easy to explain why this subject has received very little or no attention in family therapy education and clinical training in Norway.

The main idea for a research project was also well received at the Tavistock, London, UK, and I started to write up a proposal. As a teacher in family therapy I was also planning the expansion of our education program in Norway to include a Master's degree. These two tasks affected each other in a productive way. I had for example the opportunity to visit several institutes that run master's degrees in family therapy and learn about their Personal and Professional Development-programmes (PPD) and share their views on the idea of working with the links between the students' personal and private life and their clinical practice.

These visits came to be an important part of my pilot project. The interviews with these professionals in Spain, Ireland, Wales and the UK came to establish the background for the first interviews with my participants. Topics such as gender, culture, family background with genogram, ethics, different ways to live together, homosexuality and other important questions that affect the relations between a family therapist's personal and private life and her or his clinical practice came forward.

When I was writing the literature review for the proposal I discovered for the first time that I was moving into a field where very little research had been done beforehand. That was a great surprise. This discovery of how small the research literature in the field of exploring relations between the family therapist's personal and private life and her or his clinical practice made me curious to try to understand this situation. I will attempt to address these questions in chapter 7. Through this research I have also discovered my own pre-existing preoccupation, both culturally and professionally, with the idea that it was the therapy (the medicine) and not the therapist that works.

Reflecting Interaction with Participants

Notes from my research diary, from my memos and the e-mails from the participants form this reflective part. At the end of each research interview I left some questions for the participants to bring "home". I made it clear that this was a possibility I gave them to open up for some more reflections after our interview and I underlined that they could use the opportunity if they wanted.

After the first interview

As a part of my validity strategy I gave the participants, after the first interview, a note with these open questions: "What do you think and feel now? Is there something you should have told me that you forgot? Are there any more topics that we should address? Any more reflections on the topics we addressed? Any other thoughts?"

Four of the seven participants made use of this opportunity, two of the "full case" group and two of the "parallel connections" group. I will here show how being interviewed about connections between personal and private life and clinical practice affected some of them. The first reflection from the first participant (Elisabeth, (1)) after the first interview opened like this:

> "*I felt enthusiastic, wanted to share, to get a response. ...I called my supervisor, (a role model). "To think that we don't talk about this together the way that I've done*

with Per today. Never really thoroughly in supervision or in discussions with colleagues or in training.

"*Write that down," said the supervisor. I went to a café and wrote: I clearly see parallel processes. I must achieve greater balance between being a therapist and developing creativity in different ways. I struggle with the fact that patients get the most support or attention for their problems or difficulties and less for their creative sides. I know my colleagues would disagree with me, but it feels that way, and that makes it difficult here, for me as well.*

Didn't you mention the suicide story from (psychiatric ward)?

I am a fellow traveller and a little of what I have in my backpack of life and learning can be useful to us along the way… I feel shaken, as though I've revealed myself. Imagine that we don't more often dive into this together."

The other "full case" participant (Adam (3)) wrote:

"*Something I've thought about afterwards is that I think it's more difficult than I thought to answer questions which have to do with the relationship between my own life and my practice. I'm fairly certain that it has nothing to do with you asking difficult questions. It might have something to do with the fact that I feel it is unusual to think along these lines – I don't have much training in it, in a way. Besides, one is in danger, when one has such a topic up for discussion, of "revealing" that there are areas within oneself which have meaning for practice that one hasn't considered before. It isn't that pleasant, and maybe comes out as a kind of cautiousness in me*."

Finally, Janne (7) (parallel connections) sums up after a comprehensive reflection:

"*The questions you asked were interesting and powerful, and I discovered as well that I wasn't as finished with these topics as I'd thought. To be interviewed myself has given me a very useful experience…Thank you for giving me this opportunity. I'll send you an e-mail again, if any further thoughts come to mind."*

"To be interviewed myself has given me a very useful experience…" Janne (7) says.

This may sum up some of these reflections. These three participants' afterthoughts reflect that to be interviewed about this topic seems to be both important and moving in different ways. They also reflect that the patterns that connect personal and private life with clinical practice have not received much attention in their professional lives.

After the second interview

When the second interview round had finished, I repeated that I was interested in their reflections. I gave them the same questions as after the first interview with one additional question.

The additional question came because I saw that I did not have much material on how practice as a family therapist has influenced their private and personal lives. I asked: "It is of special interest for me if you have some more thoughts about what the job as a therapist and that role has done to you as a person and to your life outside work."

Only two of the four "full case" participants responded. Elisabeth (1) responded with a comprehensive reflection also after the second interview. This reflection gives a further indication that these questions about connections between personal and private life and professional practice have engaged her.

Adam (3) mentions three topics connected to the question of how personal and private life may be affected by being a psychotherapist. First he underlines that it has affected his attitudes to "truth". Especially in the congregation where he belongs he has raised objections against the prevailing "truth". In his own family he once used storytelling, inspired by clinical practice, to help two of his children to solve difficulties. Finally, he mentions that as preparation for a lecture he once presented some clinical material (some drawings made by clients) to his children who were of the same age as the clients, to get their comments. This worked for him as confirmation of the value of using them in his lecture.

At the end

Towards the end of the research project, I sent an e-mail to all participants where I asked them four questions. I asked if there was anything from these interviews that has made any special impressions upon them, if they had developed any new ideas or confirmed any ideas about the relation between the personal/private and the professional, if this has had any consequences for clinical practice and if it has had any influence on personal and private life.

All participants responded to this e-mail. This may also be connected to me asking them to confirm some personal information. Two of the participants responded merely by saying they had not had any afterthoughts whatsoever. One remarked however that she continued to work on these topics in supervision.

To the question if there was anything from these interviews that had made any special impressions, Karen (4) responds. Karen (4) says:

> *"It is probably mostly that someone interviews you about the relationship between professional and private life, which increases consciousness about this. I realised that my strong stomach and quiet mind in working with break-up situations is connected to my own break-up experiences in relationships."*

To the question of whether they had developed any new ideas or confirmed any ideas about the relation between the personal/private and the professional, Adam (3) and Elisabeth (1) commented.

Adam (3) remarks:

"But I think that it maybe has a clearer connection than what I thought previously. I can also see that the "gaps" between these two areas are less than I've thought previously – that is to say that I wonder whether I'm more under the influence of the personal in my professional life than I've thought."

Elisabeth (1) says:

"Yes I have gone a few more rounds about the private and personal and I think it's even more important to stop and take a step to one side when one feels oneself drawn into something or becoming very eager. The question about whether they would have had better help from others than from me will always be present in encounters with others."

The third question concerned whether participating in this research project had had any consequences for clinical practice. Erik (2) says:

"I think I share more, and (am) conscious / thoughtful, but the personal and private are still important distinctions. The terms shyness and dignity come up here. I think I am more careful about not offending other's values while at the same time I believe I can be more direct."

Adam (3) says:

"I share with colleagues to a greater extent regarding relationships from my private life. I say a bit more about relationships that can interest me, and about relationships that I associate with my own background and upbringing."

My last question was concerned with whether participation in the research project has had any influence on personal and private life. Karen (4) says:

"OK seeing one's private challenges in light of what can be worse. I find that I become more tolerant and less caught up in imperfections in my own life and relationships."

Anne (6) says:

"...but I know very well that the job has changed me. The way of meeting people in private has changed a good deal. In a completely different way, I am listening in my life. The genuineness in listening becomes more and more important in my life. I can step back more. But at the same time maybe I step forward more as well and become

clearer about everything I have and know. But exactly this movement between stepping back and stepping forward is part of that. The job has contributed to my being able to practice that movement and to make it clearer for myself in the private, personal encounter."

Elisabeth (1) remarks:

"I have started in therapy again. I've become more conscious of my own boundaries or lack of boundaries and that this is something I can change now. This is not directly connected but indirectly connected with what came up in the interview and the video. I need courage to become clearer in encounters with myself and others."

Finally, Erik (2) sums up his experiences and remarks:

"I don't think so. But as we know the fish is the last to know that it's swimming in water."

These last responses cover the range of responses to being a participant in the project, from experiencing the project as a strong influence to the participants that report minor or no influence from participating. It is, however important to notice the range of responses. The participants report the impact on them of the research process in different ways. Some find it influential and important and claim that they are surprised that personal and private life is so close to clinical practice. They have been inspired to rethink parts of their practices and claim that this should be worked on more. The participants, who report the research process as less influential, claim that this topic has been a part of their reflections all along in their clinical practice. I have no representatives who claim to be scientific practitioners or family therapists who claim their practice is evidence-based. This is a weakness in my selection of participants. Erik (2) was the closest I came to this position, but he would not call himself a scientific practitioner. However, participants' identification with the research question varied greatly, as shown in the above comments from the participants.

Possibilities and Limitations of the Methodology

Introduction

All methodologies have some advantages and some limitations. It is only afterwards that it is possible to be aware of what could have been done differently and what then could have been gained or lost. I will here say some words about my bias in sampling, some re-thinking of the use of Grounded Theory and theme analysis and the use of video. The question of saturation

needs some specific comments and the possibility of using other methods will be commented upon.

Bias in the sampling

This research project is based on the idea that there might be meaningful and important connections between a systemic family therapist's personal and private life and her or his clinical practice. This assumption, presented to all participants in the information sheet and consent forms before they agreed to participate, may have influenced them to look for experiences that confirm such kinds of connections and patterns in their own life and clinical practice. This may be seen as a limitation of the project. It could be difficult to claim that there were no links between personal and private life and the therapist's practice. Nevertheless, one of the participants (Erik (2)) did not connect his clinical practice to any specific personal and private experience from his life history.

Most participants knew me as a teacher in family therapy and an author of several family therapy textbooks. This may have influenced some of them to present narratives of the kind I asked for. On the other hand, only one therapist who was asked to participate answered "no" (without giving any further reasons). This means that the participants who were asked as part of the theoretical sampling process are contributors to this research project.

However, it would be interesting to hear the participants' reflections about a more open research question. Such a research question might concern examining how they thought about possible links between their own personal and private life and their clinical practice, the meaning of such ideas and the importance of working and reflecting about this issue. However, my starting question in the first meeting with the participants was an open question such as: "If you have been thinking about this interview beforehand, have any ideas or experiences or stories come to mind?"

Re-thinking the use of Grounded Theory, paradigm cases and theme analysis

"The basis of grounded theory is the idea that any theory gains meaning by being grounded in good, powerful, convincing examples" (Dallos and Vetere, 2005, p. 53). This has been the leading idea for this research project. Several aspects of Grounded Theory, such as its suitability for use in relatively under-researched and under-theorized fields and the possibility to do theoretical sampling promoted the use of GT. The possibility to create a middle range theory from the GT findings and from the paradigm cases was also exciting. In this perspective,

the choice of main method was a relatively easy choice and was a good fit with the research aims.

The idea of using paradigm cases as part of further exploration of the findings in detail was meant to make it possible to tell some "thicker" stories about connections between personal and private life and clinical practice that could illustrate the GT findings and that we could learn from as family therapists.

Theme analysis was used to analyse the video of a first session of family therapy for the first four research participants. This was done to try to explore any links between the findings in the GT analysed transcripts from the interviews with the participants and the same participant's clinical practice.

I used two methods of gathering data: interview and observation. The use of video was reserved only for a first session of each participant's meeting with a family, a couple or a client. This was based upon the idea that the participant (the therapist) had few or non-specific ideas about what the client's needs were in the first meeting.

However, this methodology has some possibilities that could be further developed. Videos from different parts of the therapeutic process would make it possible to include even more personal and private elements in the material. For example, most topics connected to self-disclosure often appear later in the therapeutic process (Protinsky and Coward, 2001; Roberts, 2005) as the therapeutic alliance develops and strengthens.

In a therapeutic process new themes and topics may occur in any part of the process. That means that links to the therapist's own life may occur in all parts of the therapy. The use of video has proven to be one way of making such connections. Some of the connections that are described in this project would not have come forward without the video material. This is a good reason to widen the use of video in such projects, to include observational work as part of qualitative research.

One of the main stages in the GT analytic process is to gain knowledge about what people are doing, that is what systemic family therapists are doing regarding handling their own personal and private experiences when they work as therapists (Dallos and Vetere, 2005). Several participants told stories where they connected their personal and private experience to different stages of the therapeutic process. However, examples based on the connection between the video and the interviews are only based on a video of a first therapy session. This research would have gained more complexity with the inclusion of videos from further stages

of the therapeutic process. This would probably also have generated more paradigm cases and some thicker findings.

Possibilities with other methods

It would have been meaningful to use both quantitative and qualitative methods in researching my research questions. Quantitative methods could have been used for example to do a survey of Norwegian family therapists to measure the importance of potential links between their personal and private life and their clinical practice. This could have been using questionnaires with scales where the participants are invited to mark all questions. However, material gathered through quantitative methods would be of a different kind than material gathered through qualitative research. However, both research methodologies are relevant in this research. Quantitative and qualitative methods could also be combined in researching links between family therapists' personal and private lives and their clinical practice. "Although quantitative and qualitative research methods are located in different epistemological paradigms they can provide helpfully different perspectives for each other" (Burck, 2005, p. 238).

Different qualitative methods can be used to shape and deepen the same research project. This is also the case when it comes to my research questions. One such alternative research method could have been discourse analysis. It would be interesting to have some ideas of what might emerge if I had subjected the data to a discursive reading. The focus on examining meaning in research interviews and therapy sessions takes a different form in discourse analysis and grounded theory (Burck, 2005). Discourse analysis is, among other things, applicable in reflecting power relations and how they change in social and cultural contexts over time. Discourse analysis for example also seeks to understand how a specific discourse is undermined or promoted. The researcher may also use discourse analysis to highlight the subtext, the hidden meaning in a text (Dallos and Vetere, 2005). These characteristics of discourse analysis would probably have had different consequences both for how my research was conducted and for the analysis of the findings. Probably cultural and political topics would have been more in the forefront, such as gender and family, children in a family perspective and family therapy traditions and the therapist.

What would be different and what could be the same?

The use of theoretical sampling and observation (the videos) made it possible to take part in the research process in a way that developed the research project and gave it a direction from the very beginning. Variation as a leading idea helped my selection of participants with dif-

ferent experiences, backgrounds, viewpoints and specific connections to specific parts of a therapeutic process (parallel connections). The grounded theory analysis has made it possible for seven categories to emerge. These categories emerged after long and meticulous analytical work. Through including observation (videos) in the analytic process some categories emerged that would never have come forward without observation. For example Erik's (2) intervention when he came close to advising the couple to inform their parents about their problems as a couple, would have been left unknown without the analysis of the videos and the comparison with the transcripts. Elisabeth's (1) connection to alcohol abuse at home and in therapy and Karen's (4) link to treating the new partner's children badly would have remained likewise unknown. In the same context, confirmation of Adam's (3) mediation skills was made possible by the video. The seven categories would probably not have come forward in the same way with the use of any other research method.

The use of discourse analysis would have focused on the participants' language in a different way. Discourse analysis would probably have provided this research with a richer understanding of the participants' own language and how they choose this language to give meaning to their ideas about the links between their personal and private life and their clinical practice. It would also be interesting from a discursive point of view to try to link the participants' language to some of the discourses that define family therapy and psychotherapy in general.

The paradigm cases would probably have been the same and complemented the discourse analysis, and they could have been used as examples of different discourses the participants used to interpret their understanding of the narratives that connected their personal and private life to their clinical practice.

Finally I will mention that it could be an interesting project to combine theoretical sampling from grounded theory with discourse analysis. When the complete theoretical sampling was finished, it would be interesting to do the rest of the analysis as an analysis of discourses. This would also include analysing the relations between interviews. Family therapists are skilled in talking with more than one person at a time. In an article where three different qualitative methods are used to analyse the same research material Charlotte Burck ends up reflecting on the development of qualitative research and comparing the researcher's position with the clinician and claims:

> "Because systemic clinicians are highly skilled at paying attention to the processes and the complexities of interactions, it is they who seem most qualified to develop these qualitative methodologies further for use in interactional ways, and so to make signifi-

cant contributions to the burgeoning field of qualitative research" (Burck, 2005, p. 259).

The question of saturation

The concept "saturation" as a Grounded theory term is somewhat difficult in this research project. However, I will here divide "external saturation" from "internal saturation".

The idea that the field covered by the research questions should be completely saturated in a sense that nothing new would appear seems close to impossible. I have denoted this as "external saturation". One reason for this difficulty is the variety of experiences from personal and private life that might influence a family therapist's clinical practice. Another difficulty is the size of such a project. When it comes to the content the research question covers, the material could be almost infinite (see Appendix 9). It would probably include several doctorates. On the other hand, the GT categories and GT sub-categories presented in this research project probably cover many of the findings that would emerge in further research on the connections between systemic family therapists' personal and private lives and their clinical practices.

However, the concept of saturation gives meaning to this project as "internal saturation". By "internal saturation", I mean that the findings provide some useful answers to the research questions and that the material gathered is completely analysed. The comprehensive analysis of the complete material to extract categories at the conclusion of the research process ended with the realisation that my material was drained. In this context, the concept "internal saturation" seems useful to describe this research project.

The personal element in therapy

Most therapists would probably agree that the personal element is of great importance in clinical practice. To leave this field to chance (and possible misuse) and to exclude it entirely could be perceived as a serious loss for a family therapy education programme. It could also be regarded as an ethical issue in both clinical work and the training of students. Students must be willing to examine their own assumptions and biases to develop a professional and ethical clinical practice. Such examinations of one's own personal and private background have not been an obligatory part of family therapy education in Norway until the last few years. The Master's degree in Family Therapy and Systemic Practice at Diakonhjemmet Uni-

versity College introduced a PPD module of 100 sessions in 2004[31]. This may be viewed as a preliminary outcome of this research project.

Based on my own clinical experience, my practice as a supervisor of family therapists and family therapy students and on my professional stance, I think a family therapy education program is incomplete without a focus on reflection on relations between the student's personal and private life and clinical practice. This topic may be introduced in different ways, from one's own therapy to integration in different parts of the program. However, it is my conviction that it should be there.

This conviction has influenced the research question and the research project in the way that I, as the researcher, have seen this topic as meaningful and important from the very beginning. However, I did not know how my methodology would work or what I would find at the beginning. Despite my uncertainty about how the project would function, I may have influenced the participants with my "convictions" throughout the research process. However, no one mentioned this kind of influence from my side.

Ethical issues

Several ethical issues have been enlightened and reflected upon earlier in this thesis. It is however necessary to say a few more words about the ethical issues. This research project has included the participants' personal and private histories. To some extent, this will also include the narratives of some third persons close to the participants. The need for anonymity in this context is sometimes a sensitive issue. Norway is a small country and the group of family therapists is limited. To be absolutely sure that no third persons could be hurt by this research project I have decided to leave one of the stories from one of the participants out of my material.

Initially the plan was to invite the participants to participate in a focus group at the end of the analytic process. The plan was to first conduct a member validation by letting the participants read some of the analysed findings and then having them discuss the relevance of the categories for clinical practice and for family therapy education. However, to include the participants in a focus group would be another way of revealing their identity, and the idea was excluded for ethical reasons. Afterwards I see that it could have been possible to convene another group of family therapists to deliberate the findings.

[31] I was in charge of this first PPD module and the first 20 students finished their Master's degree in family therapy and systemic practice in June 2007.

Validity and Trustworthiness

> "The issue of what is valid, true knowledge in the social sciences involves the philosophical question of what truth is" (Kvale, 1989, p. 75)

Concepts like validity, replicability and reliability have numerous definitions. They are concepts drawn from quantitative and positivistic oriented research methods. In the positivistic traditions different areas of validity (construct, internal and external) are quite well defined (Robson, 2002). When the same concepts are transferred to and used in a qualitative research project it is of the greatest importance to the particular understanding of validity and reliability as clear as possible. It is "…validity and self-reflexivity (that) support qualitative research" (Dallos and Vetere, 2005, p. 201).

According to Jonathan Smith (1999) qualitative research should not be evaluated using the same criteria as quantitative research. On the other hand, there is no common agreement on criteria for validating qualitative research (Richardson, 1996). Thus we need to ground and validate our findings so we can use them to hypothesize and generate theory for further research.

The question of validity may be described as both internal and external. This study is internally valid when it describes the meaningful state of affairs within this setting. When that is done the research project has reached trustworthiness. External validity cannot be established unless more research is performed that generalises the findings to population. As mentioned earlier, the idea of researching the narratives that connect a family therapist's personal and private life with the therapist's clinical practice was supported by most of the people who heard about the project plan. Therefore, it was important to let the idea of validity accompany all steps in the research project. This leaves the concerns about generalisability and generativity. What is valid in this research project is not necessarily valid in other contexts.

Respondent validation

Respondent validation is suitable for qualitative research in general and for a grounded theory project in particular. "Respondent validation is often used when the researcher is attempting to represent the views, opinions and experiences of the research participants" (Dallos and Vetere, 2005, p. 205).

Respondent validation has been a key validation strategy from the very beginning of this research project. The basic idea in this research project was that the participants' validations of the initial findings should form the trustworthiness of the project. After analysing the first interview and the first video, the relation between the two of them was analysed. Meaningful links between the interview of a participant and her or his video of a first family therapy session were then brought back to them in a second interview. This is an ethnomethodological approach to interviewing.

The possible, meaningful links between the first interview and the video was an outcome of my preliminary analysis of the relations between the two. However, from the very beginning I was aware of the limitations of links as meaningful for the participants. However, it was my idea that their evaluation of the meaningful link in the second interview should form the main outcome of these analyses. As shown in the findings, we were able to establish meaningful links between all four videos and the first interviews for the first four participants.

Further on, all seven participants were invited to give additional comments to me through e-mail responses. All of them came back to me with at least one such response during the research period.

As mentioned in the paragraph about "Ethical issues" (p. 67) I decided not to perform the focus group as an attempt to protect the participants' anonymity. Instead, I decided to send each one of them the findings chapter before the thesis was completed. At the end, when the findings chapters were finished I therefore offered all participants a final opportunity to comment on the analysis and categories that had emerged through the research process. This was done to ensure their interviews and videos were given a serious and professional treatment and that their anonymity was kept within a responsible frame.

All together these elements form an important part of the validation strategy are attempts to reach trustworthiness.

Triangulation

"Triangulation as a strategy is based on the idea that different perspectives on the same phenomenon can enhance our understanding whilst at the same time can provide a basis for cross-checking and cross-referencing our findings" (Dallos and Vetere, 2005, p. 205). In the process of building the validity strategy into the research project, triangulation was used to increase this aspect. The triangulation model in this research consists of the literature review, interviews analysis and videos analysis. Being able to create meaningful and powerful links be-

tween these three key elements in this research project should be part of establishing both validity and trustworthiness in the interpretation of the research findings.

Audit trail.

The audit trail seeks to participate in the creation of validity by showing how the research project as a whole has been built. This is done by casting a backwards glance on the project to show how it fits together. This backward glance will add transparency to the project.

"If we use different methods of data collection, we will expect them to enrich our understanding of the issue at hand" (Dallos and Vetere, 2005, p. 207). To show how I have reached this enriched understanding I will recapitulate the research project backwards as steps. When a (research) process is converted into steps some qualities that are characteristic for a process might be lost. For example, the categories did not only emerge at one certain step in the project. One category emerged very early (parallel connections) and some categories were given finishing touches up until the thesis was finished.

My supervisor(s) have participated closely every single step on this journey. Some main steps on this road to completing the research project were:

1. In the findings, to be able to present the paradigm cases and the seven GT categories and show that all are grounded in direct quotations from the interviews and from the videos, I had to:
2. Construct the categories emerging from my material and form the paradigm cases. To be able to do this, I had to (see Appendix 7):
3. Analyse the possible links between the interviews and the videos to form categories and extract the paradigm cases. To be able to do this, I had to:
4. Analyse all research codes by sorting them into piles of codes that fit together and going through a process of constant comparison. To be able to do this, I had to (see Appendix 5 and 6):
5. Conduct the theoretical sampling procedure where seeking variation was the leading goal when I picked new participants. To be able to do this, I had to:
6. Complete the second interview with the first participant and present my findings from analysis of the first interview connected to the video of the first session. To be able to do this, I had to:
7. Analyse the first interview and connect it to the video of a first session. To be able to do this, I had to:

8. Invite a first participant to join the research project for a first interview and to make a video. To be able to do this, I had to:
9. Prepare the information sheet and agreement to participate in the research project. To be able to do this, I had to (see Appendix 1 and 2):
10. Get ethical approval for my project plan from the examination board for the Doctorate in Systemic Psychotherapy at The University of East London (Tavistock Clinic site). To be able to do this, I had to (see Appendix 3):
11. Prepare my project plan with the help of my supervisor and put in for recognition by the examination board. To be able to do this, I had to:
12. Do the pilot preparations by interviewing experienced family therapy teachers in Spain, Ireland, Wales and Norway about the relations between a systemic family therapist's personal and private life and her or his clinical practice and reading what was written about it. To do this, I had to:
13. Apply for and be recognised as a doctoral student at the Tavistock Clinic. To be able to do this, I had to:
14. Ask Diakonhjemmet University College for time and money to participate in the Doctoral program at the Tavistock Clinic. To be able to do this, I had to:
15. For many years, be puzzled with the questions about the relations between a systemic family therapist's personal and private life and her or his clinical practice and what the understanding of this area may mean for family therapy education and practice.

To give further documentation of this audit trail I will in the appendix put in translated and coded transcripts to show how categories emerged, the information sheet and the consent form for participants (see Appendices 1, 2, 3, 6 and 7).

Reflexivity and self-reflexivity as context

The reflexive process in this research project was initiated from the very beginning. Reflexivity and self-reflexivity have been a part of the research diary and the memos. The participants sent reflections to me after the first and the second interview and at the end of the whole process.

Supervision has been an important element in making clear how I as a researcher have influenced the development of the interviews and the GT analysis. I also had an independent audit. The supervisor audited a sample of the analysis.

Research participants had the opportunity to comment on and develop ideas from the first interview in the second interview. In addition I have invited the participants to give e-mail reflections after each interview and at two other points. A summary of these e-mail reflections is presented earlier in this chapter (see pp 161-164).

I attempt to show how my personal background and engagement in the field of family therapy education in Norway may have influenced this research project and the research process. My aim is to make a reflective overview of all stages in the research process. This includes the planning of the research process, the interview and analytic process and the phase of writing up the thesis.

As mentioned, I also invited all participants to send me reflective e-mails after all interviews. Most of them made use of this possibility. After about one or one and a half years I invited them again to reflect upon the project and their involvement in it. All of them answered this last invitation and presented their reflections.

I also wrote a research diary from the very beginning of the research project. Since this research project has stretched out over several years this diary has been of great importance to help me recall the sequences as they occurred during the project period.

To further address self-reflectivity, a colleague who holds a research doctorate has interviewed me about my motives, interests and own experience with the topics covered by this research. This interview forms an important background for this chapter. However, I will not use direct quotations from this interview because many of the ideas and reflections that come forward in the interview are ideas and reflections that I have had and also used earlier in this work. For example, I had to be confident that the project had a design that was trustworthy and that the documentation of the research accounts for what has been done and explained throughout the complete research project.

The use of triangulation, with the literature review as one leg, seeks to increase validity in the project by linking the categories and sub-categories to psychotherapy research, supervision theory and other experiential and relevant theoretical inquiries about topics related to my research question.

The videos represent an attempt to increase validity in the project. The videos represent an element of observation that includes behaviour and analogue communication as a part of the material. The videos are from “an ecologically valid context” -namely the therapist’s own therapy room (Dallos and Vetere, 2005, p. 204). They represent a second leg of triangulation.

In addition I have used respondent validation (Dallos and Vetere, 2005). The most important element in this process is bringing my analysis of the possible connections between the first interview and their video of a therapy session back to the "full case" participants. In this second interview they were invited to comment on and validate my constructions of meaningful connections and patterns. Also through inviting all participants to send e-mail reflections and through inviting them to comment on the first draft of the thesis, respondent validation took place.

All together, these elements form the basis for the trustworthiness of this research project. Without trustworthiness there can be no validity.

Generalisability

Generalisability is connected to validity in a way that broadens the understanding of validity. My research findings may be valid in one setting and not in another setting. Generalisability is about how to understand in which contexts these research findings add meaning. Systemic family therapists have been participants in this research project and all were informed beforehand about the topics and the research aims. This may have influenced some of the participants to look for some certain kind of answers that fit these topics. Only one of the participants could not tell any histories that linked his own personal and private life to his clinical practice. The lack of participants with this experience and understanding of their own practice may reduce the research project's generalisability both inside the field of systemic family therapy and the field of psychotherapy in general.

On the other hand, the many findings that this research project presents from all participants (Erik (2) included) may also trigger curiosity for further research, both in the field of systemic family therapy and in the field of psychotherapy in general. This research project is performed in a country where PPD work in general is weak or unknown and where self therapy has been removed from family therapy education many years ago. In this context, these research findings could promote further research.

Generativity

Generativity is defined as "having the ability to originate, produce, or procreate" (The free dictionary: http://www.thefreedictionary.com/Generativity). In this research project generativity occurs in three areas. First, a middle range theory has been developed by looking for relationships between categories helped by the method of constant comparision. Second, the need for more research seems to be obvious and may be seen as a part of generativity. Third, the

findings should have some consequences for our family therapy education programmes in Norway. A PPD module or the like to cover these questions should probably be a compulsory part of such a program.

Summary

In this chapter I have given an account of my own engagement in family therapy education in Norway and how it could happen that personal therapy has been dropped from curricula and not replaced with anything else. On this basis I reflect on my research question and view the possibilities of constructing other and more open research questions.

Inclusion of participants' reflexive contributions widened the frame for reflexivity in the project and put self-reflexivity into context. This led to the discussion on validity and trustworthiness in this research project. The limitations of the methodology used in this project points to possibilities for new research projects.

7. The lack of interest in the therapist's personal and private life in psychotherapy research

Introduction

In this chapter, I will discuss the apparent lack of interest in the therapist's personal and private life in psychotherapy research in general and suggest some main explanations that can make this situation understandable. I will also look at the consequences for practice.

The first research question in this project is: "How do we understand that so little research has been done on the links between the psychotherapist's own personal and private life and her/his clinical practice?" To answer this question it is necessary to get an overview of some central ideas in psychotherapy research in general. Family therapy research is here located within psychotherapy research.

In Norway, family therapy may be studied both within the college system and in other institutions and institutes. Until now, the course of study connected with the college system has been for a lower degree or for no credit. Research within the fields covered by this course of study has thus been either extremely modest or totally absent in our country. In countries where family therapy practice is more closely linked with the academic system of education, however, we find comprehensive research activities underway, mostly in connection with family therapy practice, but also connected with other types of systemic approaches (Stratton, 2005).

Psychotherapy Research and different models

> "I would happily give up my perspective if the scientific evidence supported the current trend to conceptualize psychological treatments as analogues of medical treatments."
> Bruce E. Wampold, 2001

It is an important ongoing discussion to find out which theoretical framework is most meaningful to understand and explain psychotherapeutic practice. Three models try to answer the question of "what works in therapy", and many attempts have been made to integrate them. The first and dominant model is the "evidence-based model" (Lambert 2004). This model is also often called the "specific factors perspective." The second model that offers an alternative to the evidence-based model is often called the "common factor model" (Hubble, Duncan and Miller, 1999), but is also known as the "contextual model" (Wampold, 2001). The third

and most recent alternative may be called the "integrative model" and tries to combine the two first perspectives (Simon, 2006). We will here focus on the two first models.

The discourse of the medical model has not only been applied to the human body but also to the understanding of the family and to the practice of family therapy (Cheal, 1991). Criticism of non-evidence-based practice comes from many sources, much of it from general medical practice. For example, one could get the impression that a practice that is not evidence-based is a poor or indefensible one. Emphasis on the idea of objective findings leads to a prioritisation of technological and biomedical perspectives. Elements such as communication, empathy, ethics and caregiving will then be placed in the background (Ekeland, 1999).

By making instrumental rationality the basic model, we may be harming an approach whose foundation is the relationship between people. Hans Skjervheim called such a technical-rational model the "instrumentalistic error" (Skjervheim, 1976, p. 260ff.; Sørbø, 2002, p. 115). By using a model for technical or methodological procedures as the actual basis of a clinical approach, we may lose the very qualities that constitute an interpersonal approach. Tom Andersen takes a similar point of view when he states:

> *"Sometimes ... both therapists and researchers try to create a common dominating background, a consensus background. This is meant to contribute to firm and objective evidence-based knowledge, in that the therapist and the researcher try to remove all of their personal issues from the background they are using as a basis for their understanding. [I] not only think that it is a misunderstanding to believe that this is possible, but also that it is an unfortunate misunderstanding" (Andersen, 2002).*

Andersen claims that this situation is responsible for creating distance within therapeutic circles and between researchers and therapists. This distance makes it difficult for members of these groups to conduct fruitful discussions.

American psychotherapy researcher Bruce E. Wampold compares the medical model of psychotherapy with the contextual model of psychotherapy. The medical model of psychotherapy originates from Sigmund Freud's concept of psychoanalysis and from behaviourism, and consists of four elements:

1. An illness or a problem (for instance, hysteria or what is today called a DSM IV diagnosis);
2. A scientific or psychological explanation of the illness (a repressed traumatic occurrence, or irrational or inappropriate thoughts);
3. A mechanism for creating change (insight into the subconscious mind, or the changing of irrational thoughts); and

4. Specific therapeutic actions (free association or special methods taken from a manual that describes the treatment of a specific illness) (Wampold, 2001, pp. 11-14).

Through the aid of psychotherapeutic treatment manuals, the therapist wants to ensure that the patient receives a standardised treatment, thereby ensuring that all patients receive the best available treatment for their particular problems. Such standardisation also gives researchers an opportunity to compare and measure the effects of particular forms of treatment. Here we again find the evidence-based model in the form of the medical model of psychotherapy. According to Wampold, this model dominates the research circles involved with psychotherapy. Michael Lambert and Benjamin Ogles sum up the discussion to date by saying; "…it seems imperative that we continue moving toward an understanding of how change occurs in psychotherapy – whether through common or unique mechanisms" (Lambert and Ogles, 2004, p. 175). In what follows we will discuss how we can understand the relationship between the therapist and the client(s) in psychotherapy. This topic is connected to my research project when the therapist's personal and private experiences influence the therapeutic process.

The Relationship in Therapy

Many politicians, authorities and clinics demand that research provide documentation as to which method is the most effective in treating specific illnesses, preferably formulated in medical language. However, we know intuitively that the brilliant practitioner is not always the most luminous academic, just as the solid academic is not always the best practitioner, whether in the areas of music, literature or therapy. On this basis, research can represent a bridge and a meeting point connecting the clinician and the researcher, where they can develop mutual cooperation. Sometimes the clinician and the researcher may even be the same person.

In connection with some remarks about communication, K. E. Løgstrup says that language must be both "**reference and address**" (Løgstrup, 1982, p. 182; Buur Hansen, 2000, p. 57). In this context, ***reference*** means that a clinical practice must have solid professional content. Most people take it for granted that the therapist has a solid professional background and that his or her approach is based on such a background. But according to Løgstrup, reference is not enough. A clinical practice also needs ***address***. This refers to therapy as an inter-person approach, an approach that is perhaps more similar to an artistic activity than to an instrumental or technical approach. When we refer here to address, we mean entering into a relationship

characterised by communication, reciprocity, cooperation and respect. This has to do with people who have contact with one another – who have entered into a relationship marked by empathy and a shared search for meaning and solutions.

According to the two psychotherapy researchers S. Soldz and L. McCullough, psychotherapy encompasses a complex inter-person interplay that cannot be reduced to "findings" in a scientific investigation (Soldz and McCullough, 2000). In daily experience in a therapeutic setting, it is not always obvious that people fit neatly into ready-made categories. Sometimes we must look beyond that kind of science if we are to establish an adequate understanding of what is going on in the therapy room. In this connection, it is often said that therapy is both an art and a science. Such a statement could indicate that some therapeutic techniques are located outside of what we would usually define as science, and outside the areas that are encompassed by evidence-based research. The expansion of qualitative research may include more aspects of psychotherapy into scientific research.

If this is the case, then it applies to both quantitative and qualitative research, both of which are based on rational and logical analyses. In this context, I want to emphasise that analogue or creative aspects of therapy entail a different type of knowledge than the rational and analytical knowledge produced by research. This type of knowledge can be seen in those aspects of communication that cannot be captured in digital language, but that are nevertheless essential elements in determining how relations between people are experienced and can be understood (Jensen, 1994, p. 62ff.).

After many years of research, one of the most productive pioneers within family therapy research, Jay Haley, took a position in which he claimed that research and therapy could only be useful to each other to a limited extent. In his view, the therapy process is an endlessly complex tapestry of interactions, emotions and value judgements, which research will never be able to capture totally (Dallos & Draper, 2000, p. 151).

What works in therapy?

Most research in the field of psychotherapy tries to answer the question, "**Which therapy technique has the best effect on which mental health problems?**" Eisler (2006) points out that from a systemic point of view, to ask questions of what comes first and what is most important, is not only surprising, but also unhelpful. In 1969, Paul asked this original question about psychotherapeutic technique: "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" (Wampold, 2001, p. 21). It seems apparent that it is impossible to answer this ques-

tion unless we construct a systemic perspective of psychotherapy (Larner, 2004, p. 20). Based on the knowledge we have today about how we can understand the processes that are encompassed by psychotherapy, a great deal indicates that we must depart from the idea that it is only the intervention that is the effective element. On the contrary, there is every reason to believe that we would benefit from spending more time and energy in understanding the therapeutic relationship and the impact of the therapist's personal history. In this context, it is probable that in the future, too, there will be a great need to seek additional answers to the question, "**Which therapist can offer the best treatment to which client?**" This question includes the answers that can describe the therapist's clinical competence and the range of therapies that are available from the therapist. However, this also include what the client brings into therapy and what in the clients environment that supports change.

The relationship between therapist and client has, as previously mentioned, been discussed since Freud created psychoanalysis. Psychotherapy researchers have tried to minimise the effect individual therapists have on therapy when studying a specific intervention. However, research indicates that the results of therapy *between* methods vary less than the results of therapy *within* any one method (Wampold, 2001 p. 202). As we have seen, this means that various therapeutic traditions achieve very similar results in treating the same problems. When the results of therapists within one therapy tradition are compared, however, the variation is significant. "The conclusion is that who the therapist is makes more of a difference than which method is used" (Rønnestad & Skovholt, 2002, p. 3). This point is underscored when J. Brown states, "Response to treatment in the first few sessions is highly predictive of the eventual outcome" (Brown et al., 1999, p. 390), and Beutler et al. claim that they "…urge consideration of what works with whom, under what condition (Beutler et al., 2004, p. 228). In a research study called "The psychotherapist matters: comparison of outcomes across twenty-two therapists and seven patient samples" Luborsky et al. (1997) found that some therapists were only effective with specific types of clients (diagnoses) while others were effective with a wide range of clients.

In an editorial for the Journal of Family Therapy Ivan Eisler (2006) suggests that we should move on to the question of "…*understanding how therapies work* rather than *knowing what* works" (p. 332). Perhaps it is time to try to answer the question of **which therapist can best serve which clients or families**.

Consequences for the understanding of family therapy practice

We have seen that there are different answers from the field to the question "What works in therapy?". The evidence-based traditions tend to point at the relation between the specific diagnoses and a specific therapeutic technique to explain what works. Others claim that we need to study the interaction between "the common factors" to understand what works in psychotherapy. The common factors are often defined as the therapeutic relationship, expectancy (placebo effects), techniques and extra-therapeutic change (Hubble, Duncan, Miller, (eds) 1999, p. 8ff.). None of these models include the therapist's personal and private history in the understanding of the therapeutic process or in the understanding of what works in therapy. The therapist's personal history is both personal and part of a culture and a society. Culture and society represent the collective level of a therapist's references. Let us look at how the tension between our understanding of the person and of the collective becomes visible in psychotherapy research.

The Person and the Collective

Our Western culture and societies are known to be oriented around the individual or the person. The person is often described as a unique individual with her or his own identity that is genuine and inviolable. This perspective on human life is often held as a core value and the person is viewed as an inviolate human being. This perspective on human life is often held as counter to the view of the person understood as a member of a collective group. Medical diagnoses are, however, examples of collective groups. It is when you are the bearer of a specific disease that you qualify as a member of a diagnostic group. When people are given medical diagnoses, for example a psychiatric diagnosis, they are placed into large collective groups and treated, not as genuine and inviolable persons, but as members of a specific group. They are no longer treated as individuals, but only as group members. The therapy they are offered is designed on the basis of group identity and not for individuals.

The tension between being treated as a member of a collective group and the demand to be treated as a unique individual is not much discussed in psychotherapy research. Psychotherapy based on diagnosis means that you are treated as a member of that diagnostic group and not as a person. This view is much different to that of the Norwegian psychotherapist Svein Haugsgjerd when he writes:

> "When someone comes to me today for help, I never think: Yes, I recognise this from before, either from my own practice, a textbook or a course. Instead I think: This person has something new, something unfamiliar and different about them. I do not wish

> to solve a mystery, I want to become acquainted with this person *as themself*, as different from all others, as special, as unique. I want to get so close that I can almost see the world with the other's eyes, hear music with the other's ears. At the same time I know that this is not really possible" (Haugsgjerd, 2005 p. 163).

From the Theory of Logical Types we have learned that there is discontinuity between a member and a class, a person and the group of which the person is a member (Bateson, 1972). When you are treated according to the diagnostic group in which you have membership, you are not treated as a person but according to the same principles as those of somatic medical treatment. This mode of treatment has been a huge success in somatic medicine. The question is if it is meaningful in psychotherapy or if it constitutes an instrumentalist error in our clinical society.

Instrumentalistic Error

In all clinical work, from traditional somatic medicine to psychotherapy placebo effects are well known and a part of the understanding of what works, (Ekeland, 2004). In his book *The Great Psychotherapy Debate* (Wampold, 2001), Wampold presents a version of Skjervheim's "instrumentalistic error". In this context, the instrumentalistic error occurs when one transfers the idea of specific effects, such as the effects certain medicines are known to have on certain illnesses, to psychotherapy. In other words, one believes that just as certain medicines have a specific effect in the field of medicine, certain therapeutic methods have a specific effect in the field of psychotherapy. Wampold claimed, after studying thousands of research documents (Wampold, 2001, p. Xii; Wampold, 2006), that research clearly shows that the medical model of psychotherapy, based on the idea that benefits from therapy are linked with a specific component of therapy, do **not** indicate that any single component is effective (ibid. p. xii). The instrumentalistic error will in this example consist of drawing a parallel between how somatic medicine works to how to understand what works in therapy. It is the substance in the pill that works and not the physician in the same way as the therapeutic intervention works and not the therapist.

Common factors and the instrumentalistic error

The common factors model may take credit for opening up the understanding of what works in therapy for reflection on the therapeutic relationship, the meaning of placebo, the role of therapeutic techniques and the source of extra-therapeutic change. When Michael Lambert presented the model in 1992 he admitted it was "…not derived from strict statistical analysis"

(Hubble, Duncan, Miller, (eds) 1999, p. 8). The common factors may be seen as the *ingredients* of psychotherapy. They are sometimes presented as the ingredients of psychotherapy almost in the same way as the right amount of flour, milk, butter, sugar and baking soda will end up as muffins after baking. When the common factors model is presented as the ingredients of psychotherapy stipulated in percentages, I believe we have another version of the instrumentalistic error. This mechanistic model of how to understand psychotherapy will not offer much help in understanding what works in a specific family therapy case study, because in a particular family therapy session, as when Elisabeth (1) meets the couple where the husband has an alcohol problem, Elisabeth's (1) own particular family situation forms a context to understand what is going on.

The common factors model is of course not meant as an analytic tool to analyze a single psychotherapy session. However, a contextual understanding could never include a rigid model like the common factors model as a basis for understanding psychotherapy.

The contextual model

The same research usually used to corroborate a medical model and evidence-based practice clearly shows, according to Wampold, that the contextual model is more meaningful in understanding psychotherapeutic techniques (Wampold, 2001 p. 148). When a contextual model is applied in family therapy practice, understanding is based on how the therapeutic context offers meaning to all the participants. The present research project has not studied the whole psychotherapeutic process, but rather episodes from systemic family therapy processes.

In this research project the family therapists' personal and private experiences have formatted the context for understanding episodes from systemic family therapy practice. In terms of rethinking family therapy practice this perspective invites prudence and modesty.

The contextual psychotherapeutic model is the framework for contextual practice. The contextual psychotherapeutic model often encompasses viewpoints promoted by those who endorse "common factors" as effective in psychotherapy (Hubble et al. 1999; Wampold, 2001). However, the contextual model in psychotherapy also makes reference to Jerome Frank (1991). The model consists of four elements:

1. Psychotherapy represents an emotional and trusting relationship with an involved therapist.

2. It is a healing setting in which the client or clients meet a professional whom they believe can help them.

3. There is a rational group of concepts or the creation of a myth that is able to provide a plausible explanation for the client's problem. According to Frank, this explanation must be accepted by both the client and the therapist but does not need to be "true".

4. The client must believe, or be led to believe, in the treatment itself. Frank claims that psychotherapy is a form of healing rhetoric rather than an applied science (Wampold, 2001, p. 25).

Family therapy as ***contextual practice***, in this sense, represents practice on two levels. One level might be described as symmetrical, representing a meeting point between two "equal" persons meeting as human beings. This meeting also includes the family therapist's personal and private history and this aspect needs to be taken into consideration when the processes are explained and developed. The other level is commonly described as complementary. This level represents a meeting between a professional and a family or client where the clients achieve hope that problems might be solved and life can be better.

Conclusion

It is probably in understanding the nature of ***evidence-based practice*** and the ***scientist practitioner*** model and its position in the field of psychotherapy that we best can understand how the link between the therapist's personal and professional life is not very central in psychotherapy and in family therapy education. However, when the therapist as a person is included in understanding psychotherapy, many new questions occur and many new areas of research come forward.

Most psychotherapy research seeks to answer the question: *"Which therapeutic technique has the best effect on which mental health problem?"* The idea of evidence-based practice excludes the therapist's personal and private life from the field of interest in understanding the therapeutic process. This exclusion of the therapist's personal and private life as a frame for understanding psychotherapy is based on the idea that medical practice and psychotherapy might be understood as analogue activities. It is the medicine (for example the pill) that works and not the physician. In psychotherapy the analogy is the intervention and the therapist: it is the intervention that works and not the therapist.

However, in light of this discussion of how to understand the processes in psychotherapy, we have seen indications that the idea that it is interventions that work alone in psychotherapy should be reviewed. This research project has shown that it could be useful to use more time and resources on understanding the therapeutic relationship and the meaning of the therapist's personal and private narratives and their influence on family therapy.

The nature of evidence-based practice and the scientist-practitioner model and its position in the field of psychotherapy research provide a context for understanding why the therapist's personal and professional life is almost excluded from evidence-based psychotherapy research.

8. A Middle Range Theory of Systemic Family Therapy Practice

Introduction

In this chapter a middle range theory, called the map of resonance, will be presented. This middle range theory is based on the relations between the GT categories that emerged through the data analysis of interviews and videos combined with some results from psychotherapy research in general. The concepts that are developed here are based on an understanding of the interaction between the therapist and the family or client as different types of resonance. Some results from psychotherapy research concerning the relation between the therapist and the client will be added to support the map of resonance. I will supplement systemic communication theory with ideas about resonance.

I will discuss the consequences for family therapy practice and look at some consequences for family therapy education. Systemic communication theory will form the theoretical framework for the discussion. To develop further understanding of the research questions I will use *context* as a central concept.

In this qualitative research study, it has been helpful to include some discussion in the analysis of the interview data (see chapter 5). However, I will here re-present some of the main findings and develop them in the framework of a middle range theory. The middle range theory I offer is about understanding the different ways in which therapists' own values and personal and private experience create a context for their therapeutic work.

Power as context?

The understanding of psychotherapeutic relationships as a type of power relation is rather uncommon in handbooks and textbooks in psychotherapy. Some of the main handbooks (Lambert, (2004): *Handbook of Psychotherapy and Behavior Change*; Hubble, Duncan, Miller, (eds) (1999): *The Heart & Soul of Change: What Works in Therapy*; and Hougaard, (2004): *Psykoterapi – teori og forskning*) do not even mention power and power relations in their comprehensive documentation of psychotherapy research. Power is not at all a context for understanding psychotherapy in these handbooks.

On the other side, Foucault claims that power is relational appear in all kinds of relations, (Holmgren 2006). Foucault claims power gains momentum as more people come to accept the particular views associated with a belief system as common knowledge. Belief systems define their authority figures, such as priests in a church or medical doctors. Within

such a belief system ideas seem to deal with what is *right* and what is *wrong*, and similarly, with what is *normal* and what is *deviant* (Schaanning, 1993).

Psychotherapy in general and family therapy in particular may be viewed as a practise of power and should be viewed this way to some extent. When it comes to topics such as gender (Burck and Daniel, 1995), ethnic minority situations (Hildebrand, 1998; Cross and Papadopoulos, 2001) and professional culture (White and Epston, 1990; Ekeland, 2001) the need to analyse power relations seems to be as pressing today as it was forty years ago.

In the constructing of this middle range theory, I will use the concept of power in a limited way. However, in terms of developing the understanding of particular categories connected to influence on clients of the family therapist's personal and private values and culture, the concept of power and power relations will be employed.

The history of the middle range theory

The idea of constructing middle range theories was developed by the American sociologist Robert K. Merton in 1949 as a new approach to sociology and an alternative to abstract theorizing and more narrow empiricism.

> "For Merton, middle-range theory meant a set of techniques to analyze reality and allowing to produce theoretical accounts that engaged with that reality in order to communicate with others, whether policy-makers or scholars from other disciplines; and providing ideas for future work" (http://en.wikipedia.org/wiki/Middle_range_theory_%28sociology%29).

According to Merton (1968), a middle-range theory can be used to derive hypotheses. It has some specified assumptions; it contains concepts, relational statements and propositions. In addition, a middle range theory is delimited in scope, is empirically based, is somewhat abstract, fits with many grand theories, and is logical (Dunn, 2004). Middle range theory starts the theorizing with a more narrow aspect of a social phenomenon. It is a ladder of abstraction, a movement from an abstract to the more specific use of concepts (Smith and Liehr, 2003).

Resonance

In this research I chose to explore how the therapists' personal and private context adds meaning to her or his therapeutic practice. My starting point is Bateson's idea that context is our mental or psychological frame of understanding of our own life and experience. The context

that has interested me is when resonance between the therapists' personal and private life and therapeutic practice forms a meaningful whole.

The Belgian family therapist Money Elkaïm introduced the concept resonance to help us understand the dynamics between how one part of life may influence another. He says: "Resonance occurs when the same rule or feeling appears to be present in different but related systems" (Elkaïm, 1997, p. xxvii). What occurs then is a kind of symmetry that invites the person to relate in certain or similar way to what is going on. I will emphasise *resonance* as a concept for giving meaning to the circularity that occurs between the therapists' personal and private lives and clients' narratives. Martha Rogers broadens the understanding of resonance by presenting it in a relational perspective. She says that resonance with the environment sometimes may be "harmonic, sometimes cacophonous, sometimes dissonant …" (Rogers, 1970, p. 219).

Relational resonance

In this middle range theory, the concept of resonance is developed to include both as personal resonance and as relational resonance. This means that resonance both takes place in a therapist's mind and emotions (personal resonance), and at the same time between the therapist and the family or client.

The concept of resonance is developed to include parallel connections; that is what occurs when a client or a family presents narratives that remind the therapist of her or his own personal and private experiences. The two aspects of life we are studying here are the resonances between a family therapist's personal and private life and her or his professional life. The emphasis on resonance will be developed to include several related concepts that add new meaning to the findings in this research project.

The therapeutic relationship is one of the factors that promote change in psychotherapy. How this element in the therapeutic process adds meaning to clinical practice is important to understand (Wampold, 2001; Skovholt and Jennings, 2004; Lambert, 2004; Orlinsky and Rønnestad, 2005). In this perspective, the influence of the therapist's personal and private experience on the therapeutic process is one important factor to take into account and understand. Skovholt and Jennings' claim in their research that master therapists describe their awareness of their "selves" as "… an agent of change in the relationship" (Sullivan et al., 2004, p. 63). When Elkaïm mentions "the same rule or feeling" it is possible to think that rules are articulated or possible to articulate and that feelings are unarticulated or a part of

analogue communication. Feelings may of course be articulated, but the articulation is not the feeling, in the same way that the map is not the territory.

The map of relational resonance

From this point of view, the grounded theory findings and the paradigm cases presented in this research project are a meaningful starting point for a middle range theory about systemic family therapy. The map of resonance are meant to add reflections to the understanding of what is going on **in the therapy room** when it comes to how the processes are influenced by the therapists' personal and private experiences. An overview of the structure and the concepts used in the middle range theory is presented below:

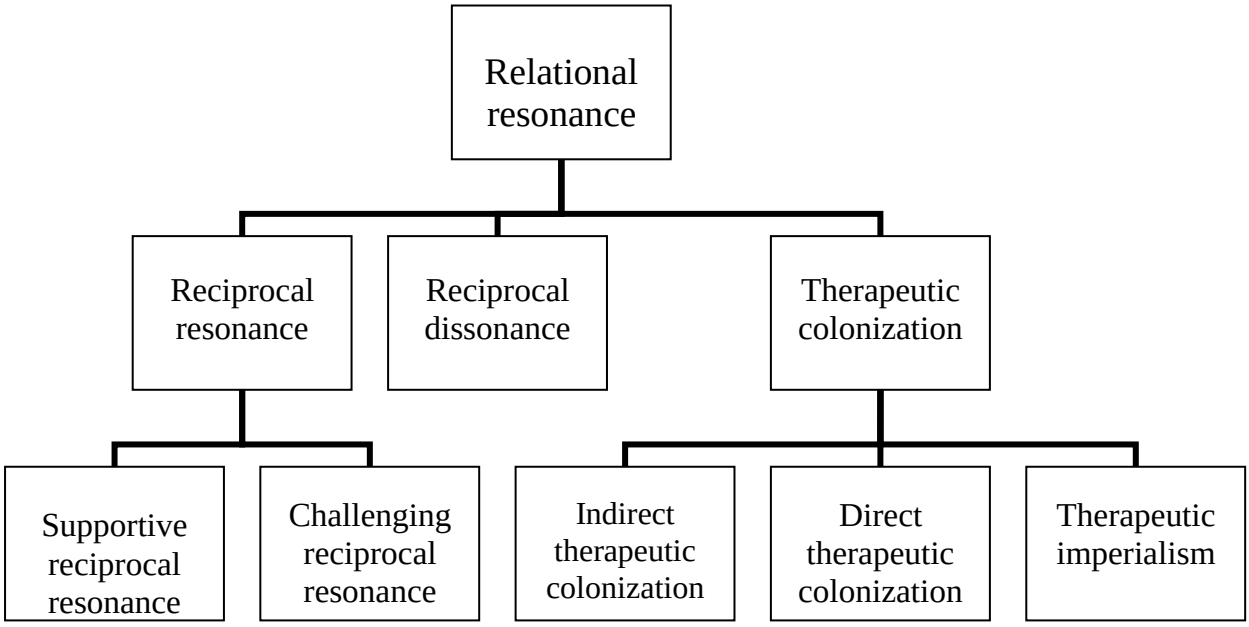

Table 20. The map of relational resonances.

This relational map of resonances will be developed to a middle range theory that adds meaning to how systemic family therapists in this research project influence their families and clients with their own personal and private backgrounds.

In addition to this map of resonance, comes the resonance from how therapeutic work can influence personal and private life. This type of resonance is called "Professionalism in private life". Professionalism in private life will be presented last in this section.

Reciprocal resonance

Reciprocal resonance covers a therapeutic process where the relation between the therapist and the clients has the character of mutual understanding. "In many studies, what therapists

say and do in the therapy hour that promotes a good working alliance has proven to be the single most important contributor to change and positive treatment outcome" (McClure in Jennings et al 2003, p. 65).

Although I have not interviewed the clients, and in that way are able to support the concept "reciprocal" with their own words, I will use this concept anyhow. This is based on how I observed the relations between the therapists and the clients on the videos and how psychotherapy research emphasize the importance of the therapeutic relationship as a starting point for a successful therapeutic process (Høglend 1999; Hubble, Duncan, Miller (eds) 1999; Wampold, 2001; Jennings et al 2003; Hougaard, 2004).

Reciprocal resonances cover therapeutic meetings where the client's history or situation recalls memories and emotions by the therapist that connect the therapist and the clients in a common way. This connection might be articulated or unarticulated.

Reciprocal resonances are not either supportive or challenging, but may be punctuated as more or less supportive and more or less challenging both by therapists and clients. One main finding in this research project is that six of the seven participants could tell important stories of how their personal and private experiences in life have influenced their therapeutic practice. Also the final three participants, who were invited to participate because of their having narratives about their experiences with being in a parallel situation to their clients, told additional stories of how their personal and private life has influenced their therapeutic practice. The one participant who did not tell stories that linked his personal and private life to his therapeutic practice was open to look for such links and found such links logical and possible.

In all four of the first "full cases", we (the participants and me) found important and meaningful links between the videotaped therapy session and told stories from my first interview with them. This means that **all participants in this research project were able to identify meaningful connections between personal and private life and their therapeutic practice**.

The key findings that are connected to the relation between the family therapist's contemporary life situation and her or his clients' living through some parallel life events describe reciprocal resonance. These stories vary, from therapists that find ways to handle and learn from these parallel experiences, to those who find themselves in a personal crisis that makes it impossible go on working as a family therapist in the situation.

Reciprocal resonance might occur in relations that can be described as both symmetrical and complementary. Basically, the relation between a family therapist and a client will be

described as a complementary relation. The client asks for help or support and the therapist will offer help or support. However, a therapeutic relationship might also take the form of a symmetrical relation in sequences or parts of the process. A client or a member of a family in therapy might enter into a fight or a competition with the therapist to represent the best or the right understanding of a problem, and the therapist may seek to get into an expert position to gain respect or show competence.

Supportive reciprocal resonance

Supportive reciprocal resonance may be viewed as part of joining in family therapy (Minuchin, 1977; Jensen, 1994). However, supportive reciprocal resonance is meant to cover a more specific and narrow part of a therapy session or a therapeutic encounter. Supportive reciprocal resonance describes the elements in joining that stem from the therapist's personal and private life and that are brought into therapy by the therapist's interaction with clients. Supportive reciprocal resonance forms the frame for a sequence or sequences in therapy, in which resonance from the client's stories, manners, behaviours, culture and background support the therapist in a way that comes to affect the relation between the therapist and the client(s) and give the therapy a new direction based on this supportive resonance.

All participants claim that their personal and private experience has been meaningful and supportive in their therapeutic practice. In a general way, Karen's (4) interest in talking and listening to people (see category 1b, p. 93) may be seen as an important kind of supportive reciprocal resonance that forms the starting point for a therapy session with Karen (4). Perhaps this is the most basic starting point of them all for a systemic family therapist.

Erik (2) says that it from time to time has been profitable for him, for example, that he is familiar with the pietistic religious milieu that forms part of his own background (see category 5a, p. 112). In the same way, Adam's (2) role as an intermediary in his own family from early life on has formed some of his ways of entering into conversations in the therapy room (see category 1d, p. 95).

This kind of supportive reciprocal resonance is based on common experiences and culture of the therapists and clients. Karen's (4) narrative about the importance of being heard (see category 2a on p. 97) can illustrate how supportive reciprocal resonance can be established and be a part of a systemic family therapist's clinical practice. Karen's (4) experience with being heard herself stems from being in therapy herself because of problems in her own marriage. There she discovered the importance of being heard and today she says that …

"*Each voice has the same importance"* (8, 331) and that it is an obligation to let everybody be heard.

Although Adam (2), as a systemic family therapist, had supported the idea of "the not knowing position" for many years, it was first after being in therapy himself that his role as an expert was challenged (see category 2b, p. 98). Being a client himself added some new dimensions to his understanding of therapeutic practice, such as feeling trapped in the therapy room although he knew he in principle could walk away.

Challenging reciprocal resonance

Challenging reciprocal resonance forms the frame for a sequence or sequences in therapy, where the resonance from the client's stories, manners, behaviours or culture and background challenge the therapist in a way that comes to affect the relation between the therapist and the client(s) and gives the therapy a new direction based on this challenging resonance. This may limit or endanger the therapeutic relationship, but it may also offer some new directions for the therapy.

One of Anne's (6) stories (see p. 138) is an example of challenging reciprocal resonance. Challenging reciprocal resonance occurred when Anne (6) met with a woman frustrated because of her sick husband. The woman was healthy and would be living with this sick man for a long time. This story gave resonance to some of Anne's (6) experiences with her own sick husband. Anne says that she recognised aspects of her own experience in the woman's stories. Anne (6) thought it was a mistake for her to go on without commenting on her own parallel situation. She says: *"... I have been through similar things in my life. And it affects me and it makes it so that I think that you should go to another therapist"* (10,10). The woman chose to go to another therapist and Anne (6) had to go for a sick leave not long after this.

Another example of challenging reciprocal resonance from category 4d is Elisabeth's (1) link between her experiences as a young woman in a religious charismatic group and her view of these groups today (see p. 108). She says that she is one of the few *"...that dare to say that I wish that (*The charismatic group*) would be taken away from patients*" (2, 83). She does not refer to any professional explanations or research to give reasons for her opinion, but to her own personal experience with being a member of such a group. Elisabeth was not asked in the study if this was her only argument for saying that psychiatric patients should be kept away from such religious groups. However, in general I will claim that it is very dangerous and unethical to use one's own personal experience as the only reason for this kind of advice.

This could lead to what I call "therapeutic colonialism" or "therapeutic imperialism" (to be discussed further on).

Reciprocal dissonance

Cognitive dissonance is a social psychological theory. Festinger (1957) points out cognitive dissonance represents lack of accord between values, attitudes, ideas, understandings and experiences in a person's life. In our lives, we strive for dissonance reduction (Saugstad, 2007).

Reciprocal dissonance occurs when clients awaken feelings and behaviour in the therapist that she or he finds unpleasant and that hinder her or his curiosity and empathy and drives the therapist to reduce or end the therapeutic relationship. If the therapist stops here, she or he will probably end up in an unfruitful therapeutic process.

Some clients act and behave in a manner that some therapists find hard to handle (see category 6c, p. 121**).** It may seem that it is the therapist's emotional and moral reaction that formats the main context in these situations. Two typical topics that trigger some therapists emotionally are clients that tell the same story over and over again or repeat the same theme repeatedly.

Another topic is complaining**:** clients who complain without making any move to make a change or who act in a demanding way to gain some advantages. Both Karen (4) and Erik (2) tell stories about complaining clients that are examples of reciprocal dissonance (se p.121).

On the other hand, reciprocal dissonance might create interest that could promote new understanding and bring new possibilities to the therapist's clinical practice. Reciprocal dissonance offers opportunities for the therapist to work across differences and in this process develop her or his ability to meet clients from a different background and with experiences out of the ordinary.

Therapeutic colonization

Therapeutic colonization is one special form of resonance. Colonization is best known as a political concept used as a framework to understand what goes on between powerful nations and their relations with developing countries. Jürgen Habermas built on the ideas of Talcott Parsons in his use of the term 'colonization' when he speaks about "colonization of the life-world" (Schaanning, 1993). In linguistics, the concepts "linguistic colonization" and "linguistic imperialism" were coined to develop an understanding of how language constructs and

constrains our worldview (Vedeler, 2007; http://en.wikipedia.org/wiki/Linguistic-_imperialism).

When I use the concept *therapeutic colonization*, it is to describe how a systemic family therapist's personal culture, experience and moral values in different ways influence her or his therapeutic practice. Therapeutic colonization represents the creation of a context that reduces the sphere in which reciprocal communication operates. The reduced sphere for reciprocal communication is based on the therapist's use of her or his power to define and introduce topics for conversation. This use of the therapist's power to form the conversation makes it necessary to bring in discussions of ethical accountability into the understanding of systemic family therapy.

Direct therapeutic colonization

When direct therapeutic colonization occurs it is the therapist that uses her or his power to define the topics for discussion despite what the clients ask for or introduce as their concerns or needs. In this way the sphere in which reciprocal communication operates is reduced. A power relationship is thus established. Direct therapeutic colonization is often articulated as and may take the form of clinical methods such as "externalization" (White, 1997) or "enactment" (Minuchin, 1977).

Elisabeth (1) shows one example of direct therapeutic colonization in the video of a first therapy session (see paradigm case about "Alcohol abuse at home and in couple therapy" p. 144 ff). The couple she meets make a relatively clear and distinct request for help. The woman opens by saying that they had decided to divorce but as they have two children they need help to communicate. Although Elisabeth (1) asks about the family as a whole and all their severe problems, the husband's alcohol abuse is only one among all these problems. However, after these opening questions and answers, Elisabeth (1) uses almost the whole session to talk about the husband's alcohol abuse.

When I came back to Elisabeth (1) for the next interview she relates that she thinks her husband drinks too much and says: *"…It isn't more than one or two years ago that I sat in a Family Consultation Office and said 'I'm leaving if this doesn't get sorted out"* (3, 36). Although Elisabeth (1) was aware of this parallel when she conducted the session she did not manage to come out of it or give the therapy session the direction the couple asked for. Her repeated punctuation of the husband's alcohol abuse reduces her ability to listen to their needs and what they came for.

This example illustrates how a personal and private situation may form and organise a therapy session so that direct therapeutic colonization can take place. This illustrates how a therapist may lose her curiosity and openness and let her own private situation govern the therapy session. However, since these processes are articulated they are open for supervision and for adaptation. Indirect therapeutic colonization, on the other hand, is often unavailable to ordinary supervision. Direct supervision and observation is necessary to capture what is going on.

Indirect therapeutic colonization

Indirect therapeutic colonization occurs when the therapist's own personal and private experience influences systemic family therapy in an unplanned and unarticulated way. The therapist does not need to be aware of what is going on, and this may create a context that could be understood to be outside what the therapist claims as her or his professional practice. The power relationship might be hidden both for the therapist and the client.

One example of indirect therapeutic colonization is when Erik (2), at one point in the videotaped therapy session asks the couple if they had talked about the problems in their marriage to anyone else. When I point out to Erik (2) that he is close to advising the couple to tell their parents and siblings about their problems, he confirms that to him these kinds of stories represent an important part of his value base in his understanding of being a family. At the same time, he is surprised that he really said what he said or gave that advice. To do this is, contrary to his ideas about how therapy should be done.

The therapist's own ideas about what governs her or his therapeutic practice are often a main source of understanding what is going on in a therapy session. These professional ideas may, however, from time to time be overruled by other aspects than those considered to belong to professional practice. When a therapist claims that she or he is governed by her or his professional background and experience, he or she is claiming that professional considerations form the *context* for her or his therapeutic work.

These examples have shown that indirect therapeutic colonization may occur even in the practice of a very experienced therapist. When in a sequence the highest context seems to be the therapist's personal and private value base, a sequence of the therapy session may be formatted by these values. These examples may give a rationale for direct supervision, not only as part of family therapy training programmes, but also of normal clinical practice.

Therapeutic imperialism

The concept of imperialism is a political one coined in the late 1500's to reflect and give a name to the politics of expansion into Africa and America. The concept is integral to different political theories and is used to give an understanding of how power may be used to oppress a state, culture or a people. Imperialism is usually defined as a term applied to a state that tries by force to conquer and shape other societies to conformity with its own ideas or values. In addition, if we look at the concept from an etymological point of view, we find that "imperial" stands for "order" or "command" (http://www.snl.no/article.html?id=604052&o=-1&search=imperialisme). Therefore, the concept is most appropriate in describing a relation where the distribution of power is unevenly divided and where one part uses power to support his or her concerns.

I will define "therapeutic imperialism" as a situation or a sequence in therapy where the therapist's ***with direct force*** articulated personal value base or personal experiences from private life form the direct background for clinical interventions, against the will of one or more members of the family in therapy. The use of force and going ***against the clients' explicit will*** makes the difference between therapeutic colonialism and therapeutic imperialism.

I have coined the concept "therapeutic imperialism" to create a framework for the understanding of the action Elisabeth (1) and her colleague took in the family where the father refused to let his new children know that he had two children from a former marriage (see page 106). Based on her own experience from a parallel connection as a child, Elisabeth (1) stated that it is wrong to keep this kind of secret from children, and against the father's will they told his new children that they had two half-siblings. Elisabeth (1) worked as a co-therapist in a family unit when she worked with this family. This probably means that a majority of her fellow family therapists supported the intervention. However, I question seriously whether personal and private experiences and values are a sufficient foundation for clinical interventions like this.

Ethical considerations are important when reports like this are received from therapeutic practice in the creation of ethical accountability. Family therapists are meant to respect and support clients' own values and culture as a point of departure for therapy. When ethical standards collide or conflict inside a family or between the family and therapists, the therapists need to carefully take up and discuss these types of conflicts and problems also from an ethical point of view. In these situations, applications of the therapists' power are obvious and visible for all involved.

Professionalism in private life

Professionalism in private life represent the therapist's attempt to share and influence her or his family and friends with the therapist's professional ideas and experiences. The influence of working as a family therapist on the therapist's personal and private life yielded the least and most general findings. Only three participants told stories that linked their therapeutic practice to their personal and private life. These were stories that seemed to be of lesser importance in their lives. Erik (2) on the other hand, claimed that professional practice does not affect private life directly (see category 7d, p. 125). However most emphasized that working as family therapists has offered them particular attitudes, values, capacities and experiences that they make use of in their personal and private lives, such as being able to listen to others, being curious about other people and about new people and tolerant of other people's ways of living and experiencing life. These aspects are in line with the systemic worldview.

There are two examples of **Professionalism in private life** that may illustrate this area. One is when the therapist is using "family therapy techniques" on his or her own family (7a) and when experiences from systemic family therapy influence the therapist while herself going through a divorce process (7b). The first one represents some direct professionalism in private life as the therapist uses some common family therapy techniques on her own children (see category 7a, p. 122). A more indirect version of this professionalism derived from the therapist's practice as a systemic family therapist is when the therapist brings her therapeutic experience into her own divorce process. In this case, a circularity occurs in which the therapist's therapeutic practice is brought into her private life as preparation and knowledge in use in her own divorce process.

Conclusions

The development of the middle range theory has resulted in the construction of a map of relational resonance. The resonance occurs both in the therapist's mind and emotions and in the relation between the therapist and the clients. This map of relational resonance might be described as a continuum that spans from reciprocal resonance to therapeutic imperialism and includes therapeutic colonialism and professionalism in private life.

This middle range theory has formed a map of relational resonance that may offer both a constructive and a critical perspective to family therapy practice. An in depth discussion of these concepts for understanding and developing systemic family therapy are needed. This is an area for further research.

The relational map of resonance may also be an important element in family therapy education and training. In understanding and conducting family therapy and systemic practice the relational map of resonance has a potential to be developed as an evaluation tool and a helpful framework for discussing therapeutic practice. This is also an area for further research.

Implications for family therapy education and supervision

When we need to reflect upon the links between private life and professional practice, should we then ask for therapy, consultation or supervision, (Jones 2003)? This question is often supported by the idea of a strict division between what is private and what is professional. Today, this division between professional and private seems to confuse our understanding of for example psychotherapy. A more fruitful position could be to look for "...how to achieve an appropriate balance between the 'private' and 'professional'?" (Graff, Lund-Jacobson and Wermer, 2003).

The family therapy education field in Norway does not have tools like "The Blue Book" or "The Red Book" (developed by The Association for Family Therapy and Systemic Practice) as in the UK, which regulates standards of training and family therapy education programmes. This means that we do not have any common standards to refer to regarding the content of a family therapy education program in Norway.

My planning of this research project ran parallel to my being in charge of planning the Master degree in Family Therapy and Systemic Practice at Diakonhjemmet University College in Oslo. In the planning of the master degree, I visited several institutions in Belgium, USA, Spain, England, Ireland and Wales. As mentioned earlier, I asked about the Personal and Professional Development modules in some of these places. It became obvious to me early on that we needed to include a PPD module in our new plan for a master degree. Inspired by some of these programmes and from preparing my own proposal for a doctorate, we included a 100-hour training module as part of the curriculum.

PPD was not a part of family therapy education in Norway. All participants in this research project had finished one or more of the family therapy education programmes in Norway. Most of them had few reflections and theoretical ideas on how to understand relations between personal and private life and their therapeutic practice when they connected these ideas to their family therapy education program. There had been little or no work of this kind in the education programmes. In Orlinsky and Rønnestad's research on how psychotherapists develop, "experience with patients" ranks as the major positive influence (89%).

However, "getting formal supervision" (80%) and "getting personal therapy" (77%) follow immediately after (Orlinsky and Rønnestad, 2005, p. 137).

This research project indicates that working and reflecting on the relations between personal and private life and therapeutic practice is necessary and advisable to increase the potential for understanding and developing therapeutic practice and to educate even more qualified systemic family therapists in Norway.

The multicultural society

Therapeutic ideas are not outside culture and society. Therapeutic ideas are a part of culture and come forward in a culture. For example, the idea of the "self" is of another kind and much weaker in some eastern cultures. In his book "Rewriting the self. History, Memory, Narrative." Mark Freeman claims that "...a life history, rather than being a 'natural' way of accounting for self, is one that is thoroughly enmeshed within a specific and unique form of discourse and understanding" (Freeman 1993, p. 28 in Johansson 2005, p. 230). Personal stories like biography or personal narratives are nothing natural or universal but they are cultural constructed.

In the same way, many of the western and protestant ideas about God and religion seem to change in the meeting with clients for whom religion is central to their lives. The protestant division between the two regiments (the doctrine of the two regiments) has made some of us keep a division between church and society, between religion and professional work. In a more cross-culturally society, religion will become more of an issue for systemic family therapists.

The cultural constructions of the self and religion and other cultural differences are among the aspects that actualize and makes it necessary to develop the map of resonance as a tool in family therapy education.

Dilemmas in Family Therapy Education

Introduction

We have several family therapy education programs in Norway. When they started in the beginning of the 1970's they were aimed to qualify family therapists mainly for work in the psychiatric field and in family counselling offices. In the 1980's and 1990's these education programs grew both in numbers and in scale. More and more students attended the education programs to use what they learned in their ordinary work as child protection workers, psychi-

atric nurses, in drug addiction work and so on. Most of these professionals did not practice family therapy in their daily work and some of them had problems when it came to fulfil the family education programs demands when it came to practice and supervision.

Some of the education programs also required that the students had to have a family therapy practice to attend the program. At the same time the employers required family therapy education to let them practice. Many professionals found themselves in a "catch 22" situation.

To change this impossible situation some of the programs widened their premises for admission and changed the name of the education program. Some programs skipped "family therapy" as a part of the name of the program. However, most programs added an extra name to the family therapy education. After several attempts to find a good new name, most ended up with a name like "family therapy and systemic practice".

This situation has created some new dilemmas in some family therapy education programs. How should we now define practices that are approved to be a part of the education program?[32] How should "direct supervision" be defined when almost every type of clinical and pedagogical practice are included as approved in the program? It seems like many students tends to denominate their practice as "family therapy" regardless of what they do as long as they may connect it to the family therapy education program. How does this situation affect our understanding of psychotherapy?

Personal therapy

Most of the participants in this research project have been in personal therapy themselves to help with their own life problems. Some of them directly refer to these experiences as very important steps in their own development as family therapists (Karen, Adam and Elisabeth). Freud recommended therapists resume their own therapy every fifth year.

When Orlinsky and Rønnestad carried out their comprehensive research on how psychotherapists develop, 3 in 10 of the Western therapists actually were in personal therapy when they participated in the study. They also found that "Clinicians with no experience of personal therapy showed the lowest rate of felt progress and the highest rates of regress and stasis. By contrast, practitioners who were currently in therapy showed the highest rate of progress and the lowest rate of stasis" (Orlinsky and Rønnestad, 2005, p. 121).

[32] In some programs, students fulfil their practice in their ordinary work place. Supervisions also take place locally and are not organized by the college.

The question is if, in addition to PPD work, the time is right to re-introduce discussion and reflection over the need for and benefits of doing personal therapy as a compulsory part of the education program for a student who wants to qualify as a family therapist.

The structure of family therapy education programs

To illustrate the dilemmas that has occurred in family therapy education in Norway it is necessary to look at some common elements in the education programs. All education programs require both clinical practice and both direct and indirect supervision. When clinical practice was defined as family therapy, this model worked fine. When clinical practice was widened to include both all kinds of health- and social work and pedagogical practice, it has been more difficult to use a common framework in describing and understanding practice in family therapy education.

The map of resonance is meant to add language and reflections to the understanding of systemic family therapy. Some of the concepts used in the map of resonance will not be useful in the same way in for examples child protection work and pedagogical work. For example when we name a process as "therapeutic colonization" in the therapy room, a similar activity seems to be good and necessary work in child protection. In for example child protection work may personal and private experiences go together with what is professional practice in another way than in the therapy room. In that sense, the map of resonance may be helpful to draw distinctions between systemic family therapy and other forms of clinical and pedagogical work. However, child protection work and pedagogical work can be misled by personal values.

In a domain of reflection, the map of resonance may clarify which values that guide practice and it may offer help to sort out the difference between own values and the values the therapist should administer.

The Map of Resonance in family therapy training

The map of resonance is meant to add meaning both to systemic family therapy in general and to family therapy training especially. In family therapy training, the map of resonance may help us to know when we are talking about systemic family therapy and when we talk about some other kind of clinical work.

In family therapy training, the map of resonance goes together with family therapy theory and methods. That means that the map of resonance should not stand as an independent element but be viewed together with other central elements in the education program. Since

the map of resonance reflects the relation between the therapists' personal and private life and her or his clinical practice, it needs to be supported by family therapy theory and methods.

Relational resonance

As mentioned earlier (p. 48), Cross and Papadopoulos (2001) point out that our own family, culture, gender and ethics, are four areas to focus on. They ask some questions that are relevant when we are looking for relational resonance. These questions are:

> "What does culture have to do with how I work as a therapist?"
>
> "What does my family have to do with my practice as a therapist?"
>
> "What does it mean to be male or female, and, perhaps more importantly, what are the implications of these meanings?"
>
> "What is the relationship between my personal morals, values and professional ethics?"
>
> "What can I personally bring to the practice of therapy?"

It is my opinion that it is necessary for a systemic family therapy student to work with and be able to include her or himself in the reflection upon these questions.

Relational resonance are here defined both as the resonance that appear within the therapist's mind and between the therapist and the client(s). One example of relational resonance is the therapist's inner dialog or inner conversation. Tom Andersen says: "When I talk with others, I partly talk with others, partly with myself" (Rober 1999, p 213).

Rober (Rober 1999, p 213) claims that the inner conversation can be summarized in the following three statements:

1. The inner conversation is a conversation between *two aspects of the person of the therapist*, namely, the self of the therapist and the role of the therapist.
2. The inner conversation is a *negotiation* between the self and the role of the therapist.
3. The negotiation is about what aspects of the self can be used to open space for the not-yet-said in the outer conversation, and in what way these aspects can be used.

This inner dialog might be the therapist's inner professional conversation with herself. What is going on in the therapy room might remind the therapist of some theoretical or methodological issues. It is important to mention that theoretical and professional ideas also might represent "...a tyranny of certain ideas of the therapist that would close any space for alternative ways of relating to self and/or others" (Rober 1999, p 213).

However, what is going on in the therapy room might also remind the therapist of some personal and private experiences from her or his own life. On these occasions, the inner dialog promotes relational resonance.

This meeting point between the therapist's (or a family therapy student) map of resonance and her or his theoretical and professional standpoint will be important elements in her or his family therapy practice. This model may illustrate the situation both for the family therapist and for the family therapy student:

Table 21. A context for family therapy training.

When it comes to supervision as part of family therapy training, it is necessary to develop this meeting point between the map of resonance and family therapy theory to include both aspects in the supervision process. This could take place both in ordinary supervision and in a PPD module.

The family therapy student's own experience from family therapy practice should be included both in the understanding of the map of resonance and in the understanding of how the student is supported by family therapy theory and methods.

Supervision and PPD-work as part of training

Supervision and personal therapy are ranked as more important than case discussions, taking courses, reading books or journals, giving supervision, working with co-therapists and other qualifying and developing tasks, (Orlinsky and Rønnestad, 2005, p. 127).[33]

Formal supervision is an acknowledged and approved part of family therapy education in Norway. However, it was nothing in the education programs that said the students had to

[33] "Doing research" ends up last of the formal categories with 19%.

work on the relations between personal and private experiences and clinical practice.[34] The importance of working with the relations between personal and private experiences and clinical practice seems to be necessary. Rober (Rober 1999, p 215) constructs this figure to illustrate what is going on in the therapy room.

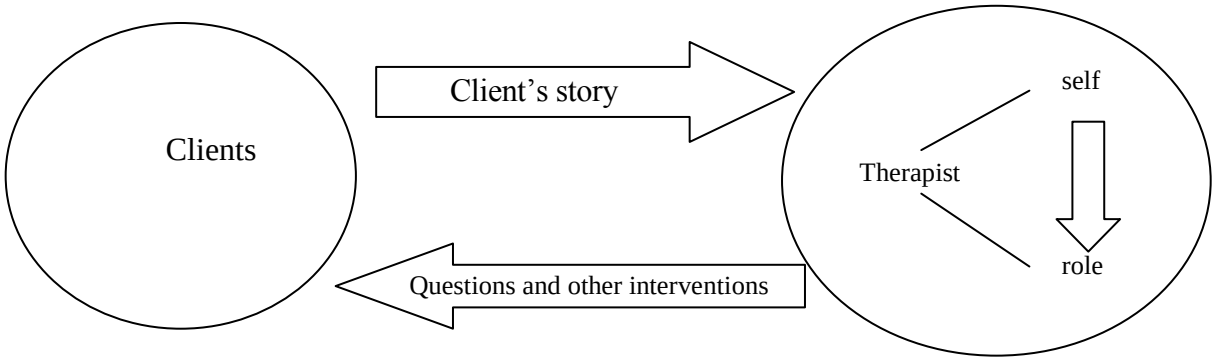

Table 22. The dialogical process.

Rober claims that if the self of the therapist is left out this might represent a missed chance for the therapist to get "...access to things that haven't yet been said" (Rober 1999, p. 216). However, Rober does not connect the self of the therapist directly to the therapist's personal and private life.

In the following, we shall discuss how the map of resonance may be helpful in understanding supervision and PPD work. The map of resonance may help us point out how personal and private experiences may be useful and form a constructive supplement in family therapy education and family therapy practice. In a similar way, the map of resonance may help us understand what happens when experiences from personal and private life interfere in family therapy practice in a way that is inappropriate, that seeks to cover the therapists' own value system and interests, and in a way that can even seem unethical.

Reciprocal resonance and therapeutic colonialism in family therapy training

When reciprocal resonance and therapeutic colonialism come forward in supervision or in PPD work, this should be viewed as possibilities for development and change.

McGoldrick (1992) argues for trainees to work with their relationship to their own family. As mentioned earlier (p. 44) she claims that it is her impression that such work benefits the trainee's clinical work, and that is particularly helpful in aiding trainees to shift from

[34] The first family therapy education program with a compulsory PPD-module started 2005.

linear to systems thinking. She sums up by stating that: "…it is my strong impression that one tends to get blocked with clinical families in the same ways one does in one's own family" (p. 20). Instead of being blocked, the family therapy student should get help to discover innovative possibilities and new ways to go in family therapy practice.

Reciprocal resonance in students practice

To illustrate how the concepts direct and indirect reciprocal resonance may widen our understanding of PPD-work and supervision in systemic family therapy education, I will turn back to the literature review. I will only use one examples of each kind of reciprocal resonance.

McGoldrick tells the story (p. 45) about the student "Peter" and the "Arthur" family. Through a supervised process, "Peter" identifies common themes from his own family in working with the family. Through supervision and willingness to open up and bring these themes into the therapy room through self-disclosure, he gains new experience as a family therapist. This is an example on how indirect reciprocal resonance might be turned into a constructive element in a therapeutic process.

An example of direct reciprocal resonance is the "trigger family" in a case study by Monica McGoldrick. The trigger family is defined as a family where the relation between the issues in the trainee's own family and the family in therapy are close to his own (McGoldrick 1992 p.17). In the same way as with the "Arthur" family, the trigger family made it possible for the student to develop the therapeutic process.

These two examples illustrate how the map of resonance is able to add some new language to the descriptions of processes in systemic family therapy. These two examples also illustrate how reciprocal resonance promotes development in the family therapy students' clinical abilities.

The Grounded Theory categories presented in this research should be helpful in introducing areas and topics to ask for and introduce both in PPD-work and in supervision. One of the main areas that occur in this research is how the therapists' cultural, personal and private values influence family therapy practice. Examples of GT categories that deal with the familt therapy students values are categories 3, 4 and 5:

> *The participants' explicit personal values that influence family therapy practice.*
>
> *Dynamics that show how personal and moral values influence therapeutic work.*
>
> *Therapists' acceptance and avoidance of the idea that personal and moral values influence their therapeutic work.*

The map of resonance offers a language to put experienses from family therapy practice into a new context. However, the GT categories in this research are based on the study of only seven family therapists'. To expand the understanding of how family therapy might be influenced by the therapists' personal and private values, the research in these areas should be continued.

Therapeutic colonialism and imperialism in students practice

After a brief presentation of the map of resonance, a prominent family therapist told me that when he was a young student and in family therapy training, he attended family therapy himself. In his own therapeutic process an important topic connected to his relationship with his own father occurred. He felt that his father never had expressed that he loved him and appreciated him for whom he was. The therapist suggested inviting his father to a therapy session. His father came to a session and that made it possible for him to give words to his feelings and how he missed his father's acknowledgement. The father was not able to say much during the session but some days later the father called his son and the father was really able to tell his son that he loved him and acknowledged him. This was the turning point for this father-son relationship.

The young therapist from now on thought he had found the way to work when a father-son topic occurred in a therapy session. His own experience from therapy came to form how to deal with topics like this. However, it never worked the same way. "I think what I did as a family therapist, after my own experience from own therapy, is an example of therapeutic colonialism," he said.

In my literature review, I am not able to find examples of therapeutic colonialism and imperialism. However, as I have pointed out in this chapter, therapeutic colonialism and imperialism add meaning to some of my research findings. The GT categories 4b) Raising children and the Paradigm Cases concerning "Parallel Connections" about Alcohol abuse, at home and in couples therapy, covers examples of therapeutic imperialism and colonialism.

Some of the participants were able to tell stories about therapeutic colonialism and imperialism. However, some of the most important stories about therapeutic colonialism only occurred after video observations were connected to the transcribed interviews. Direct observation with the supervisor behind a mirror or in the therapy room or videotapes of the students' clinical work should probably be a compulsory part of systemic family therapy training. Especially video tapes of family therapy sessions offers possibilities for micro analysis of

communication that promote access to the links between the therapists personal and private life in another level than ordinary supervision inside or outside the therapy room.

In working with questions concerning therapeutic colonialism and imperialism, the clients' perspective can be of importance. It should be helpful to develop methods where the clients' voice about these issues would be invited into the conversation. The clients' experiences from therapy can be enlightening for therapists and help them address blind spots and pitfalls in their practice. Issues could come forward which the therapist can bring to supervision sessions for further development.

Reciprocal resonance, therapeutic colonialism and the supervisor

These perspectives also call for some developments concerning supervision and of the supervisors' skills. Mason promotes the idea of risk-taking as an element in supervision when it comes to "... address sex, sexual orientation, race and culture, gender, religion/faith and disability," (Mason 2005, p. 299). In lining up some dimensions for supervision, Haber and Hawely point out four aspects. These are: "methodology (''hands''), ideology (''head''), use of self (''heart''), and creativity/intuition (''nose''), (Haber and Hawley 2004, p. 375). In this context, use of self and creativity/intuition seems to add meaning to the supervision process. Haber and Hawely discuss how bringing supervisees' family members into supervision might open up for new development. This could create some possibilities for a ''growing edge'' and for opening up for talking about the map of resonance and relational resonance.

The supervisor both need to add the map of resonance to her or his own priorities and punctuations and to the students' angles and contexts. The stories and the topics that occur in supervision also awaken and promote resonance in the supervisor's mind and will probably have some of the same implications for a supervisor as for a therapist.

It will always be a balance between supporting and challenging a student or a family therapist in supervision. On one hand, by being supportive on specific topics or on the understanding of certain narratives the supervisor might contribute to clinical colonialism and imperialism.

On the other hand, by being too challenging one can get the therapist in a defensive state. A defensive state might hinder the student's development and possibilities to reach new understanding. In the next round, a dynamic like this, might be an element that hinder opportunities for a new practice for the student. When a student is stuck in his or her own understanding or biases in such a way that the therapeutic process suffer, it is a challenge for the supervisor to facilitate a communication that can open up and create disturbance in the thera-

pist's interpretation and understanding. This process can be seen as a parallel pattern to what is going on in the therapy.

Elements of therapeutic colonialism and imperialism might promote the supervisors own moral and personal ideas. Such ideas might turn the supervision session into the supervisors need to "correct" or guide the student in a certain direction. The supervisor needs to listen to her or his resonance to find the best direction forward. When it comes to therapeutic colonialism and imperialism, the supervisor needs to learn how to see the students' punctuations as resources for development of clinical work. It is a challenge for the supervisor not to get in the same mode with the therapist as the therapist is with the family: knowing best how to think and what to do.

As a supervisor for family therapists my own agendas about how to work as a therapist and how to understand family dynamics may influence my supervision. It can be difficult to create a conversation in which the therapist will be able to address his or her own biases. In working with these issues as a supervisor, it is important to pay attention to the analogic level of communication and work with the communication in different manners and promote an aspect of observation as an inspiration to self-reflexivity. Videotapes, both of the therapy and of the supervision can be a helpful resource in addressing these perspectives.

The dynamics between challenge and the support and one's own ideas and biases about professional growth is important to deal with. The supervisor could need a supervisor. It is necessary to develop methods and ways for this part of family therapy training.

Relevance outside the therapy room

The map of resonance is developed to widen the understanding of systemic family therapy. However, the map should also be considered relevant in decribing and understandin clinical work outside the therapy room. Phenomenons like relational resonance of different kinds and therapeutic colonialism and imperialism are likely to occur in all kinds of clinical and pedagogical practises. The map of resonance should be developed to gain relevance also in these areas.

Summary

The implications for family therapy education and supervision cover a range of topics and ideas for further research. One of the main topic to develop in norwegian family therapy education is new approces to our multicultural society. Dilemmas in family therapy education are conected to how to think and act when it comes to personal therapy as a part of family

therapy training. The map of resonace promote a language to widen and expand clinical supervision and PPD-work as a part of family therapy education. The GT categoreies offer examples of topics and ares to work on in supervision and PPD-work. Although the map of resonance is developed to widen the understanding of systemic family therapy the map should also be considered to be relevant in decribing and understandin clinical work outside the therapy room.

Ethical implications for family therapy education and practice

The findings in this research project could also be discussed from an ethical point of view. Some of them are closer to ethical considerations than others. One example of a finding that needs ethical consideration is Elisabeth's story about the relation between her own personal and private values and experiences with a half-brother and her encounter with a family in a parallel situation (see p 106). That she, in cooperation with a colleague, nearly forced her own values on the family could have resulted in a violation of the father's ideals and way of organising his own family life. According to Elisabeth, this was not what happened. However, stories like this bring up the need for discussions of family therapy practice in an ethical framework and the need for ethical guidelines.

The Norwegian government does not recognise officially psychotherapists (including family therapists). This is a task professional unions in Norway currently perform. Only the Psychological Association and the Medical Association offer recognition to psychotherapists. Under these circumstances it may seem a peculiar situation that the Norwegian Family Therapy Association does not engage in family therapy training or in recognition of family therapists in Norway. However, academic and therapy staff at the Master degree in Family Therapy and Systemic Practice at Diakonhjemmet University College in Oslo do therapeutic evaluations as part of the students' exams. We not only evaluate students' academic standards but also their therapeutic skills. This should impose responsibilities on us that go further than merely delivering certificates to students.

Ethical guidelines

Most clinical practitioner psychotherapists do their work supported by an ethical standard and ethical guidelines. Ethical guidelines are drawn from culture, personal background, theory and professional training. Professional unions in Norway have developed specific and formally articulated ethical guidelines for clinicians.

In psychotherapy, only clinical psychologists and psychiatrists are supported by ethical guidelines when they practice as psychotherapists. The Norwegian Association for Psychotherapy (NAP), a member of the European Association for Psychotherapy (EAP), has developed guidelines for psychotherapists that are in line with EAP's guidelines. Only a few Norwegian family therapists are members of NAP. The Norwegian Family Therapy Association is a special interest organization for family therapy and systemic practice in Norway, and this union is not involved in family therapy education or in developing ethical standards for practitioners. There are health laws and other ethical guidelines that support and regulate family therapy practice in Norway. However, social workers, nurses and other family therapists outside the psychological and medical associations are not supported by any ethical guidelines for family therapy practice.

As a university college that offers the students clinical evaluation and in that way communicates that they are qualified to practice, we should also develop ethical guidelines and seek to tell both our students and their clients that such guidelines exists. Diakonhjemmet University College offers students clinical evaluation as part of the Master program in Family Therapy and Systemic Practice, and should develop the PPD program further in establishing an ethical base in the formation of guidelines communicated to our students and their clients.

Summary

In the discussions of the key findings, the research shows that both the practice of family therapy and the therapist's personal life may be influenced. Family therapy education may also be affected by new knowledge of how personal and private influences may affect clinical practice. Is it time to make personal and professional development programmes compulsory in family therapy training? Is it time to rethink the role of own therapy as a part of family therapy education? The ethical considerations, among others, point to the need for ethical guidelines for family therapy practice. This research project may also be seen as an invitation to rethink how family therapy practice could be understood. The project shows that personal and private experiences sometimes form a main framework for understanding sequences of family therapy practice. This realization should not be overlooked in the future and calls for further development.

PPD has not been part of family therapy education in Norway as a formal part of any program. This research process has pointed out the need for such a program in Norwegian family therapy education.

We do not have ethical guidelines for psychotherapy from the Norwegian state or from the Norwegian Family Therapy Association. As a university college offering students clinical evaluation and thereby communicating to them that they are qualified to practice, we should also develop ethical guidelines and seek to tell both our students and their clients that such guidelines exist.

9. Areas for further research

Introduction

The areas for further research within this research project are numerous. Here I will first take a look at the areas where there are parallel connections between family therapists' lives and their clinical practice. I will then raise several areas for further research that I view as particularly important and interesting to explore in the years to come. Development of these areas will probably result in many new research questions.

Further research on parallel connections

Throughout this research project and looking back on my own experience as a family therapist and contacts in the clinical field, I can identify ten areas for parallel connections. In the Appendices 9, I will briefly give an overview of these ten areas with their 40 sub- categories. This will broaden the possibilities for further research on parallel connections.

Alternative research questions

An open research question would probably give the participants in the research project more freedom to explore more ideas. An open research question might ask among other things what and how the participants think about relations between personal and private life and systemic family therapy practice. They might also be asked how they think these areas should be handled, for example: Which ideas do you have about the possible connections between personal and private life and your practice as a systemic family therapist? The influence of clinical practice on the therapist's personal and private life is an area that is open to a research project in its own right. An independent research project in this area would probably produce further interesting findings and analyses.

New research questions

Areas such as culture, religion and socio-economic background are topics of major importance. There are numerous possible research projects in connection with developing understanding of how these areas are an integrated part of systemic family therapy and how they may influence clinical practice. These are areas of high importance also for family therapy education in Norway because we have changed from a rather homogeneous culture to a multicultural society.

The question could be raised of whether it is time to try to answer the question of which therapist can best serve which client. This question emerged in my discussion of evidence-based research and evidence-based practice. Examples of such research are the works of Skovholt and Jennings (2004) about master therapists and Orlinsky and Rønnestad's (2005) ongoing research on how psychotherapists develop.

When we talk about therapists' experience we most often refer to their trained background and professional life. Personal and private experiences are often left out or overlooked as part of what belongs in a professional context in terms of the experience considered to be part of clinical competence. The process of learning family therapy while grounded in the connection between personal and private experiences and clinical practice might provide a research area with many exciting topics (Simon, 2006). In this research project, the context for studying connections between family therapists' personal and private lives and clinical practice has mostly been the study of episodes in the therapeutic process. Further research might focus on such connections in the context of complete therapy processes.

None of the participants in this research project used any form of manual in their practice. It could be interesting to compare two groups of therapists (one group of therapists using manuals in their clinical work and one group that do not use manuals) to explore the influence of personal and private life on family therapy. Would there be any differences and if so, how could these be described and understood?

The different concepts and the relation between the concepts in "the map of relational resonance" represent a framework for further research. The map of relational resonance carries out some questions and challenges that need further research to widen our understanding of systemic family therapy and systemic practice.

The map of relational resonance also offers a language and carries a potential as an evaluation tool both in family therapy education, and in evaluating clinical practice in general. New research questions might be asked to explore and develop this aspect of our understanding of clinical practise.

PPD research

The last area I will mention for further research is connected to the development of the modules often called "personal and professional development" (PPD) in family therapy education. Research projects in this area might be projects where more than one education programme might cooperate in developing, evaluating and performing PPD-modules as a part of ongoing education programmes.

The map of resonance*

How do family therapy students handle situations when the student's own values and culture are challenged? Are such topics avoided? This could be seen as the opposite side of influence of the therapist's personal and private values. When the therapist does not even raise questions that are in line with her or his own values, this might be seen as avoiding difficult situations. The question could be asked about what therapists do when topics that are close to their own value systems appear. Do they enter into these topics? Do they avoid them? How do they influence topics like this? These are some additional areas for further research.

Finally, I will suggest that research questions be asked and developed regarding the relation between PPD work and clinical practice.

Summary

The areas for further research are numerous in the field of patterns that connect family therapists' personal and private lives to their clinical practice. In the areas of parallel connections, life cycle theory alone offers frameworks for several research projects. Research projects that both open up questions about connections between the therapist's personal and private life and her or his clinical practice and look at the entire therapeutic process could be initiated. Research projects that investigate and develop education programmes could be started. Some of this research could look into the meaning of introducing own therapy as a part of family therapy education.

My wish for this research project has been to develop our knowledge of the patterns that connect systemic family therapists' personal and private lives to their clinical practice. I think I found some meaningful connections in this research project. However, I think there are many interesting and important new research projects that might follow up this one and explore personal and private connections to clinical practice in the years to come.

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Appendices

Appendix 1. Information sheet

INFORMATION SHEET FOR RESEARCH PARTICIPANTS

Research project: Research Study of Family Therapists' Personal Life's Influence on Clinical Practice

Who researcher is

My name is Per Jensen and I am working as an Associate Professor at Diakonhjemmet College in Oslo. My research project is part of my Doctorate in Systemic Psychotherapy at Tavistock Clinic/ University of East London.

Contact Telephone Number/e-mail address:

You are welcome to ask for further information on telephone number 22 45 19 87 or contact me on e-mail: jensen@diakonhjemmet.no

Purpose of study

During the 1970's and the 1980's, in Norwegian family therapy education, the personal therapy on offer was only 20 hours. The main idea was to give the students the experience of sitting in the client's position and working with material from their own personal life. For some of the students this gave thin profit inside such a frame.

A lot of motions were put forward to change this part of the family therapy education program. Some meant we needed to get therapists that had a practice that was in tune with the program. Some meant the students needed to bring members of their family into the therapy room and some meant their personal therapy should get more space and hours in the program. But most students and teachers meant that this part of the program should be taken away and that the ordinary clinical supervision should cover this field. Their main argument was that personal therapy was based on psychodynamic theory and that this element in the education program contradicted and even undermined the rest of the program. The result was to take personal therapy out of the program and from the end of the 80s personal therapy has not been a part of family therapy education in Norway

My question is whether we have "thrown out the baby with the bath water". Most therapists will probably agree that the personal element is of importance for clinical practice. To leave this field to coincidence (and possible misuse) and to exclude it from the program can look like an important loss for the program. This can also be seen as an ethical issue both for clinical work and for the training of students.

The primary purpose of this research is to explore in depth the patterns that connect therapists own personal experiences and life with their clinical family therapy practice. Each therapist will be treated as a separate case study. Two interviews will be conducted with each therapist, punctuated by watching a video of a first family therapy session in between the interviews. At the end of all interviews I will convene a focus group of the participants following completion of the interviews.

To be a participant you must give consent to: a) two interviews, b) viewing a videotape of your family therapy practice, c) participate in one group meeting with other participants, d) publication of the material.

Official research question

The Pattern Which Connects: Looking for patterns that connect therapist's personal lives with their clinical practice. How do we work with personal narratives in family therapy training and clinical practice: How does the therapist's own life history and personal experience influence the way he/she understands and practices systemic family therapy? What are the influences from systemic family therapy on the therapist's own life and how he/she thinks about the way he/she lives it?

Use of tape or video recording

With permission, I intend to watch a videotape of one of your family therapy sessions. Through this I hope to get access to the assumptions and expectations you refer to and how these assumptions are realised in practice. This analysis will form the basis of our second interview.

How results will be used (including publication)

My research work is part of my Doctorate in Systemic Psychotherapy at the Tavistock Clinic, that is a Doctorate Dissertation. In addition I will (probably) write an article aimed for a professional journal on the basis of my Doctorate Dissertation.

What is involved for the informant

I hope for your participation in order to illuminate thinking and experiences in family therapy practice, and in this endeavour it is important to get a rich variety of experiences and opinions that I can consider, with implications for further family therapy training.

It is very important to me to obtain a fruitful interaction with you during the research process. Therefore I will on the way bring my observations, hypotheses and reflections back to you and ask for your comments and viewpoints. At the end, before I conclude my report, I will

send you a rough draft to ask for your comments and views and finally arrange a focus group where all participants can meet and discuss the research question.

As participants you will need to be interested in professional questions as exemplified above and be willing to participate with your experiences and views and share your opinions and reflections with me during the research process.

Why you have been chosen

I am writing to you because you, at first hand, were recommended by … . …. has given me some information about your ways of working, and this may in my view be valuable perspectives and experiences in my project. However, I will need to inform you about my project in more detail, about my aims and how the study could be carried out. I therefore want to invite you to a meeting in order to discuss your possible participation. I enclose a copy of my "research proposal" so you can have a look at my perspectives and my project plans so far.

Confidentiality

First, I must tell you that the data I collect is to be used in a research project and that also the other course members (3 other students) and the supervisory staff at Tavistock Clinic in London will have access to the data that I use in my analysis.

The point of some of this project is not at all to define whom is working in the right or wrong way or to point to how specific persons are working. Therefore I want the participants to be anonymous, and in my descriptions I will conceal information that may identify you. All names and places will be substituted by "given" names, and I will also avoid specific descriptions that indirectly may identify you. Examples or quotations that may imply that client cases could be identified will be correspondingly concealed. Though, I surely know that the family therapy field in Norway is limited. It may be an agreement between us that neither you nor I should talk about your participation to 'outsiders', but of course I want to listen to your opinions about such questions if you are interested in participating. We then have to find solutions to such issues together.

My transcriptions (in Norwegian) will be confidential and only used as material during my analysis (according to given rules). My videotapes will be locked up in a safe at Diakonhjemmet college when not in use.

Withdrawal at any stage of the research

Individual members of your group who do not wish to participate are free to stay outside the project. You may also withdraw from the project at any stage, and I will not use material that has been given so far if you do not want me to.

Further Information:

If you have further questions or other comments as to the project or your possible participation, please contact me on the telephone number or e-mail address given above.

Yours sincerely,

Per Jensen

Researcher

Diakonhjemmet September 2003

Appendix 2. Consent form

CONSENT FORM

Project: Family Therapists' Personal Life's Influence on Clinical Practice

Name of Researcher: Per Jensen, Diakonhjemmets høgskole, Oslo.

Contact Phone No: 22 45 19 87 or best: e-mail: jensen@diakonhjemmet.no

1. I have read and understand the information sheet and have had the opportunity to ask questions.

2. My participation is voluntary and confidential and I am free to withdraw at any time, without giving any reason or legal rights being affected.

3. I understand that any tape or video-recording made will be destroyed at the end of the research.

4. I understand that any publication resulting from this research will not identify me in any way.

5. I agree to take part in the above study.

Name **Date** **Signature**

Address of Informant

Researcher **Date** **Signature**

1 for informant; 1 for researcher;

Tavistock & Portman

Appendix 3. Research ethics committee

Research Ethics Committee
Approval Form[35]

All research proposed by staff or students, directly or indirectly involving human beings (patients, volunteers or others) must have the prior approval of the Research Ethics Committee.

Your name: **Per Jensen**
Your address: **Bestumveien 86F, 0283 Oslo, Norway**

Tel +47 22 45 19 87 Fax +47 22 45 19 94 Att: Jensen E-mail: jensen@diakonhjemmet.no

Present Position (full details) Associate Professor and Course Director at Diakonhjemmet College (post graduate education in family therapy)

Course you are attending at Tavistock and Portman

No: M 10 (Norway, distant learning group) Name: Doctorate in Systemic Psychotherapy

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Name of your supervisor at Tavistock & Portman: Arlene Vetere, Ph D

Present position: Senior Lecturer in Systemic Psychotherapy
Address Tavistock Clinic:

Tel 02074357100 **Fax** 02074473733 **E-mail**: a.l.vetere@reading.ac.uk

Name of external supervisor (if applicable): Solrun Williksen, Ph D

Present position: Social anthropologist

Address; Sosialantropologisk Institutt, Universitetet i Trondheim, Norway

Tel +47 73 59 50 00 **Fax:** +47 73 59 65 55 **E-mail:** solrun.williksen@svt.ntnu.no

Name(s) of other Ethics committees who need to agree your proposal.

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[35] With changes on the background of comments from Research Ethics Committee (meeting on the 13th of December 02).

Name of Norwegian Committee involved: The National Committee for Research Ethics in the Social Sciences and the Humanities (Oslo, Norway).

When do you plan to start your research? November 2003

1. Title of your research project:
"The Pattern Which Connects". Research study of the influence of family therapists' own personal lives on their clinical practice

2. What is your research question? (use plain English, approx 250 words)
The Pattern Which Connects: Looking for patterns that connect therapist's personal lives with their clinical practice. And my research question is: How do we work with personal narratives in family therapy training and clinical practice: How does the therapist's own life history and personal experience influence the way he/she understands and practices systemic family therapy? What are the influences from systemic family therapy on the therapist's own life and how he/she thinks about the way he/she lives it?

3. Who do you plan to interview? (Please give full details)

- **clinical patients professionals:** Using the theoretical sampling strategy of grounded theory, my primary strategy will be to recruit between 6 – 9 family therapists with different lengths of practice experience from inside Norway. There will be 3 groups. Two or three therapists will be beginners (novices), two or three will be recently qualified and two (three) will be very experienced family therapists.

- **relatives of patients**

- **non-clinical population**

- **others (who?)**

4. How will your informants be

- **Selected:** To approach and address the research question I will do individual interviews with three different groups, (two or three family therapist's in each group with different experiences). Two groups will be recruited from inside a Norwegian family therapy education programme and one group will be recruited outside an educational program in family therapy. Participants from inside a program should come from the first year and the final year to sample therapists with both less and more experience with the education program. I will not choose participants that I have supervised clinically. Participants from outside a program could be graduates from Diakonhjemmet College or other programs and be without formal training. The main concern here is that they should be experienced in comprehensive practice. I will consider gathering "paradigm cases" from these three groups. A paradigm case is a case that is typical for some of the participants and it is constructed from their stories.

- **recruited:** A letter describing my research program and requesting participation will be sent to a possible participant after an oral enquiry from me. The letter will emphasize that my criteria will meet gender, multi-educational background, experience, age and systemic training. I will encourage potential participants to thoroughly discuss the implications of participating before agreeing to take part in the research.

5. **What arrangements have been made for individuals for whom English is not a first language?**

I will conduct all my practical research work in Norwegian, including devising my questions for the interviews, Information Sheet for Research Participants and Consent Form. I will transcribe case discussions and interviews in Norwegian, and translate into English only the sequences that are relevant to refer in my final report. My reflections and analysis on the way will be carried out in Norwegian, and then my final report will be written in English.

6. Is there any payment to your informants? No X Yes (details)

7. Describe your professional relationship, if any, to your research informants.

I will not choose participants that I am closely attached to. I am partly known as a teacher and supervisor within the field, and I will discuss my "reputation" with possible participants in order to identify if there are problems attached to our relationship. I will not seek participants for whom I have been engaged as supervisor.

8. Does your research involve (give details)

- **video analysis** Yes. After the first interview I will videotape one session with each therapist. Then I will interview the therapist again about his/her thinking and methodology and about the practical implications of their professional assumptions, aims and methods.

- **tape recording analysis**
- **research records**
- **case notes/clinical files**

9. Will your research data be stored on computer? No Yes X

My transcriptions of discussions and follow-up-interviews will be stored on my computer, and I will follow the instructions given by the Data Inspectorate (Datatilsynet) in Norway. I will register my study with them according to their rules.

My videotapes will be locked up in the safe at Diakonhjemmet college when they are not used.
I will delete all data from case discussions and interviews and my videotapes when I have finished my analyses and my report.

10. a. Is this study likely to cause discomfort or distress? (details)

According to my research question, I aim to focus upon and analyse my participants' pattern which connect their personal lives with their clinical practice. I will ask how the therapist's own life history and personal experience influence the way he/she understands and practices systemic family therapy. Further I will ask what the influences from systemic family therapy are on the therapist's own life and how he/she thinks about the way he/she lives it? It is to be hoped that this will be instructive also to the participants. However, I expect that to be interviewed, to be under observation and to be interpreted may represent some elements of stress and insecurity, and I may of course come up with observations and interpretations with which they disagree or even feel uncomfortable.

b. How will you respond to this?

It is very important to obtain reflexivity and a positive interaction between me as researcher and my participants, in order to get maximum "depth understanding" of dilemmas and challenges in family therapy practice. I need to communicate with my participants throughout the research process and at the end, when working on my final report. Therefore I will on the way bring my observations, hypotheses and reflections back to the participants and ask for their comments and viewpoints. Finally, I will send my report (a rough draft) to my participants and ask for their comments and views. I will arrange a focus group that consist of my participants before my report is concluded. I regard this as crucial in order to obtain validity and trustworthiness to the gathered data and to my analysis and perspectives. I also suppose that the issue of being observed and interpreted will be part of my running communication with them. If I find it necessary, I will be prepared to terminate sessions.

11. **Describe fully the ethical implications of your research**

As a researcher I have extensive power as to the way I ask questions, collect data and how I handle the gathered material. For example I could manipulate with quotations, t. i. with the contexts I put their statements into. Further, I am in position to 'belittle' their views and ways of working through my way of writing. I also could be unfortunate enough to make 'generalisations about professionals' on the basis of my findings. I see this as possible ethical implications that I should be very aware of in my project. I will try to avoid such misuse of my participants' information. By staying in interaction with them, discussing my reflections and observations on the way, and by use of supervision, I hope to avoid such pitfalls.

When I view a therapy session it implies that I will get information about concrete client cases. My videotapes and transcriptions of case discussions then will of course contain information about the cases discussed. I will start with asking what permission is needed to use a case discussion in this way, and the agency I go to must of course have cleared such a permission. Moreover, I will disguise all client information in my report. In addition I should state that, in my analysis and final report quotations that implies revelation of case data is relatively irrelevant, since it is the therapists` understanding of their own personal influence that is my focus, not their client stories.

12. Outline your proposals on confidentiality and anonymity of your material

First, I must tell my participants that the data I collect is to be used in a research project and that also the other course members (3 other students) and the supervisory staff at Tavistock Clinic in London will have access to the data that I use in my analysis.

However, the participants will be anonymous, and in my descriptions I will conceal information that may identify the participants. All names and places will be substituted by "given" names, and I will also avoid specific descriptions that indirectly may identify the members. Examples or quotations that may imply that client cases could be identified will be correspondingly concealed. Though, the family therapy field in Norway is limited, and I will propose to my participants that neither they nor I should talk about their participation to 'outsiders'. In the end then, we have to find solutions together with my participants. I will discuss questions regarding confidentiality with them and I will follow the procedures and solutions to such questions as far as possible.

My transcriptions (in Norwegian) will be confidential and only used as material during my analysis (according to given rules), and my videotapes will be locked up in a safe when not used.

13. What steps are you taking to ensure consent of informants

I will carefully inform my participants about my project (see above), and when I finally choose the participants, I will, before starting the project, get a written consent from all participants. It should be clearly underlined that the participants should at any time have the right – and possibility - to withdraw from the project (see Information sheet later).

I will also ensure I have written consent from the families that are videotaped during the project. The involved therapists and agencies will be responsible for the client's consent to be videotaped.

14. If you are considering publication of your results, how are you obtaining consent for this?

I will inform my participants about how the material will be used, and their consent will include that they are aware of and accept my publication plans (se Consent Sheet).

15. If your study is retrospective, provide details of permission from professionals responsible for the case

The information in this form is accurate and I take full responsibility for it.

Signature of Applicant **Date**

Signature of Tavistock & Portman Supervisor **Date**

Signature of External Supervisor (if applicable) **Date**

4 copies of this form (completed in full), the information sheet and consent form and one copy of your protocol should be sent to Lucy Ettinger, Secretary of the Research Ethics Committee, Adult Department.

Examples of completed forms, information sheets and more detailed information on the committee's requirements are also available from her. Contact Lucy Ettinger (0171 435 7111 Ext. 2459).

*** No application can be considered by the Research Ethics Committee without these papers, and the signature of your Tavistock & Portman supervisor.**

Appendix 4. Semi-structured interview

Themes for the first interview:

1. When you have been thinking about this interview; have you seen any connections between your personal and private life and your clinical practice?
2. Are you able to tell a story about how and why the family perspective engaged you?
3. Could you tell a story about some important experiences that has formed your life?
    a. Do you remember a situation where your own values have directed your communication in family therapy?
4. Tell about some important relations that have been important for you.
    a. Are you able to discover any connections between these relations and how you have developed your clinical practice?
    b. Do they have any influence on what engaged you when you meet clients?
5. How do you want to situate yourself politically/religious/ideologically and may you mention any consequences of this in your life:
    a. Consequences for choice of occupation?
    b. Consequences for were to work?
    c. Consequences for how you develop your profession?
6. Mention some important values you keep as true or important.
    a. How does it show in your work?
7. Do you carry any central ideas/convictions/professional ideas about what is important when you work with families?
    a. Why do you hold it for important?
    b. Are you able to discover connections between these topics and experiences from own family life?
8. May you tell a story from your clinical practice where you found yourself over engaged or unprofessional?
    a. What do you connect it to?
9. Do you have any cretin private experiences that color you as a professional?
    a. How does it influence you?
    b. What do you have to keep on to?
10. May you tell me about a case that you have worked with that has moved you personally?
11. May you tell me about a case that you have worked with where you're personal experiences have been of important use?

Appendix 5. Open codes

Open codes (in Norwegian)

1. Aksept
2. Alene
3. Alkoholisert
4. All right menneske
5. Alle sukker
6. Alltid velkommen
7. Ambivalens
8. Angst
9. Annerledes
10. Avlyse
11. Avstengt
12. Bakgrunn
13. Barna
14. Barnevernet spøkelse
15. Berørt
16. Beskrivelse av verden
17. Besøk
18. Betydd mye
19. Bli likt
20. Bli president
21. Blir sett
22. Blitt berørt av?
23. Bor alene
24. Bruke hele meg
25. Bruke hennes utdanning
26. Burde jobbe med
27. Burde tørre
28. Bygge
29. Datter og stesønn
30. Deprimert
31. Destruktivt
32. Det indre som teller?
33. Det ville være fantastisk
34. Dikt
35. Egen familie
36. Eksempel?
37. Eksperimentering
38. Eksperten
39. Eksperten på ditt liv
40. Ektefelle
41. Eldre
42. Eldre dame
43. Elendighet
44. Er amerikansk
45. Er det likeverdig?
46. Er sta
47. Faglig identitet
48. Fam avd
49. Familie
50. Familieterapi
51. Fasade
52. Feige
53. Fetter og kusine
54. Film
55. Flere?
56. Folk jeg liker
57. Folk tenker
58. Fordømmelsen
59. Foreldre
60. Forelsket i terapeuten
61. Forstyrrelse
62. Forsørge
63. Fortalt
64. Fram og tilbake
65. Fremmed
66. Fysioterapi
67. Følte
68. Få på banen
69. Fått blåmerker
70. Ga meg masse
71. Gi trøkket
72. Gift før
73. Gikk i terapi
74. Gitt mest
75. Gitt mot
76. Gjensidig
77. Gjør det gjensidig
78. Glede
79. Godt og vont
80. Gravde i jorden
81. Gå en gang i måneden
82. Gå tur
83. Går bra
84. Går tur med henne som en hund
85. Gått i terapi
86. Hadde vont
87. Halvsøster
88. Han ambivalent
89. Han døde før mor
90. Han gift med barn
91. Han holder henne informert
92. Han ringer
93. Handler annerledes
94. Hans smerte
95. Har fri
96. Har ikke hørt det før
97. Helt skutt
98. Heve opp
99. Historier
100. Hjelp
101. Hjelpsom
102. Hjemmesykepleier
103. Hobby
104. Holdt fast
105. Hun er åpen?
106. Hun har gått i terapi
107. Hun må betale
108. Hun skal ikke vite
109. Hun vil ha jobb
110. Hun vil ikke høre om det
111. Hun ville ha meg
112. Hun visste at jeg ikke likte det
113. Husker eget ubehag av å se terapeuten
114. Hva drømmer du om?
115. Hva har du tenkt?
116. Hva kan jeg
117. Hver dag, hele tiden
118. Hvis han går frakone og barn?
119. Hyggelig
120. Ikke hjelp å få
121. Ikke ivaretatt
122. Ikke kunne jobbe
123. Ikke late som
124. Ikke mulig å jobbe med
125. Ikke sagt til klienten
126. Ikke spurt teamet
127. Ikke store ord
128. Ikke sunt
129. Ikke tydelig?
130. Ikke vært inne i leiligheten
131. Imot
132. Incest
133. Ingen så
134. Innlagt

135. Innledet forhold
136. Insestbakgrunn fra far
137. Isolering
138. Ja, at hun stiller spørsmål
139. Jeg fått ny pasient
140. Jeg har ikke svarene
141. Jeg kjenner konflikten
142. Jeg må bearbeide henne
143. Jeg trakk meg
144. Jeg vet du ikke liker det
145. Jobben
146. Jobber med ikke-psykotiske
147. Jobbet i skolen
148. Jobbet med barn
149. Julekort
150. Kaffe
151. Kan svarene
152. Katten døde
153. Keramiker
154. Kjenner igjen
155. Kjærlighet
156. Kjøpe
157. Kolleger
158. Kom ikke videre
159. Komme ut
160. Kommer fra en familie som er moderne i dag
161. Kreative
162. Krenket
163. Kultur
164. Kusine
165. Kutte med terapeuten
166. La på
167. Langt inne
168. Lese en bok?
169. Leveregel
170. Lidelseshistorie
171. Livshistorie
172. Lokke
173. Løgn
174. Løsninger
175. Male
176. Male og sy
177. Mannlig terapeut
178. Masse styr
179. Mer personlig
180. Min datter
181. Min pappa?
182. Mine dine og våre barn
183. Mitt ansikt i de rette foldene
184. Mor døde
185. Morbror og morfar
186. Mormor
187. Møte med meg selv
188. Møtes ute
189. Narrativ terapi
190. Nettverk
191. Noe du har tenkt?
192. Noen få
193. Nytt for han
194. Nytt prosjekt
195. Nærmeste venn
196. Nærvær
197. Nøytral
198. Når tenkte du terapeut?
199. Og dette forteller hun meg med min bakgrunn
200. Om du vil være med?
201. Onkel til
202. Opp i halsen
203. Oppdaget
204. Oppegående dame
205. Overengasjert
206. Overgriperen
207. Overta pas
208. Pasienten
209. Piggene ut
210. Positiv
211. Privatpraksis
212. Profesjonell
213. Prosessen
214. Prøvd annen psykiater
215. Prøvd ut sånne spørsmål
216. Psykiatri
217. Psykiske problemer
218. På graven
219. På kafé
220. På vei ut av Modum
221. Påstålig, fordømmende
222. Rart å si
223. Relasjon
224. Respekt
225. Respons
226. Ressurser
227. Ressurssterk
228. Roller
229. Samme kveld
230. Sammen
231. Samtalepartner
232. Samtaler
233. Samtaletemaer med pasientene
234. Sant og riktig
235. Seksualitet
236. Selvbilde
237. Selvtillit
238. Ser noe av det destruktive
239. Sin vei
240. Sinne
241. Skilsmisse
242. Skolen
243. Slitsomt
244. Slår konen
245. Smertefulle ting
246. Småprate
247. Snakke
248. Snudd henne ryggen
249. Spennende
250. Spes. viktig menneske
251. Spl. ikke kommet noen vei
252. Spør med bakgrunn i egen erfaring?
253. Spørsmålstegn
254. Stefar
255. Stemor
256. Stesønn
257. Stor tjeneste
258. Stort kaos
259. Stort vektproblem
260. Streve
261. Studerer og jobber
262. Støtte
263. Stå for det
264. Ståsted
265. Sveket
266. Sykepleie
267. Sykepleier
268. Sykepleieskolen
269. Systemisk tenkning
270. Sørgelig
271. Søsken
272. Så rødt
273. Ta ansvar
274. Ta mer tak
275. Ta ped.sem.
276. Ta ut ting
277. Tabu
278. Tam
279. Tatt det opp?
280. Taushet

281. Tema
282. Tenker
283. Tenåring
284. Terapeuten
285. Terapi
286. Tilhørighet
287. Tillit
288. Traff mine foreldre
289. Tre etasjer
290. Tro på meg
291. Tungt
292. Tur
293. Tvil
294. Tydelige historier
295. Tykk
296. Tøft
297. Tårene
298. Undervisning
299. Utakknemlig
300. Utdanning
301. Ute av kontroll
302. Uten å oppdage
303. Utfordring
304. Utformet yrkesrollen?
305. Utslitt
306. Uærlighet
307. Valget
308. Vanlig i stefamilier
309. Vanlig og forståelig
310. Vanskelig
311. Var for moralisering
312. Veiledning
313. Veldig berørt?
314. Veldig personlig
315. Verdier
316. Vet ikke
317. Vil du noe sted med henne?
318. Vil ha time hos terapeuten
319. Viste bilder
320. Voksne
321. Vold
322. Være åpen
323. Yrkesrollen
324. Ærlighet
325. Ærlighet i familien?
326. Ødelagt familien
327. Åpenhet

Appendix 6. Examples of transcribed and coded interviews

From the first interview with Erik (2)

Open codes	Transcript	Research codes
	23. P: How long ago was this, that you had children?	
24 years ago	24. E: It…(Anne) is…she'll be 24 this summer.	
Have you recognised the situation of having a child outside of a relationship in your work?	25. P:…Yeah, a grown-up girl…now then you say, this is one side of my life now. Are there any…if I was to ask about the relationship between that and cases you've worked with, are there any cases you remember that in a way have touched that part of your life?	Sees no direct connection
Not directly But knowing the religious chapel house milieu has been usefu Insurance Christianity Open dialogue at home	26. E: Not quite, like, directly but, I've thought that in some contexts, not that I've brought it out directly in relation to clients, I've thought that knowing the Chapel house milieu and that sort of thing, that that has been useful. I've also thought about this shifting between going from a religious background to actually go over into a, into a life where to believe in it, that that isn't me. And that shift, but at the same time I think some…understanding, as well ehhh about that change that can happen and actually also a discussion with my own parents about that sort of insurance Christianity; it doesn't hurt to continue being Christian, and that sort of thing as well and that was an open discussion at home…I've thought in many ways that I've been quite lucky in that, in spite of something that could seem narrow it wasn't actually like that at home after all. There was the opportunity for quite an open dialogue about most things.	Sees a connection Helpful to know the Chapel house
Do you recognise this?	27. P: Have you encountered that position or what should we say, that theme in your practice, that you yourself have been involved in, with in a way leaving…	
No	28. E: …not really, I don't think… 29. P:…no, no.. 30. E: …I don't really think so.	Sees no direct connection
	31. P: The other part, that you've lived alone, is that what you'd say, which means that you've lived in your own apartment and had a partner, but one who's also had their own place.	

Each weekend and every second Wednesday	32. E: And who didn't live in any relationship either so that we were more or less free both of us to do what we wished and had our own sort of arrangement for being together as well. Each weekend and every second Wednesday.	Family relationship
	33. P: That was…(overlap) and over 14 years, you say so this was…	
	34. E: Yes, over roughly 10 years…	
Is this a model?	35. P: …OK, was a kind of model. Ehhh..mmm…Is this model in a way…what do you think about this way of living?	

From the first interview with Karen (4)

Open codes	Transcript	Research codes
Self-critical of cynicism	94. K: – Luckily I had enough experience that I didn't let it shine out too much, but I think I was probably a little quick to close – I mean it seems like you two can handle this – not without problems and suffering, but that you're handling it well enough – I will suggest that we close there and you can come back instead if – I think so. But I was self-critical of that cynicism.	Self-critical
Too strong word?	95. PJ cynicism – is that the best word you know to cover that?	
	96. K: – maybe that's too strong – I don't know what I should call it – call it that now then.	
	97. I don't think it was so, - I think many of the difficulties were so trivial – and then – but I remember that those times –	
	98. PJ but then you were through your second break-up right? Was that more painful than the first for you?	
Had to go into therapy to say no	99. K: – it had a very different character though. The first time it was more me that chose to leave – and then I had to go into therapy in order to say no, put the phone down and – But the second time it was more	Own therapy

Badly treated	like I think I had been quite badly treated – I was more furious and angry and rejecting then –	
	100. PJ how long did that relationship last then?	
	101. K: – it lasted for 10 years – we lived together for 7	
Values and attitudes	102. PJ when you think about what you yourself can display in the way of feelings, own attitudes and values and the like in the therapy room – what do you think about that – is there any of that that you in a way think you can present with – or how might one say – that you can share? Take feelings for example.	Value
Good humour	103. K:-yes, at the moment we share many feelings of having good humour – starting to laugh at something – not unusual.	
	104. PJ crying then?	
Does not cry	105. K: – I don't cry – not with anyone	
	106. PJ no matter what dramatic stories they might tell?	Feelings
	107. K: – don't cry no	
	108. PJ never done it either?	
Does not have the crying rags out	109. K: – no, I don't even have the crying rags out	
	110. PJ no that's true, they're usually always out – you've got them under there then	

Appendix 7. Construction of a category

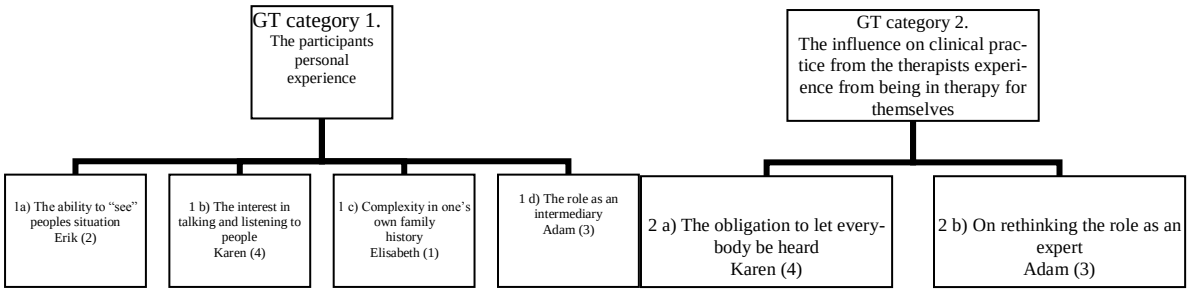
Construction of category "Personal and moral values and personal experience influence therapeutic work".

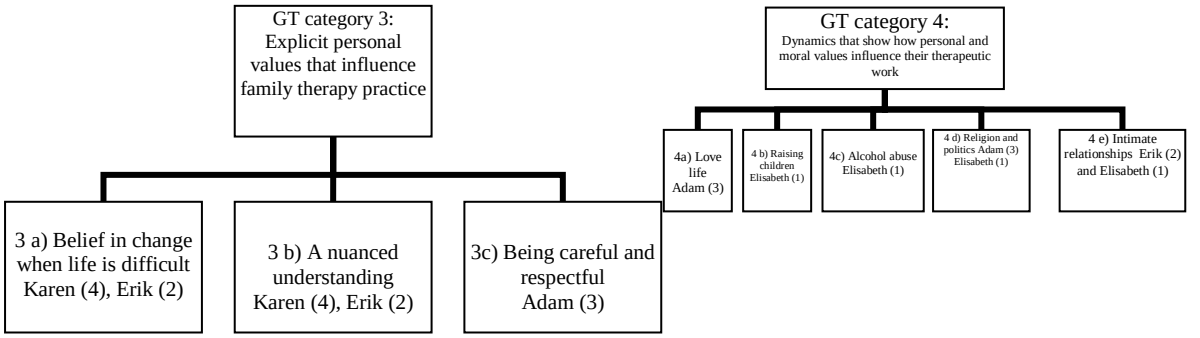
Text	Categories	Research category
48. My father has been married and divorced three times and I am a child of his first, his second marriage. He has a daughter from his first marriage, she is (9) years older than me, and then he has a son from his third marriage. I am in the second, and it was my mother's first marriage and there was a great deal of age difference between them, my mother was 2(0) and he was 1(5) years older in (Middle-East) and my mother took me back to Norway when I was (3)…and they were divorced. Ehhh and then my mother met another man when I was 5 and they married when I was 10, and he had a daughter from an earlier marriage where he had scarcely lived together with her. And then they had a child together ehh and then they had a "project" to bring about a good family. I then took his name and from that time on it was just us, and I was very proud about many things and I was very proud that I was an (Middle East) citizen and that I had a father in (Middle-East). So we have, in a way, two parallel histories, he tells his colleagues on his job a great deal about me being his daughter and I tell people he is my stepfather. We moved to (Tromsø) when I was 1(5) because he had started taking courses at a medical school. I have always felt, or early on in life, that I was a person who where unthankful because I didn't accept his love the way he wished. And I wanted nothing to do with their new "project" because I saw it as something that would fail. For example, my sister, half-sister, who was born when I was 1(6); she was 8 before knew that I was her half-sister and that (Ann), her father's daughter from an earlier marriage wasn't her cousin, but was her sister, because they were attempting to protect her. And I am very much opposed to that, because I have, she is one of theirs; if a person becomes over…tell if one time you were knocked off your perch and you were overly engaged. I don't think I would be professional because I would be in a setting, I was at (Åsgård) working in the family unit….	Divorced One daughter from first marriage Mothers first marriage Back to Norway Divorced Married again Daughter from earlier marriage New child Good family Proud He is father She is stepdaughter She felt unthankful Nothing to do with new project Half sister 8 before she knew Not cousin They would protect her I am opposed to that Tell!	***You should tell children the truth***
49. E.: It was at the family unit where there was a therapist who went out in…we have both therapists and co-therapists in the unit…. It was a somewhat new therapist who was a social worker who has the head therapist, and there was a nurse. They had been there with an experienced nurse but she went on leave for childbirth, so I almost got the family in my lap. And that was a family with a mother and father and two small girls, one who was 5 – 7, yes 5. Yes, 5 and 7. Perhaps one was 6, she had not begun to go to school by any means. 4 and 6, or 4 – and 6 years in age. And they had…and the father was depressed and had many anxiety	Therapist and co-therapist A new therapist Got the family in lap Two small girls Depressed and anxious father	

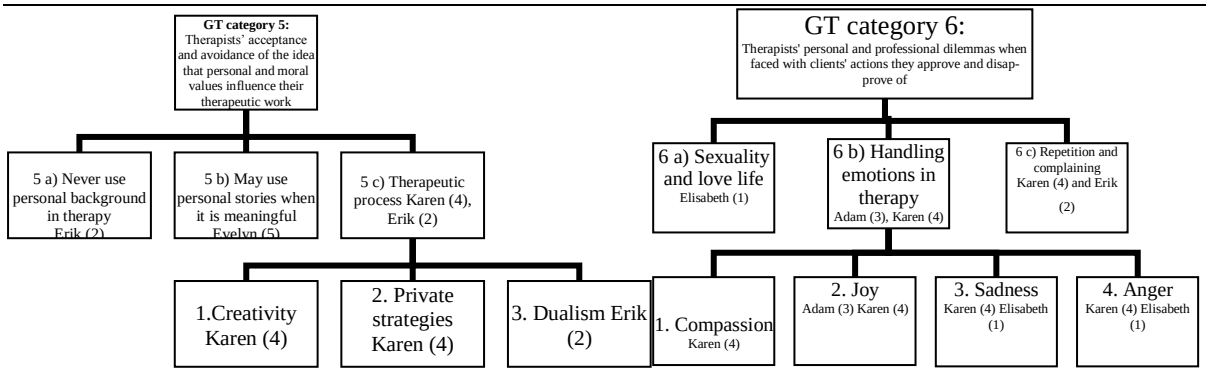
	problems and things of that nature. Then, in one of the appointments he disclosed…something that caused him to be so very depressed and so anxious because he had two children where were, yes, around 13 and 15 years old. And they came...there…on a visit and it had functioned so poorly when they came and he felt they wanted to have nothing to do with him. And then it came forth that they were introduced as cousins to his new daughters.	Two children from former marriage Introduces as cousins to new daughter	
50.	P.: Um hum, this is parallel, yes..		
51.	E.: Then I saw red, real red. Yes. We attempted to speak about all of this and I attempted to ask questions, as did their therapist, but we couldn't make any headway. I then had a discussion with their therapist asking that I be permitted in one way to give the force I had and that she would remain neutral and provide them a little support. I thought this was somewhat clever. So I came to an appointed time and said what I thought of all of this and that I had lived in such a situation and how that…how it feels to visit one's father only to hear that it is…shall pretend that he is an uncle during the entire weekend or throughout Christmas. That, that…then one does not have any desire to visit and that which I could... And they were very disturbed and went forth and back with each other, and then they decided to tell all of this to the daughters. And then it is the nurse who is at the house. Ehhh so I arrived the morning after and was met by a chalky white man who said he never wanted to see me again and that I had ruined his whole family. He was enraged.	Saw red Speak about it Asked to be permitted to tell Told what she meant Told about own experience How it feels to pretend Decide to tell to daughters Ruined the whole family	***Personal values appear*** ***Personal experience influence therapeutic work*** ***Personal and moral values influence therapeutic work***

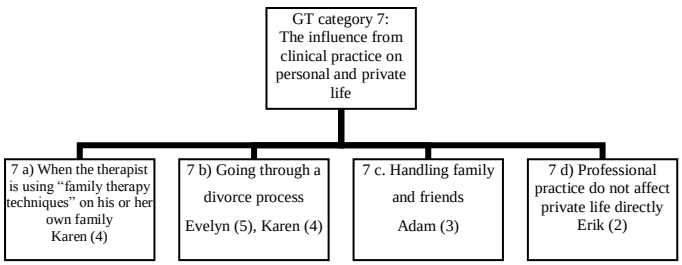
Appendix 8. Map of GT categories

GT categories with sub and sub sub-categories









Appendix 9. Further research on parallel connections

In the following presentation of my research, we will briefly get an overview of these ten areas with their forty sub categories. Then we will look closer into four different cases connected to four of these areas. I have chosen four examples that can stand as paradigm cases and represent different situations and contexts where these parallel connections give meaning to the clinical practice.

1. Difficult relationships and divorce

It is a huge literature on for example couples therapy, unhappy relationship and sexual problems. From time to time, these kinds of problems also affect family therapists (Hårtveit and Jensen 2004; Jensen 1994; Caillé 1992). Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- Unhappy relationship
- Divorcing a spouse or breaking up an intimate relationship
- Adultery
- Sexual problems in relationship.

2. Difficulties with children

The whole field of family therapy in many ways emerged from clinical work with families with troubled children, (Don Jackson, Jay Haley, Virginia Satir, Salvador Minuchin, Mara Palazzoli Selvini and John Byng-Hall among others). Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- Children's psychiatric disorders
- Children's somatic disease
- Children's social problems
- School problems

3. Drug and alcohol abuse

The family perspectives have influenced and shaped the understanding and treatment of alcohol and drug abuse (Stanton and Todd 1982). Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- A child with abuse problems
- A spouse with abuse problems
- A family member (a parent or sibling) with abuse problems
- The therapists own drug or alcohol abuse
- Friends with abuse problems

4. Violence

Violence has in many ways been a difficult topic in the field of family therapy. Although the relational perspective is highly relevant when it comes to violence, it was not much focused on these aspects of family life in the first decades of the family therapy movement. Family therapists have also been criticised for not being sufficiently aware of and sensitive to this topic when it occurs in therapy. Especially the feminist criticism has been important and has made a difference when it comes to clinical practice (Cooper and Vetere 2005). Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- Physical and/or psychological battering
- Incest
- Experience from rape and other sex related violence

5. Eating disorders

Although eating disorders usually are seen as a psychiatric disorder I chose to treat it separately because this is a fast growing disorder and an important topic in the development of family therapy (Hårtveit and Jensen 2004; Jensen 1994). Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- Therapists own eating disorder
- Child's eating disorder
- Family member's eating disorder
- Friend's eating disorder

6. Psychiatric disorders

Some could claim that the article "Towards a theory of schizophrenia," from 1956, by the Bateson-group formed a starting point for the relational oriented family therapy field. In the first years of the development in the field traditional psychiatric

disorders were very much the centre of attention in the field (Hårtveit and Jensen 2004; Jensen 1994). It is enough to mention Jay Haley, the Milan-group, Salvador Minuchin and Carl Whitaker. Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- Therapist's own disorder
- Family member's disorder
- Friend's disorder

7. Somatic disease and death

Somatic disease and the loss of a spouse or partner, parents, children, siblings and friends will influence a therapist's mind in significant ways. In our western society, the probability for a woman to be a widow is four times higher than for a man losing his wife. Fredda Herz Brown claims that the degree of disruption to the family system is affected by several factors. The most significant factors are (Carter and McGoldrick 1989, p. 458):

1. The social and ethnic context of death
2. The history of previous losses
3. The timing of death in the life cycle
4. The nature of death or serious illness
5. The position and function of the person in the family system
6. The openness of the family system

Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- A spouse with disease or dying
- A child with disease or dying
- A family member with disease or dying
- A friend with disease or dying

8. Problems connected to work life, economy or studies

In family life cycle theory, career issues are mostly connected to the launching of the single young adult. The question of career is also a topic connected to lower-income families (Carter and McGoldrick 1989). Problems connected to work life, economy and studies may however affect family life at any time in the life cycle. Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- Therapists' own problems
- Spouse's problems
- Children's problems
- Problems in the rest of the family
- Friend's problems
- Problems connected to different local family cultures

9. Sexual preferences

It is a part of the political discourse today to make marriage neutral from sex. From 1993, gay and lesbians in Norway could enter into an official partnership. Although our view of gay, lesbian and other variation connected to sexual orientation has changed the last thirty years it is still an important and not very much persuade area for many family therapy students and therapists in Norway. Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- Lesbian/gay therapist
- Transsexual therapist
- When the therapist is a fetishist

10. Cultural expectations

The sociocultural context of the family is often overlooked when it comes to understand for example divorce (Stern Peck and Manocherian 1989, p. 335). The cultural questions are personal and often hidden topics in a therapist's life and probably in need of being lifted forward in a more profound way than today. Some central areas where the therapeutic process could be affected because of the therapist's parallel experience in own life could be:

- Family from different cultures
- Different values
- Religious views
- Political views

These 10 main topics and 40 subtopics emerged from my research interview material and from my experience as a family therapist and from my knowledge from the field of family therapy. This is not meant to be a complete list of topics and themes but rather a first draft and a point of departure for further research in this area.

Through this research project and by looking back on my own experience and contacts in the clinical field, I could identify these ten following areas for parallel connections, either simultaneously or as a part of the therapists life history. When we include sub areas, we reach 40 areas and themes.