

VOLUME I- RESEARCH COMPONENT

**Literature review: What can be Learnt about
Power Relations in Family Therapy to Reduce
Power Differences in the Therapeutic
Relationship?**

**Empirical paper: Curious about Curiosity in
Family Therapy**

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*A thesis submitted to
the University of Birmingham
for the degree of
Doctor of Clinical Psychology*

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June 2011

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Overview

This thesis is submitted as part of the requirements of the degree of Doctor of Clinical Psychology at the School of Psychology, University of Birmingham. It is comprised of a research and a clinical volume.

Volume I contains a literature review paper and an empirical paper. The literature review examines the family therapy literature that explores power in the therapeutic relationship. It is argued that therapists have elevated influence and status compared with clients, and therefore it is important to reflect on issues of power in the therapeutic relationship. The conceptual understanding of power is elicited from the literature, alongside the clinical implications for clinical practice for reducing power differences in the therapeutic relationship. Creative ideas from the literature are proposed to promote a more egalitarian relationship in therapy, but empirical research is required to support claims and develop concepts. The Australian and New Zealand Journal of Family Therapy is the nominated journal for this review paper.

The empirical paper is a qualitative study that implemented Foucauldian Discourse Analysis and Interpersonal Process Recall (IPR). Therapists were interviewed about curiosity, a key principle in family therapy, to learn about how they constructed it, to contribute to the limited evidence base. Findings highlighted how curiosity was understood in context of patterns of discourse related to a commitment to the systemic model. Further discourses constructed curiosity in relation to skill and as a natural personal quality. Conflicts and paradoxes within the data highlighted implications for clients and therapists in terms of positioning and subjective experience. Dilemmas arose for therapists when managing their therapeutic intentions and the agendas of clients. Clinical implications are discussed including the potential for curiosity to contribute to a flexible, rewarding therapeutic approach and also the role of empathy in family therapy. The IPR process appeared to provide insight into the clinical practice of participating therapists, suggesting that it could be used as an effective supervision tool. The Journal of Family Therapy is the identified journal to submit this research paper to.

Volume II is the clinical component of the thesis, consisting of five clinical practice reports (CPRs). They summarise and evaluate my clinical work that took place during placements through the three year course. The first report “the case of a 24 year old woman experiencing dizziness formulated from a Rational Emotive Behaviour Therapy and a Psychodynamic perspective” used two psychological models to formulate and understand the dizziness experienced by a woman attending therapy sessions in a Community Mental Health Team. The second CPR documents the therapeutic work that took place, utilising a single case experimental design in “an A-B single case experimental design to test the effectiveness of Rational Emotive Behavioural Therapy with Tina who was experiencing low self-esteem and anxiety”. A service evaluation that I carried out from a Community Psychology perspective is detailed in the CPR titled “a qualitative evaluation of a drop-in service provided for children, young people and their families in a socially and economically disadvantaged area in Birmingham”. In the fourth CPR, the systemic therapy sessions that took place with a woman labelled with a learning disability are documented in a case study named “using the systemic model with Sally and her carer Carol- a case study”. The fifth CPR was an oral presentation that articulated the Narrative Therapy work that took place with a woman titled “Rose, a story of relaxation, determination, independence and new possibilities”. An abstract is included to provide an overview. Clients’ details have been anonymised.

Acknowledgements

I would like to thank my supervisor Sara Willott for introducing me to Foucault and supporting me through this process. I enjoyed having the occasional supervision session in the local cafe, which provided a different context and some well needed inspiration. I would also like to thank my supervisor Michael Larkin for his inspiration, dedication and those imperative last minute supervision sessions that were squeezed in.

Furthermore, I need to thank the family therapists who participated. I was fascinated by your discussion of curiosity and my understanding of systemic therapy has greatly improved due to having the opportunity to interview you. Finally, thank you to the people who were using the family therapy service, who kindly agreed for the use of their session DVDs for the purpose of this research.

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What can be Learnt about Power Relations in Family Therapy to Reduce Power Differences in the Therapeutic Relationship?

Abstract

It is argued that family therapists are in a position of elevated power compared with clients due to a number of factors which are explored. As therapists are in a responsible and influential position, it is important that they reflect on the role of power in the therapeutic relationship. This conceptual review examines the family therapy literature that discusses power, to learn about how it is defined and consider implications for clinical practice. Common themes informing ways of reducing the therapist's elevated power are examined, including having an awareness of cultural, social and political influences that construct therapists' status, valuing client expertise, working collaboratively and helping clients challenge subjugation due to constructed societal norms. Creative, client-centred ideas are asserted by the literature, but on the whole, they are not underpinned by empirical evidence within an epistemological framework. Thus, the need for research to strengthen these claims is proposed, with suggestions for future studies.

Introduction

The nature of power relations between therapists and clients in systemic family therapy is the area of interest for this literature review. Social psychology experiments have illuminated the ease with which formal power relations can lead to obedience and collusion (Haney, 1973; Milgram, 1974). Masson (1992) controversially criticises all forms of psychological therapy, including family therapy. He believes therapists are indoctrinated through training, and that their pride and status are caught up in their professional role, brandishing a harmful level of power. To answer this accusation, therapists must be able to critically reflect upon the operation and flow of power in their therapeutic practice. They are in an influential and responsible position with the potential to be abusive towards clients.

The term “power” appears to be a complex concept to understand and define in therapeutic relations. At a general level, it can be understood in relation to an inequity of opportunity, knowledge, resources or abilities between therapists and clients. The issue of power is attended to in the theory and practice of some models within systemic family therapy. This is an overarching term incorporating a variety of therapeutic approaches, understanding difficulties experienced by people in the context of their relationships. Many family therapy approaches are grounded in social constructionism (e.g. Willig, 2008), in which knowledge is argued to be contingent, connected to power (Hacking, 1999) and formed in a historical and social context.

I believe that it is important for therapists to understand and recognise the presence of power inequalities in the therapeutic relationship and work towards reducing these as much as possible, to promote helpful therapeutic change with clients, and avoid inadvertently abusing them. From the literature, I am interested in exploring the nature of possible power disparities that can occur in the therapeutic relationship, and the clinical practices that can help reduce these. Therefore, the following questions will be systematically asked of the literature:

1. How is power defined and understood?
2. What are the clinical implications of the literature’s claims in promoting a more egalitarian therapeutic relationship?

Ideas that are considered theoretically relevant and clinically helpful will be drawn out, with the intention of making this information easily accessible to therapists. The aim is to enhance their knowledge and skills in delivering ethical family therapy, which prioritises the needs of clients and reduces power disparities. The current review is justified, as following the systematic search performed, no previous literature review was found that specifically focuses on power relations between therapists and clients in family therapy, other than a comparative review of the role of power in Solution Focussed Therapy, Narrative Therapy and Collaborative Therapy (Sutherland, 2007). The current review is different as it is not comparative, but draws out common applicable therapeutic practices

to help reduce power differences across a wider range of family therapy approaches than investigated by Sutherland (2007).

The databases PsycINFO, Ovid MEDLINE (R) and ASSIA were searched for literature investigating power relations between therapists and clients in family therapy. Narrative Therapy, which falls under the umbrella of family therapy was included as a search term, as considering power is a key tenet of this approach. The five references discussing power solely in relation to feminism were excluded, as they could be examined as a standalone literature review. Please see appendix 1 for the complete search strategy. The 15 references from the search to be reviewed are listed in Table 1. Further literature to the identified references is also discussed in this review to enhance the understanding of power and its implications for practice.

Table 1
Literature generated by the search strategy

Reference	Type of reference	Theoretical approaches drawn upon
Amundson, J., Stewart, K., & Valentine, L. (1993). Temptations of power and certainty. <i>Journal of Marital and Family Therapy</i> , 19(2),111-123.	Conceptual with a case study	Collaborative Therapy
Anderson, H., & Goolishian, H. (1992). The client is the expert: a not-knowing approach to therapy. In S. McNamee & K. Gergen (eds) <i>Therapy as Social Construction</i> . London: Sage.	Conceptual with a case study	Collaborative Therapy
Andrews, J., Birch, J., Reed, A., & Spriddell, G. (1996). The construction of authority: context and power in family meetings. <i>Changes</i> , 14, 282-288.	Conceptual with a short interview extract	Reflecting Team Foucauldian
Atkinson, B. J. (1993). Hierarchy: the imbalance of risk. <i>Family Process</i> , 32, 167-170.	Conceptual	Not clearly stated

Chapman, J. (1993). Politics and power in therapy: a discussion on the implications of postmodern ideas for therapeutic practices. <i>Australian and New Zealand Journal of Family Therapy</i> , 14, 57-62.	Conceptual	Postmodern
De Shazer, S. D. (1988). A requiem for power. <i>Contemporary Family Therapy</i> , 10(2), 69-76.	Conceptual	Solution Focussed Therapy
Goldner, V. (1993). Power and hierarchy: let's talk about it! <i>Family Process</i> , 32, 157-162.	Conceptual	Foucauldian
Guilfoyle, M. (2003). Dialogue and power: a critical analysis of power in dialogical therapy. <i>Family Process</i> , 42, 331-343.	Conceptual with a case analysis	Collaborative Therapy Foucauldian
Hildebrand, J. & Markovic, D. (2007). Systemic therapists' experience of powerlessness. <i>ANZJFT Australian and New Zealand Journal of Family Therapy</i> , 28, 191-199.	Qualitative	Social Constructionist, Feminist
Murphy, M. J., Cheng, W. J., & Werner-Wilson, R. J. (2006). Exploring Master Therapists' Use of Power in Conversation. <i>Contemporary Family Therapy</i> , 28, 475-484.	Quantitative	Collaborative Therapy, Narrative Therapy
Nichols, M. P. (1993). The therapist as authority figure. <i>Family Process</i> , 32, 163-165.	Conceptual	Not clearly stated
Piper, J. & Treyger, S. (2010). Power, privilege, and ethics. In L. Hecker, (eds) <i>Ethics and professional issues in couple and family therapy</i> . New York: Routledge.	Conceptual	Narrative and Feminist
Reimers, S. (2001). Seeing ourselves as others see us: Using video feedback in family therapy. <i>Australian and New Zealand Journal of Family Therapy</i> , 22(3), 115-119.	Conceptual with case studies	Reflecting Team
Simon, G. M. (1993). Revisiting the notion of hierarchy. <i>Family Process</i> , 32, 147-155.	Conceptual	Temporal-developmental

Sutherland, O. (2007). Therapist Positioning and Power in Discursive Therapies: A Comparative Analysis. <i>Contemporary Family Therapy</i> , 29, 193-209.	Literature review	Solution Focussed Therapy, Narrative Therapy, Collaborative Therapy
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From the literature obtained, there was one literature review, seven purely conceptual references, and five conceptual papers with some anecdotal evidence reported from the authors' clinical practice. References that carried out systematic research grounded in an epistemological approach was limited, including only one qualitative interview study and one quantitative study. The majority of the literature extracted discusses power in relation to systemic family therapy approaches that are underpinned by a social constructionist epistemology

The theoretical and family therapy approaches from the literature are summarised as follows. Postmodernism claims that subjective interpretation of phenomenon inevitably occurs, and it moves away from modernist theory that claims it is possible to objectively gain facts about phenomenon. Related to postmodern theory, Foucauldian ideas are inspired by the philosopher Foucault (1965, 1980, 1982) who theorised about knowledge, power, culture and history. Foucault's ideas provide a framework for Narrative Therapy (White & Epston, 1990) recognising that people may become distressed due to comparing themselves to idealised, unobtainable norms in society. Narrative Therapy aims to help clients to re-author an alternative story of their lives to tackle distress. Collaborative Therapy, a branch of Narrative Therapy was founded by Anderson and Goolishian (1988, 1992). They claim that the vehicle of change is the two way therapeutic conversation in which new meanings are co-constructed and client expertise is privileged.

Solution Focussed Therapy was founded by de Shazer (1982), and it aims to help clients to notice exceptions to the problem they bring to therapy, facilitating them to come up with solutions. Reflecting Team work (Andersen, 1987) uses a primary therapist "in the room" with a system of clients, and a team of two therapists watching in another room through a

one way screen. The therapists behind the screen, who have a stepped back position to the “in the room” interactions, will enter the therapy room at times and talk to each other, offering multiple reflections and ideas about what they have witnessed, for the clients to listen to, in order to help the clients change how they relate to one another. Feminist approaches were also discussed in the literature, which look at the wider cultural context, addressing patriarchal norms that are proposed to influence family relations (e.g. Dallos & Draper, 2005).

This review uses a social constructionist epistemology, in keeping with the philosophy of the main family therapy approaches discussed in the references. To start, definitions of power will be described. Following this, common themes informing the understanding of power and therapeutic practices which promote a more egalitarian therapeutic relationship have been drawn out:

- Therapists are positioned as powerful due to social, cultural and political influences
- Does the concept of hierarchy equate with power?
- Collaboration
- Valuing client expertise
- Challenging subjugation due to socially constructed norms
- Facilitating client agency
- Developing awareness of power differences

The literature is summarised overall in the discussion, and wider implications for clinical practice and future research are explored.

How is power defined?

Power is directly defined in approximately one half of the literature reviewed, summarised in this section. As a helpful starting point, the 2009 Concise Oxford English Dictionary defines power in terms of “1 the ability to act or do something. 2 the ability to influence people or events. 3 the right or authority to do something.”. De Shazer (1988) uses a similar definition in which power is represented as the ability for one person to exert influence on another person. In order to further understand power, he describes

Emerson's power dependence theory (1962) in which power is not a characteristic of a person, but a feature of a reciprocal relationship linked to dependence and resistance. Anderson and Goolishian (1990) understand power in terms of one individual influencing another and Lyness, Haddock and Zimmerman (2003) also define power in terms of relational control and influence. Sutherland (2007) describes power as a client or a therapist progressing their particular point of view or perspective in a conversational exchange.

To explain power, Chapman (1993) discusses ideas from Foucault (1988): "power over" is when a recipient is restricted in their options to respond and "domination" is described as when a recipient is fully restricted in their rights and options to respond, unable to reverse the power dynamic. Guilfoyle (2003) uses ideas from Foucault (1982), who defines power as shaping the actions of others: "a total structure of actions brought to bear upon possible actions". The reader needs to be well informed with Foucauldian theories of power in order to fully understand the above literature's definitions of power, which could be improved with further explanation. A clear summary of Foucauldian ideas in relative to Narrative Therapy is provided by Madigan (2011). He defines power in relational terms and claims it can be repressive and productive. Power is understood to be exercised at different levels in the social body, from the level of the state through to the individual. Power is also reported to be expressed through the reproduction of cultural norms via social action.

Power is understood by Piper and Treyger (2010) as being closely interlinked with the concept of "privilege", which is defined as a situation in which advantaged individuals in society who hold power, benefit from disadvantaged individuals in the same society. Power and privilege are considered to permeate all relationships. Hildebrand and Markovic (2007) utilise Keeney's (1983) definition of power, "an ability to influence and an ability to respond" and also Rampage's (1994) definition, "an ability to have an effect". Inspired by these non pathologising definitions of power, Hildebrand & Markovic (2007) provide an accessible definition of the opposite concept of powerlessness, "an inability to influence, respond and have an effect". They postulate that this can leave a person feeling

potentially stuck, useless and hopeless. Hierarchy, a concept sometimes associated with power is defined by Atkinson (1993) as a relationship in which there is not an equal capacity to say no, as some individuals may risk losing more than others in the relationship. Nichols (1993) has an alternative understanding of hierarchy, defining it in terms of people or things being ranked in order, one below another. He believes hierarchy is linked to boundaries, leadership and authority, and not associated with power or control.

A critique of the papers being reviewed that are not mentioned in this section is that they discuss power without clearly defining it first, leaving a gap in the foundation to their arguments. It may be that the reader's understanding of power is taken for granted, as it is an everyday term. However, as demonstrated, defining and understanding the principle of power is not a simple task, as it appears to be conceptual and open to different interpretations. A common understanding is that it is associated with influence in relationships.

Themes from the literature to aid the understanding of power and promote a more egalitarian therapeutic relationship

Therapists are positioned as powerful due to social, cultural and political influences

The literature reviewed discusses how therapists are positioned as having power, due to the construction of their role in society. For example, family therapists are educated, trained and highly paid relative to the average wage. This places them in an influential position, in which clients may hold them in high esteem to help with their problems. To understand the issue of power in therapy, Chapman (1993) endorses recognition of the powerful position taken up by therapists and the powerless positions that can be occupied by clients. She promotes adopting a postmodern understanding, avoiding the medical model of diagnosis, and instead valuing the client's knowledge and theories. She speculates that therapists may have too much to lose in terms of status, by adopting postmodernism, holding them back from embracing it. I agree that taking up a postmodern philosophy facilitates more of a power equality in therapeutic relations

compared with solely using the medical model, which emphasises the therapist's expert knowledge.

Andrews, Birch, Reed and Spriddell (1996) also question the power differential that may lead to privileging their understanding over their clients' understanding of the world. They recognise the challenges of encouraging staff in psychiatry services to do the same. When working with clients, in order to reduce their authority, the authors no longer offer theories to explain difficulties. They are comfortable to come from a position of "uncertainty" and "fallibility". Evidence to support the authors' ideas is provided by a small interview extract with a service user who received therapy from the authors' service. It was reported that he experienced his viewpoint as respected and that it was helpful not to be given advice.

Amundson, Stewart and Valentine (1993) state that in therapy, power is expressed through the role and status of the therapist and they describe a case example to illustrate the negative effects of therapists unwittingly exerting power with a couple. Using Foucauldian ideas, Goldner (1993) believes that therapists are implicated in the problem of social control of clients due to being constructed as experts. She proposes that power is expressed when people and particular talk are privileged. Guilfoyle (2003) suggests that power's presence in therapy is masked, but present as a result of therapists and clients being positioned due to cultural, theoretical and societal influences. Furthermore, Sutherland (2007) summarises how ideas from Narrative Therapy also state that therapists have more power than clients, due to socio-political influences and that in therapy it is important not to reproduce relationships in the client's life in which there is an unhelpful power difference. She also writes about how therapists can inadvertently advocate for dominant norms linked to distress.

Piper & Treyer (2010) feel examining power is crucial in understanding relationships. They use Narrative and Feminist ideas to discuss managing power issues in therapy in relation to gender inequalities, cultural diversity, therapist expertise and multiple relationships between therapists and clients. They draw on work by Claiborn, Berberoglu,

Nerison and Somberg (1994) and Smith and Fitzpatrick (1995), to propose that the therapist has more power than the client due to the following reasons: the client learns much less about the therapist's life than vice versa, clients may be emotionally vulnerable, clients may be scared of being abandoned if they don't follow directions from the therapist and clients may follow suggestions from therapists, despite not truly wanting to, due to responding to authority.

In summary, the literature supports the view that family therapists, relative to the average person in society can be viewed as powerful due to social, cultural and political influences. I believe this to be an important philosophy to endorse in order to illuminate and address the power differences in the therapeutic relationship, through highlighting the need for practices to reduce them. It is clear though, that it will be impossible to fully remove these differences.

Does the concept of hierarchy equate with power?

Linked to the discussion of therapists being positioned as powerful, Simon (1993) writes about the issue of hierarchy in the therapeutic relationship. He invites other authors respond to his argument, summarised in this section. Simon (1993) proposes a new way to make sense of hierarchy, inspired by Fivaz-Depeursinge (1991), using a temporal developmental framework. He believes that when using this understanding of hierarchy, the issue of power is no longer relevant, challenging Anderson and Goolishian (1988, 1990), who claim that hierarchy is associated with power. Although Simon (1993) believes the temporal developmental model does not link hierarchy to power, the author neglects to express that other issues of power in the therapeutic relationship may still need attending to by the therapist. No beneficial ideas can be extracted from this article to help reduce the power inequity in therapy.

Goldner (1993) argues that Simon (1993) has unconvincingly made the concept of power evaporate, leaving unanswered questions that need addressing. She believes that power is a problematic issue to be paid attention to in family therapy. The article provides plausible conceptual criticisms to Simon's (1993) theory. Atkinson (1993) agrees that the

issue of hierarchy is a present and pertinent issue in therapy. He claims that clients look up to therapists, viewing them as influential and powerful, even if therapists try to avoid or deny this position. The author states that therapists are abusing their position of influence when they carry out the following: promoting client dependency on them, expressing there is only one explanation for the client's difficulties and pathologising clients who have a different perspective.

As a reaction to Simon (1993), Nichols (1993) feels it is acceptable to criticise power if it is linked to control and domination, but he declares that it is important for the therapist to be in charge of therapy through leadership and authority. The author does not acknowledge the potential power abuses that may emerge from leadership and authority, and it does not seem credible that these can be easily separated from control and domination. Therefore, clinically relevant ideas cannot be extracted to help reduce power differences in the therapeutic relationship. However, some clients may want a more directive approach in therapy, which may fit with his perspective.

There are contrasting views discussed in the literature about hierarchy and whether it is linked to power. I argue that socio-political influences position therapists and clients within a hierarchy, corresponding to power differences. An awareness of this process and a commitment to promoting a more egalitarian relationship can help to reduce this inequity. However, a dilemma arises, as some clients may appreciate hierarchy and power difference in the therapeutic relationship. Paradoxically, to be respectful of their wishes and client-centred, maybe a directive approach is required in these scenarios.

Collaboration

A collaborative therapeutic relationship, in which clients and therapists both put effort into the therapeutic process is a common principle highlighted in across the literature, to help address power differences. Solution Focussed Therapy claims that therapists and clients both have power in therapy and an equal opportunity to channel the focus of the therapy session (Sutherland, 2007). De Shazer (1988) argues that power is only present in therapies that incorporate the concept of resistance. He does not feel that the metaphor of

power is a necessary concept if the therapist's approach is to focus on building on what the client is already doing to help the problem. The author suggests that this allows a reciprocal collaborative relationship of "cooperation" instead of resistance.

De Shazer (1988) does briefly recognise that a power imbalance may be present in the therapy relationship, as the client is seeking help from the therapist. However, he associates the power imbalance with resistance, when the client opposes suggestions made by the therapist. The article does not recognise that there may be more subtle power relations at play, even when on the surface, two way cooperation appears to be operating. For example, clients may discuss potential solutions that they don't truly want to engage in, to please the therapist that they may hold in high esteem. De Shazer (1988) cites his work that includes case studies (de Shazer, 1985) as evidence for cooperation being a successful approach. Using this framework may reduce power inequalities to benefit clients, but it does not seem reasonable that they would completely disappear.

Although Narrative Therapy does not explicitly state the term collaboration in its principles, it is inherent in its ethos. For example in the practice of externalisation (White, 1988) in which clients and therapists playfully conspire together against the problem. The joint process between the therapist and client of using the conversational space for new meanings to emerge appears to reflect the need for collaboration.

In Reflecting Team work, Andrews et al. (1996) carefully consider how to use the one way video screen technology so that it is liberating and beneficial for clients. They provide the family with options of how to use the technology. This is thought to develop the authority of the clients and reduce the therapists' authority, facilitating joint ownership of future discussions about problems and solutions. A limitation of this suggestion is that given clients have been found to find the Reflecting Team process intimidating (Smith, Winton & Yoshioka, 1993), they may not find it as easy as suggested to voice reservations about the presence of the one way screen. Evidence of this intimidation suggests a potentially hidden, abusive power imbalance. Also, questions from therapists asking clients about their wishes in relation to video feedback could easily be interpreted as commands (Reimers, 2001). Sells, Smith, Coe, Yoshioka and Robbins (1994) suggest that the

development of trust and rapport reduces potential intimidation. Thus, collaborative discussions, as put forward by Andrews et al. (1996), may help to promote trust and rapport to reduce potential power inequalities.

Supported by case studies, Reimers (2001) discusses the potentially therapeutic process of using recorded family therapy session videos with clients to watch back, alongside the possible abuses that could arise. He compares this stepped back reflection process to Reflecting Team work. The author explores issues for therapists to consider relating to power, as he recognises that this activity could lead to abusive treatment of clients. The author is aware that ethical dilemmas may arise if some family members do consent and others do not consent to the use of video feedback. In using video feedback with clients, the author recommends using a collaborative approach, being guided by what the client wishes. Reimers (2001) argues that video feedback has the potential to enhance the therapeutic relationship and reduce power inequalities, as it allows the therapist and client(s) to collaborate together, stepping back from any tensions that might have occurred between them during “in the moment” therapy conversations. The comments seem accessible to implement, to help give more power and influence to clients. They would have been improved with some theoretical discussion to illustrate the author’s conceptualisation of power.

Overall, using a collaborative approach in therapy is a prominent theme across modalities and it appears to be an essential ingredient in engaging clients, helping them to feel respected, facilitating new meanings to emerge and reducing power differences. However, the evidence is purely speculative, warranting research underpinned by an epistemology to provide evidence to support these claims.

Valuing client expertise

Another common theme that arose in the literature to minimise power differences was the practice of privileging the client’s knowledge and expertise. The stance of curiosity, defined by Cecchin (1987) values working with multiple points of view at the same time. He claims that it is not helpful for therapists to take full control and direct the family

according to their ideas about what is needed to help. Instead, using curiosity can support the family to discover their own resources and options to help with the problem. Sutherland (2007) explains how therapists do not aim to steer the conversation in Collaborative Therapy. Instead it is guided by the client's views and meanings. The presence of power in therapy has been criticised by Anderson & Goolishian (1990) who suggest that it is not necessary, not ethical and as a result of expert language used by the therapist. They believe that the therapist's expertise lies in using therapeutic questions to facilitate a two way dialogue. In taking a "not-knowing" stance (Anderson & Goolishian, 1992), the therapist uses curiosity to ask questions, valuing the client's language, as demonstrated by a case study. In "not-knowing", multiple explanations are valued and the therapist aims for previous experiences and understandings not to limit their current interpretations. Although the authors do not directly discuss power or a model for understanding it in the reference reviewed, valuable ideas are offered to help facilitate more equal power relations in therapy

Amundson et al. (1993) theorise that when therapists use practices associated with power and certainty, they are demonstrating dedication to models of understanding outside of the therapy room. Instead of promoting power, the authors advocate for avoiding expert language and using the client's language to promote empowerment. The authors suggest replacing a stance of certainty with curiosity, which they propose involves the client's knowledge and resources, being comfortable with uncertainty and not rushing to define the problem. Amundson et al. (1993) provide clearly laid out information describing and comparing therapy that incorporates curiosity instead of certainty (see appendix 2) and empowerment instead of power (see appendix 3). These are a helpful resource for therapists who are working towards facilitating a more egalitarian relationship with clients.

Guilfoyle (2003) argues that power is an important factor present in therapeutic relations. He values working clinically in a framework of Collaborative Therapy, although he challenges Anderson and Goolishian's (1990) assumption, that it is possible for the therapist to remove power from the conversational exchange with clients. The author

examines a therapy transcript of Anderson's to illustrate the influence of "discursive uncertainty markers" which aim to eliminate the therapist's authority in collaborative therapy, for example, the therapist saying "maybe I'm totally wrong but". He claims that as the therapist has to constantly use these markers, this is evidence that they constantly need to prove to the client that there is a power equality, which Guilfoyle (1990) believes to be evidence of the presence of a power inequality. He states that clients have access to power in therapy through ethical and legal rights and through forms of resistance, like choosing to discontinue sessions. The author provides a convincing critique and I strongly agree with his claims that power imbalances do not disappear, despite therapists privileging client expertise.

Murphy, Cheng and Werner-Wilson (2006) used quantitative methodology to analyse published commercial videos of six renowned family therapists delivering therapy. They believe that power is present in relationships and summarise each therapist's clinical orientation's understanding of power. The authors examined the therapists' use of power using a measure which codes statements as submissive, controlling or neutral. Therapists' use of power was reported to be consistent with their theoretical orientation in terms of the nature and intensity of control in the communication. The authors' analysis suggests that Harlene Anderson used limited power with the client on the therapy video, which they state is in keeping with the Collaborative Therapy approach used.

Sutherland (2007) describes the non-expert position taken in Narrative therapy, in which the therapist facilitates editing the problem story to produce a less problem saturated story. She concludes that Solution Focussed, Narrative and Collaborative Therapy all value multiple ideas and perspectives in therapy, in which therapists present their ideas to clients as refutable. The expertise of the therapist is theorised to be in facilitating the conversational process, utilising the client's resources. This offers a helpful broad framework to reduce, although not remove hierarchical differences in the therapeutic relationship.

To sum up, the literature suggests that privileging client knowledge through a “not-knowing” approach and using client language can help reduce power differences. Adopting these ideas may help to position the client as having expertise and influence, rather than dependence on the therapist to come up with solutions. However, it is argued that these power disparities cannot be removed, as taking a non-expert stance does not account for social influences and the unsaid preconceptions of the clients, which might view the therapist as knowledgeable and influential. Again, the claims are mainly conceptual, with the exception of Murphy et al. (2006). Further research is required to give strength to the argument that valuing client expertise is beneficial and minimises power differences.

Challenging subjugation due to socially constructed norms

In this section, literature will be explored that discusses dominant and marginalised discourses (a collection of assumptions and ideas) in society. The practice of helping clients challenge subjugation (being controlled due to subscribing to societal norms) will also be examined.

Goldner (1993) suggests that therapists should have discussions about marginalised discourses that might have been left out of therapeutic conversations, to understand the wider social context and take into account social hierarchy and inequalities. Helpful questions are offered including “whose ideas are most left out of our conversation?”. She proposes that this approach would not aim to rid the problem of power, but to help clearly highlight it. These ideas appear helpful to gain insight into power inequalities at play. Andrews et al. (1996) also discuss the dominant discourses that they perceive to subjugate people who have been given a label of “mental illness”. Their aim is for people with this label to avoid being stigmatised and marginalised through the use of more respectful language. Sutherland (2007) summarises how Narrative therapists aim to liberate clients from feeling like they need to live up to socially constructed norms through highlighting this process to them. Piper & Treyer (2010) also advocate for teaching clients about this model of understanding. However, it has been argued that

Narrative Therapy could actually become oppressive if client agenda is contradictory to the therapist's agenda of liberation from oppressive cultural influences (Hayward, 2003).

Murphy et al.'s (2006) analysis of Michael White's therapy video suggests that when he gave a control message, the client was significantly less likely to respond with a neutral message. The authors suggest that this may be because he is encouraging clients to protest about particular issues, to combat subjugation, complementary to the Narrative approach. Murphy et al. (2006) have implemented an innovative design to try and quantify power relationships in therapy. However, it may not be as objective and straightforward as suggested to categorise statements into submissive, controlling or neutral, as interactions may have more complex undertones that are not captured by this measure. The authors conclude that all therapists used power directing the therapeutic conversation. However, Michael White and Harlene Anderson demonstrated less power compared with other family therapy modalities, supporting the practice of Narrative and Collaborative Therapy to undermine differences of power.

I believe that it is important for therapists to have an awareness of the dominant discourses in society that marginalise people, leading to distress due to not meeting idealised norms. This is a plausible framework that embraces the often neglected and important issue of power in therapy. Introducing this idea to clients may be beneficial and liberating, but only if the concept resonates for them. Also refer to Hansen, Randazzo, Schwartz, Marshall, Kalis, et al. (2005), Hwang (2006) and Knapp and VandeCreek (2007) who explore ways therapists can enhance their cultural competence, and therefore reduce the marginalisation and subjugation of clients from minority backgrounds in therapy.

Facilitating client agency

Encouraging client agency is another theme that ran across the literature reviewed. Narrative Therapists aim to facilitate agency in clients, defined as the client's intention to take action towards their goals in context of internal and external limitations (Lee, 2004). Anderson and Goolishian (1992) claim that a "not-knowing" approach provides the

opportunity for clients to have new agency when narratives emerge. Sutherland (2007) summarises how in Narrative Therapy, agency is promoted in clients by valuing their knowledge about self-healing. In Solution Focussed Therapy, her analysis also states that therapists aim to empower clients through adopting a non-expert position and helping them to discover their own agency. Helping clients to increase their sense of agency seems to be an important concept in relation to diminishing the power inequity in the therapeutic relationship. If clients have increased agency, they may have reduced dependence on the therapist, due to owning the ability to make positive changes in their life. Unfortunately, the literature reviewed does not explicitly define agency or explain in depth how to facilitate it with clients. Further exploration of literature discussing agency would enhance the clinical application of it with clients.

Developing awareness of power differences

This section describes the literature that suggests therapist awareness and self-reflection could help enhance a more egalitarian therapeutic relationship. Atkinson (1993) expresses the importance of therapists being non-controlling in therapy at a conscious level of intent, but also at a congruent emotional level. Atkinson (1993) recommends therapists help clients to find their own path, whilst being clear about their own values, thoughts feelings and assumptions. The author makes a convincing argument that appears very client-centred, which works towards reducing power inequalities between clients and therapists. In order to raise therapist awareness and minimise potentially negative effects of power in therapy, Piper and Treyer (2010) offer useful questions to help therapists reflect on these issues (see appendix 4).

While much of the literature covered in this review is more concerned with clients being placed in a position of powerlessness, Hildebrand and Markovic (2007) interviewed systemic trainees and experienced systemic therapists to examine what made them feel powerless, a neglected area of discussion in family therapy literature. The most frequently reported reason was clients making limited therapeutic progress. It was also stated that feeling restricted by the systemic model fed into therapist powerlessness. The authors thought it would be helpful to normalise discussions of powerlessness in systemic

practice, literature and research, as they proposed it was an ignored, taboo concept. Personal and professional development groups were also recommended as a forum to help therapists understand and tackle this issue. I believe that it is helpful to recognise the issue of therapists feeling powerless, as long as it does not eclipse attending to feelings of powerlessness that clients may be also experiencing in the process. The study provides a valuable, clinically relevant contribution to the extremely limited family therapy empirical research base.

In summary, the literature suggests that power inequalities can be positively influenced through therapists reflecting on their own process and also utilising clinical practice development forums to explore power issues. It is important to promote exploration of the complex and multi-dimensional issue of power in the therapy arena, particularly as it can be neglected. Once more, research is required to back up claims about the effectiveness of forums for learning and reflecting on power issues in the therapeutic relationship.

Discussion

The literature defines power as occurring in relationships, in which people have influence over others. Privilege, control, domination, authority, resistance, hierarchy and powerlessness are connected themes. The importance of attending to power differences in the therapy relationship is demonstrated by the literature as vital, as these differences can have a detrimental impact on the therapy process. Alongside this, they can be implicated in unethical, abusive practice. Power differences can prevent clients from expressing their true wishes, reproduce unhelpful power relations in the life of clients and prevent the emergence of new valuable narratives. Therapists can also reproduce unachievable social norms compounding client distress.

A minority of the literature proposes that the power inequity between therapists and clients can be removed, using co-operation (de Shazer, 1988), a non-expert position (Anderson & Goolishian, 1990) and a temporal developmental model (Simon, 1993).

Unsurprisingly, a majority of the references support and strengthen my view point, that there is a power imbalance, in which therapists are in an elevated position of power compared with clients, advocating for therapists to have an awareness of this issue. This finding is to be expected, as most authors who do not feel power is a relevant topic for discussion would probably not bother to write about it. Across the literature, broad factors argued to maintain the elevated influence of therapists include the therapist privileging their knowledge base over the clients', the therapist not recognising and reflecting on power inequalities, and socio-political influences. An alternative perspective was provided by Hildebrand & Markovic (2007) who explored family therapists' own experiences of powerlessness.

There were common suggestions across the family therapy modalities to help reduce power differences, including adopting a postmodern perspective, facilitating a collaborative relationship, promoting client agency, raising client awareness of possible subjugation, and taking time to reflect and learn about power differences in therapy. These accessible ideas can be incorporated into clinical practice to help develop a therapeutic relationship with more equal power relations. However, the literature suggests that it is not possible to fully remove the power difference due to social, cultural and political influences. Murphy et al.'s (2006) findings also demonstrated the influence of therapist power with clients, even in Narrative and Collaborative Therapy that aim to minimise or remove it from therapeutic interactions.

Further ideas I propose to enhance more equal power relations are described as follows. Sensitively naming and exploring power differences together with clients may help reduce their negative effects. Furthermore, monitoring the use of and avoiding terminology is important, as certain taken for granted terms may be confusing for clients. Discussing diagnoses and medical understandings may be helpful if the client values that model of making sense of their difficulties. I believe a social constructionist approach can incorporate understandings grounded in the medical model, as long as other perspectives of understanding are equally valued. Furthermore, if clients do wish for a directive form of therapy which is too far outside of the systemic remit, they should be appropriately

signposted to respect their wishes and help them feel in control. To help therapists manage feeling powerless, using family therapy models in a flexible manner may help reduce them feeling constraining (Perryer, 2011). Furthermore, if the therapeutic process is feeling stuck, it may help for the therapist and clients to work with the “stuckness” collaboratively, rather than the therapist taking full responsibility, leading to them feeling powerless.

Developing ideas from the literature, a therapeutic service that values discussions and training for therapists in relation to power issues in their personal and professional life may help provide a nourishing context for therapists and clients. Supervision, sharing literature, peer support groups, attending and delivering training and carrying out research in this area are mechanisms that may enable therapists to develop their knowledge and awareness about minimising power differences in therapy. In addition, video or audio recording therapeutic sessions for therapists to watch back and reflect on could improve insight of their clinical practice (Perryer 2011), including power dynamics at play.

Ironically, family therapy literature, including the literature reviewed, is often written using expert terminology, only readily accessible to academics, further adding to power disparities (Andrews et al., 1996). Due to academic systems, this review is unfortunately also included in that elite category, although I have attempted to define terminology used. Working towards making information in the family therapy literature easy to understand and readily available to all people in society might help reduce power inequalities in a wider context.

The conceptual papers that provided anecdotal evidence including case studies provide a helpful start to the evidence base researching family therapy and power. However, a major limitation of the literature is the lack of rigorous, empirical evidence grounded in an epistemological framework, to back up assertions. The exceptions reviewed are Murphy et al. (2006) and Hildebrand and Markovic (2007). Using a method that is within an epistemology is beneficial, as it offers a transparent, systematic, purposeful process, to

gain evidence to answer specific research questions, increasing the quality of the findings. It is not clear why there is this enormous gap in family therapy research into power. Maybe the concepts are considered difficult to research, or maybe there is a trend in the family therapy field to write more conceptual literature. Clearly, there is a need for research in this area to continue the important debate about the role of power in family therapy that meets published standards (e.g. Elliot, Fischer & Rennie, 1999).

Interpersonal Process Recall (IPR) (Kagan, 1975, 1990) is a qualitative interview process that uses videos of therapy sessions in interviews with therapists and clients to prompt them to comment on what they were thinking and feeling during moments on the video. This method could be used to examine some of the assumptions made in the literature about power in therapy. IPR could explore how clients experience certain components of therapy including collaboration and the facilitation of agency, to examine whether they match the conceptual claims made in the literature. It could find out how clients experience power dynamics during therapy and in addition, what processes are experienced as dominating, influential, liberating and empowering. It could add to the understanding of how clients experience the use of the Reflecting Team and video feedback, to inform ways of implementing these approaches in an ethical manner that does not intimidate clients or position them as powerless and unable to express their true wishes. Research could also help investigate what forums would be effective to enhance the awareness of therapists about power issues. It could explore the link between forums for reflection and the impact they may have on the nature of power in the therapeutic relationship.

This review demonstrates the debate about the role of power in family therapy and ways of reducing inequalities between clients and therapists. A search of a subsample of literature could be carried out to examine how often the important issue of power in the therapeutic relationship is discussed in different therapeutic models. This would provide a more detailed understanding of how much it is attended to or neglected in various approaches. Furthermore, IPR could be used to examine the attitudes of therapists across different modalities in relation to power in the therapeutic relationship. This could inform

what the blocks and facilitators are to help all therapists consider power issues as a central component of their work.

The literature suggests that there are barriers preventing mainstream services adopting a postmodern position. Additional research could carry out focus groups with professionals working in mental health services to explore their attitudes towards a postmodern framework. Gaining their perspectives about moving away from purely diagnostic models of understanding might inform future training and consultation work to promote more client-led postmodern therapeutic services, which reduce power disparities, benefitting clients' interests.

Psychological therapy has been criticised by Masson (1992) and also Smail (1996) who believes therapy is futile, as it does not impact on the wider cultural and community influences that he theorises to cause distress. In addition, therapy is also strongly criticised by Bates (2006) who discusses cases of misconduct, and Dineen (2001) who views it as damaging to clients and an abusive profit making business. The literature reviewed demonstrates that it is not possible to make power differences in therapy evaporate, due to social, cultural and political influences. However, creative ways of working in the systemic literature have been put forward to undermine the negative effects of power. These take into account influences of the wider context, outside the therapy room. Thus, I propose that the pay off for clients entering into therapy is greater than the possible risks, if therapists have a commitment to learning about, reflecting on and reducing power differences.

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Curious about Curiosity in Family Therapy

Abstract

In the family therapy field, curiosity (Cecchin, 1987) is a widely used concept. It aims to help therapists to work with multiple ideas and perspectives simultaneously, to enable new meanings and explanations to emerge during family therapy. Despite being commonly used, there is limited conceptual and empirical evidence underpinning the understanding and practice of curiosity. Therefore, this study interviewed family therapists using Interpersonal Process Recall and Foucauldian Discourse Analysis, to investigate how curiosity was constructed and put into action by therapists. Discursive patterns from the data are described, linking curiosity to a commitment to the systemic model. Curiosity was also constructed as skill, and as a personal quality. Conflicts and paradoxes in the data were examined, highlighting the dilemmas faced by therapists in managing their intentions and the clients' agendas. How therapists and clients are positioned into different roles by the discourses are explored, alongside implications for their subjective experience. The clinical and political implications of the findings are considered, and springboards for future research are discussed.

Introduction

Curiosity is a commonly used term and concept in society which can be understood in different contexts. The groundbreaking physicist Albert Einstein (1952) reflected the importance of curiosity in his life by stating "I have no special talents, I am only passionately curious". The French historian and philosopher Foucault (1996) stated that curiosity represented an eagerness to break up familiar patterns and explore what alternatives could exist. The latter ideas are relevant to facilitating change in systemic family therapy, in which curiosity plays a central role (Tomm, 1984; Cecchin, 1987). However, following a thorough literature search, very limited empirical research was uncovered, underpinning the clinical practice of curiosity. Therefore, this study is

interested in deconstructing curiosity in the sphere of family therapy to develop the understanding of it and provide evidence to support its use by family therapists. The introduction tracks the story of curiosity from the existing literature and empirical research, including its relationship to neutrality (Selvini, Boscolo, Cecchin, & Prata, 1980) from which it evolved. Associated themes including “not-knowing” (Anderson & Goolishian, 1992), irreverence (Cecchin, Lane, & Ray, 1993) and empathy (Wilkinson, 1992; Flaskas 2004) will also be discussed. My rationale for the investigation and the research questions are then detailed.

The story of curiosity so far

The Milan principles of neutrality, hypothesising and circularity

Three interview guidelines consisting of the linked principles of hypothesising, circularity and neutrality were devised by the “Milan Team” (Selvini et al., 1980). These guidelines will be explored, as they are integral to setting the scene for the emergence of curiosity (Cecchin, 1987) in systemic family therapy, which is the concept of interest for this study. It was proposed that neutrality had been achieved by the therapist, when family members are unable to state whose side the therapist is on at the end of a family therapy session. This end result is argued to occur, as the therapist appears to evenly share his/her allegiance with all family members, following asking each member circular questions. These types of questions ask all the family members about relationships, including differences and changes they have noticed in these. Hypotheses are developed about the family and are not seen as correct or incorrect, but as more or less helpful. They are thought to guide questions that can steer therapists to uncover new information. This is thought to help the therapist and family understand relational patterns and discover new meanings, leading to the family members learning new ways of relating to each other.

Scheel and Conoley (1998) carried out a quantitative study, aiming to measure the experience of neutrality by families. Following therapy, video segments of the session were played back to family members asking them to rate neutrality when asked different kinds of questions by the therapist. The researchers deduced that neutrality was violated

more often when family members were asked interventive compared with descriptive questions. Refer to Boscolo, Cecchin, Hoffman and Penn (1987) for a description of these types of questions. Tomm (1984) asserted that neutrality was an attitude of the therapist involving curiosity, respect and acceptance. He later furnished these ideas (Tomm, 1987) by describing neutrality as taking a non-committal posture in which the therapist avoids attaching to or being repelled by comments or actions from family members.

Curiosity: neutrality re-defined

The concept of neutrality was misinterpreted and criticised for supporting subjugating practices and placing the therapist in an uninvolved, unemotional position which avoids taking responsibility for decisions (Bograd, 1984; Goldner, 1985). In order to tackle this response, enrich understanding and develop the principles of neutrality, Cecchin (1987), who was part of the original Milan Team, redefined neutrality as curiosity. This term was previously briefly mentioned in the context of neutrality by Tomm, (1984). Cecchin (1987) stated that curiosity was a stance to enable the therapist to facilitate uncovering as many different explanations from the family as possible. The therapist is not searching for a true explanation, but is interested in hearing how all the different explanations link together. If therapists think they know the answer, this is thought to easily close off further exploration and the discovery of potentially helpful new ideas. Curiosity is suggested to help generate respect for the family, which in turn then generates more therapist curiosity. If therapists stop generating hypotheses, this is considered a warning sign that they have lost their curiosity; for example if they are too closely committed to their hypotheses without the flexibility to explore and listen out for alternatives.

A long-term case study is used by Reynolds (2007) to provide evidence of the therapeutic value of practising containment (Winnicott, 1965), curiosity and consultation. Reynolds proposes that helping a client develop a new narrative through using curiosity can be containing. She also draws on Cecchin's (1987) ideas about curiosity and claims that it should be used in a slow paced, non-directive manner with clients, to help them take the necessary time to develop new meanings in an empowering context. Garven and White (2009) summarised some of the ideas expressed by first years on a systemic therapy

course about systemic therapy principles including curiosity, in order to provide accessible explanations for others. Statements about curiosity included: curiosity is a position, curiosity helps therapists to put suppositions aside, curiosity enhances manoeuvrability in the session and it helps the therapist empathise with, and validate multiple perspectives.

From curiosity to irreverence to prejudice

Cecchin et al. (1993) expanded ideas about curiosity by coining the term irreverence, which is a position taken by the therapist that moves away from having certainty and subscribing to specific models of understanding family problems. The authors believe this frees the therapist up to ask the family respectful, playful questions in order to challenge the certainty of family members that may be holding them back from achieving their goals. Cecchin, Lane, and Ray (1994) further embellished these ideas, writing about the nature of prejudice in therapy. Through a case study, Sluzki (2008) draws on Cecchin's (1987; 1994) ideas about curiosity to illustrate the importance of not becoming entrapped in fascination when working with families. The author suggests that it can become harder for therapists to promote therapeutic change when attached to a story as it limits options for alternative ideas and meanings to emerge.

Multipartiality and adopting a not-knowing stance

Anderson and Goolishian (1988) define neutrality through multipartiality, a term using similar ideas to Cecchin's (1987) description of curiosity. Multipartiality encapsulates the process of the therapist endeavouring to hear and work with every family members' perspective equally, which aims to create the environment for new meanings and horizons to emerge. It is asserted that therapists hold prejudices, which fuel curiosity and new ideas. However, the therapist must be willing to let go of meanings in order to take on board new ones in a fluid fashion, just as clients are hoped to. The authors later write about taking a "not-knowing" stance with clients (Anderson & Goolishian, 1992) which also complements the principles of curiosity. A "not-knowing" position values the knowledge and expertise of the client. Also, therapists ask clients questions, while

managing any preconceived answers, so they do not limit the direction of the therapeutic conversation.

Stancombe and White (1998) also understand neutrality as multipartiality. Discourse analysis was applied to two transcripts of family therapy sessions to explore the different ways blame is managed by therapists in sessions. They concluded that it is not possible for the therapist's perspective to be neutral, agreeing with Cecchin (1999) that instead, it is important for therapists to familiarise themselves with their prejudices. Neutrality is understood by Sutherland (2005) in terms of Anderson and Goolishian's (1988) explanation of "multipartiality". Two family therapy transcripts were analysed using conversation analysis to explore moments when multipartiality is used by therapists. It was deduced that multipartiality was performed through involving ideas from clients, expressing client language, using formulation and reformulation and making the use of multipartiality apparent to clients.

The role of curiosity in empathy: a neglected area

Wilkinson (1992) proposes that taking the position of curiosity and neutrality leads to "systemic empathy", as this facilitates systemic understanding and meanings to emerge in therapy. Using two case studies to illustrate her point, she postulates that neutrality and curiosity are comparable to the person-centred principle of unconditional positive regard (Rogers, 1961), but within the context of systemic relationships. Flaskas (2004) also considers the neglected issue of empathy in family therapy literature. She discusses implementing Cecchin's (1987) ideas about curiosity combined with Anderson and Goolishian's (1992) "not knowing" stance. Flaskas (2004) posits that when successfully employed, therapeutic empathy can result, as the client feels like the therapist is genuinely interested in understanding their viewpoint.

Summary

In summary, the literature that specifically discusses curiosity is mainly conceptual. The exceptions include case studies (Wilkinson, 1992; Sluzki, 2008) and a qualitative summary

of trainee ideas about curiosity (Garven & White, 2009). These provide a helpful start to the evidence base, but they are anecdotal and do not use a research method that is grounded in an epistemological framework. In the exploration of neutrality, the bulk of the literature was also conceptual. Empirical evidence was provided by good quality discourse analysis studies that examined the use of neutrality using family therapy transcripts (Stancombe & White, 1998; Sutherland, 2005). There was only one quantitative study which used an innovative method to assess family members' experience of neutrality (Scheel & Conoley, 1998).

Rationale

There is clearly a large gap in empirical evidence underpinning and justifying the practice of curiosity, that meets quality criteria for qualitative research (Elliot, Fischer & Rennie, 1999; Yardley, 2000) and quantitative research (Downs & Black, 1998; Deakes, Dinnes, D'Amico, Sowden, Sakarovitch et al., 2003). This is despite curiosity being a valued concept in systemic practice. The current investigation draws on ideas from Garven and White (2009), Wilkinson (1992) and Sluzki, (2008) to further investigate therapists' understanding and practice of curiosity. Due to the small number of empirical studies examining curiosity, additional ideas are also utilised from the neutrality literature. Stancombe and White (1998) and Sutherland (2005) used discourse analysis, as I intend to do, to investigate neutrality. Furthermore, Scheel and Conoley (1998) used family therapy videos in their methodological design, which I also incorporate. The current investigation aims to examine discourses linked to curiosity, and challenges to using curiosity, through interviews with family therapists using family therapy videos to prompt discussions. The intention is to provide evidence that meets quality criteria for qualitative research to support theory underpinning curiosity. This aims to enable therapists to further understand the nature of curiosity and issues relating to practicing it, in order to benefit clients receiving therapy.

Research questions

Data was collected to enable an understanding to emerge in context of the following questions:

- What discursive patterns are employed by therapists when talking about curiosity?
- How are therapists and clients positioned by these discourses, and what might it feel like being positioned in these different ways?
- What are the clinical implications of these discourses in terms of family therapy practice?
- What are the wider social and political implications of these discourses?

Methodology

Foucauldian discourse analysis (FDA)

Michel Foucault was interested in the historical and cultural context of discourse, which in simple terms could be described as anything spoken, written or communicated through signs. He theorised about the influence of different discourses on society and their relationship with knowledge and power (Foucault, 1980). Foucault studied institutions like psychiatric hospitals and prisons (Foucault, 1997) to understand and challenge how certain practices and beliefs had become the cultural norm. He was in opposition to discourses that privileged a single idea, as he saw these dominant discourses as a form of social control.

FDA is interested in the contribution of language and discourse to society. Parker (1994) defined discourses as “sets of statements that construct objects and an array of subject positions”. A discourse could also be seen as a complex collection of ideas available in society that influences what is appropriate for people to say or do. Different discourses are available within and across cultures and across history, varying dramatically. FDA seeks to understand how particular discourses position people into different subject roles and what implications that has for their psychological experience. It also seeks to capture

what discourses are available in a culture or setting, and analyse the impact these may have on the people that can or cannot access them. As the issue of power is important to consider in therapeutic work, and as taking a position of curiosity potentially influences power relations, FDA was thought to be a helpful approach, as analysing power is a central thread of this framework.

Interpersonal Process Recall (IPR)

IPR (Kagan, 1975, 1990) uses a qualitative approach to interview caregivers and service-users following a therapeutic session. The caregiver and service-user individually watches the recorded session, and then are independently interviewed about it to capture their reflections about what they were thinking and feeling at different moments during the session. Larsen, Flesaker and Stege (2008) and Elliot (1986) describe how to implement IPR. Traditionally, IPR aims to capture information about in the moment therapeutic process. In the current study, IPR was used to facilitate family therapists to discuss their constructions of curiosity through using sections of family therapy DVDs as prompts. As curiosity might be an abstract term to discuss in an interview, IPR was used to assist with stimulating discussion and ideas about curiosity. It was not important to focus the conversations purely on participants' experience in the moment during the therapeutic session, as conversations focussing on post hoc thoughts and ideas were also valuable, and in keeping with the study's epistemological position.

Epistemological position

This research is underpinned by a social constructionist position (Gergen, 1985), in which knowledge and "reality" are theorised to be socially constructed through language and influenced by social structures and history. Human experience is not considered to be an objective reflection of the environment. It is argued that people hold different descriptions and understandings about events and objects which are equally valid, and that there is no one true empirically valid explanation. Cecchin's (1987) concept of curiosity values multiple understandings and perspectives from family members and is complementary to the social constructionist position underpinning this research. Furthermore, a social constructionist philosophy underpins the psychology service in which the research is

taking place, further justifying the use of this framework. FDA's epistemological stance, in keeping with social constructionism, proposes that the text from transcribed interviews is an illustration of available discursive resources to participants. IPR does not have a specific epistemological position and it is flexible to complement the social constructionist philosophy of this research.

Design

Family therapists were asked to watch a DVD of a family therapy session that they had led as a primary therapist in the room with the family. All family therapy sessions were routinely recorded as part of the service's approach, and producing a DVD was not an extra process as a result of the study. An instruction sheet was provided beforehand (see appendix 5) to guide the participants through the process of watching the DVD. They were asked to look out for segments of the DVD that were relevant to the discussion of their curiosity and to note the time references of these points. Ideas to look out for in relation to curiosity were suggested on the instruction sheet, but it was emphasised that the participants were free to consider any aspect of their curiosity that they felt was interesting or relevant.

After therapists had watched the DVD, individual IPR interviews took place. I explained that I was aiming for the interview to be a collaborative process for the exploration of curiosity. I asked the therapists to guide me to points on the DVD relevant to the discussion of curiosity. We shared the remote control to stop the DVD at interesting points for discussion. The IPR interviews were audio recorded. I aimed for the time gap between the family therapy session and the IPR interviews to be as small as possible to aid the therapists' memory of the session. It ranged from between four hours and two weeks. The time gap between the therapist watching the DVD and the interview varied between 10 minutes and one week.

Participants and the research site

Following gaining ethical approval from a local ethics board (see appendix 6), family therapists and family members were recruited from a primary care psychology service in

the Midlands region (see appendix 7-14 for information sheets and consent forms used). The service offers individual, couple and family sessions. Five family therapists participated, of which four were clinical psychologists and one was a trainee clinical psychologist. Four described their ethnicity as White British and one as Mixed Race. In terms of training, each participant had the equivalent to an introductory course in systemic family therapy, or had completed/were completing a diploma in systemic family therapy/masters in systemic psychotherapy. Four couples and one family participated. Three of the couples' and the family's ethnicity was documented in their file as "White British" and one couple's was documented as "White Other".

The Family Therapy team

A Reflecting Team approach (Andersen, 1987) is used in family and couple therapy at the research site. Between one and two primary therapists are in the room with the couple or family, leading the therapy conversations. There is a one way screen, behind which the Reflecting Team is situated consisting of usually two team members. At times the Reflecting Team will join the couple or family in the room to share their reflections with each other, while the family and primary therapists listen. Other models under the systemic family therapy umbrella are also implemented within the Reflecting Team approach by therapists in this service.

Reflexive statement

Woolgar (1988) developed the term reflexivity, recognising that research takes place in an influential context. Harding (1991) also advocates for researchers to bring their assumptions into the foreground to enhance scientific objectivity. Therefore I recognise that I subjectively influence the process of data collection, analysis and interpretation and to enhance the validity of the research, I have stated the following reflexive comments to help the reader understand the research study in context. I value therapies in the social constructionist realm including Narrative therapy, although I also use and appreciate other therapies including Cognitive Behavioural Therapy. I have a particular interest in the principle of curiosity and I have my own preconceptions about it formed through reading literature about it and my own clinical practice as a trainee clinical psychologist.

My initial interpretation of curiosity at the start of the interviews was in relation to avoiding assumptions when working with clients and asking them questions without holding particular answers in mind. Through the interview period, I heard different perspectives about curiosity that shaped and enriched my own interpretation. During the interview period participants became colleagues, as we were employed by the same NHS trust and I was on a six month placement situated in the same building as them. This professional familiarity would have undoubtedly influenced the nature of the interview conversations. The family therapists participating were colleagues, who were in family therapy teams together and supervised each other. Therefore, it is likely that there were shared discourses available to them about the principle of curiosity.

Steps for data analysis

The interviews were anonymised and transcribed verbatim (see appendix 15 for transcription codes). The following FDA process encompasses ideas and steps described by Willott and Griffin (1997) and Willig (2008):

1. The text from the interview transcripts was split into chunks. A new chunk was signified by a change in topic by the participant or an interjection by the interviewer.
2. Discursive constructions referring implicitly or explicitly to curiosity were underlined.
3. Discursive constructions were grouped into themes and labelled.
4. Chunks of text under the same theme name were grouped.
5. Similarities and differences in how the theme is discussed were identified and labelled on postcards as "type 1", "2", "3" etc. with summaries of corresponding discursive constructions.
6. The postcards labelled type 1, 2, 3 etc. were laid out. Coloured string was used connecting type 1, 2, 3, etc. to illustrate similarities, contradictions, main categories and sub-categories.
7. The positioning of therapists and clients and implications for subjective experience was analysed for type 1, 2, 3 etc. of each theme.
8. Discourses were developed for type 1, 2, 3 etc. of each theme until a saturation point was reached and no more discourses could be generated.

9. The patterns of discourse discussed in this study either occurred frequently or pervasively or with relevance to the understanding and clinical practice of curiosity.
10. Conflicts within the discourses were analysed to learn about their implications.
11. My academic and clinical supervisor read sections of transcripts and provided their interpretations at regular steps through the data analysis process.

Results and analysis

Initially, the three discursive patterns drawn out from the interview data will be descriptively described. The following section focuses on analysing the conflicts and paradoxes within the patterns. The discursive patterns are depicted in the tables below with illustrative quotes from participating family therapists. The first two patterns are “commitment to the systemic model: curiosity is ‘led by the theory’” (see table 2) and “curiosity requires skill from the therapist: ‘quite a skilful thing’” (see table 3). These patterns are comprised of a number of subordinate constructions also listed in the tables, along with how many interviews they occurred in. For example, “Being curious is guided by ‘theory’ 5/5” is demonstrating that this subordinate construction occurred in five out of five interviews. In order to concisely illustrate the subordinate constructions, some quotes in the tables are used to demonstrate a number of them. Quotes in table 4 illustrate the pattern “curiosity is a personal quality: ‘naturally curious’” and this discourse occurred in five out of five interviews indicated by 5/5. Due to the complex pervasive nature of discourse, the subordinate constructions are often interlinked. In addition, there may be elements of the discourses expressed across quotes in the tables.

Description of discursive patterns

Table 2

Commitment to the systemic model: curiosity is “led by the theory”

Subordinate constructions and number of interviews featured in	Illustrative extracts from the interview data
<p>Being curious is guided by “theory” 5/5</p> <p>The model allows “flexibility” 2/5</p>	<p>Extract 1: D10</p> <p>I think this sparks my interest because I think it’s going to be helpful and (.) um you know there’s that kind of distinction between er or I suppose a continuum between whether you can (.) whether things have to be um quite set so that you can um you know like a framework that you can work within (.) some people um feel that that kind of restricts you and then you can’t be creative kind of within it but this is I think a way that you can get both cos that (.) the theory kind of holds me there and enables me to kind of go off because I know why that’s happening and it gives it a a framework</p>
<p>Being curious means valuing “multiple perspectives” 3/5</p> <p>Being curious means actively hypothesising 4/5</p>	<p>Extract 2: B2 & B4</p> <p>but curiosity means that you can always hopefully hold more of the multiverse than you would if you if you just kind of settled on one hypothesis [cut] I guess a a multiverse of ideas so any idea that is helpful and morally acceptable can be of equal value and er it stops I suppose multiverse rather than universe so universe might be being as we say married to your own hypothesis so (.) you might not hear or be aware of things that that actually coming up that that don’t quite fit</p>
<p>Being curious means managing “assumptions” 5/5</p>	<p>Extract 3: A132</p> <p>my hope would be that it actually showed them that I was genuinely interested (.) in them and their experience (.) rather than assuming that their experience just fitted into a box you know (.) this is what it feels like to have had bad news</p>

<p>It is important to be curious about the clients' "relationship" 5/5</p>	<p>Extract 4: A65</p> <p>it was something I was very curious about which is was thinking with them about (.) how they talk about things as a couple (.) how they communicate with each other and what it is that they do differently when they come here for their therapy sessions</p>
<p>"Client as the expert" 3/5</p>	<p>Extract 5: C24</p> <p>I think they genuinely believe that we are interested in what what you know the kind of whole ethos of you know them being the experts in their lives (.) um I think when you first meet people it can particularly feel a bit strange and not even wanted sometimes it's like no no no just tell us what to do (.) but I think they really get that</p>

In discussing curiosity, participants frequently took up positions which demonstrated their relationship and commitment to the systemic model, through the use of language linked to theory. Two participants constructed the model as providing flexibility for the therapist to use curiosity in the therapy room, so that the model provides a guide, without being restrictive. This idea was expressed by the two participants with the most training in the field. Valuing multiple perspectives, another systemic concept was also spoken about when exploring curiosity, in three out of five interviews. This represents the therapist valuing different ideas to understand an issue and valuing the points of view from different clients in a system. The systemic guideline of hypothesising was spoken about by four participants to express their understanding of curiosity. The need for tentative hypotheses, and the need to be curious about multiple hypotheses was discussed. In relation to curiosity, all five participants spoke about the importance of managing their assumptions, which was a particularly pervasive and recurrent construction in the data. They described the importance of not assuming they know how clients might have experienced events, as illustrated by extract 3, or assume that they know the answer clients will give to questions. Another very recurrent and pervasive construction was the need to be curious about relationships between clients, which is the remit of the systemic sessions. Three of the interviewees demonstrated their commitment to the systemic model, drawing on its principle of the client being the expert. They talked

about being curious about clients' ideas and knowledge and also trusting clients to come up with solutions.

Table 3
Curiosity requires skill from the therapist: "quite a skilful thing"

Subordinate constructions and number of interviews featured in	Illustrative extracts from the interview data
<p>Curiosity requires "meta" processing 5/5</p> <p>Curiosity is "a challenge" for therapists 5/5</p> <p>It is important for curiosity to not be negatively received by clients 4/5</p>	<p>Extract 6: A160 & 164</p> <p>and the language isn't always terribly easy to follow and I'm not sure if that's because it's a second language to them [cut] um but I also find myself working quite hard in the sessions just to follow what they're saying (.) and to check out that I've understood (.) um and I think that can sometimes get in the way (.) um and having to be curious about have I got this right (.) rather than being curious about the the next step um (.) so I think I think there were several things going on for me then about have I understood have I followed you (.) how can I ask without offending (.) and what exactly is it I'm wanting to ask you anyway</p>
<p>Being curious is "strategic" 5/5</p>	<p>Extract 7: E24</p> <p>I suppose it it's where I'm more present (.) as a person (.) and interested from my own perspective as a person as a therapist in the room with the family (.) as opposed to someone with knowledge and and doing a strategic kind of (.) it's a different position (.) the two feel like it's coming from a different position really one as a person in the room another one as a kind of (.) um not expert but a kind of someone with I know how to (.) um I know what I need to ask and what questions are going to get you thinking</p>

<p>Flexibility is important to attend to what is required therapeutically 5/5</p> <p>Curiosity is not always “appropriate” 5/5</p> <p>The therapist needs to manage the dance between therapist “intention” and client “agenda” 5/5</p>	<p>Extract 8: A73</p> <p>as a therapist at that point I thought what was required was empathy (.) and listening to the story of what they’d just been through (.) rather than chipping away at trying to be curious</p>
<p>Curiosity is sometimes about “holding back” 2/5</p>	<p>Extract 9: B7</p> <p>sometimes curiosity isn’t helpful and (.) sometimes curiosity means actually not (.) necessarily voicing a curiosity but actually shutting up and allowing and being curious about what they’re gonna to say rather than (.) actually mining you know</p>
<p>Curiosity requires “risk” taking 3/5</p>	<p>Extract 10: D73</p> <p>it’s a risk I think in that situation to follow that curiosity because he could have said yeah you know it’s a right pain to have to take her to her friend’s um but but I asked it anyway cos I though it was important and I was curious about it and it worked out ok cos he said no it’s fine you know as long as I don’t have to come in which is (.) fair enough really</p>

Curiosity is also constructed in the therapists’ talk as skilful, another prevailing discourse, which is more often implied than explicitly stated. The skill of meta-processing is a recurrent and persistent construction occurring in all five participants’ talk, in relation to curiosity. It refers to carrying out multiple mental tasks simultaneously when working with clients. Another common construction discussed by all participants is that curiosity can be challenging for the therapist; for example, in relation to meta-processing, trying to engender curiosity in clients, keeping the focus of the session on the remit of the clients’ relationship and the demands of wanting to ask the right curious questions to help the

family as much as possible. If curiosity is constructed as challenging, this implies that skill from the therapist is required to handle the demands that arise.

Four of the participants' talk expressed the importance of their curiosity not being negatively received by clients, commenting that curiosity could be experienced as blame, criticism or as disrespecting. It is implied that skill is required to ensure that curiosity does not have this negative impact. Curiosity was constructed by all participants as strategic, understood as a functional mechanism to help the session be therapeutic, implying the need for skill. Another prominent construction discussed by all interviewees is the need to be flexible to what is required therapeutically, which might be to attend to what the client is signalling they need from the therapist. For example empathy instead of curious questions as highlighted in extract 8. This quote also depicts how therapists constructed curiosity as not appropriate at all times with clients during therapy, articulated by all five participants.

The "dance between therapist intention and client agenda" represents talk about how the therapist may have their ideas about where it would be helpful for the session to go related to their curiosities, and clients might have their ideas about what direction they wish the discussion to go. The therapists talk implicitly constructs the need to manage the dance between these, and facilitate the focus of the session so that it is therapeutic. Extract 8 illustrates this point and describes the therapist putting her curious questioning aside to attend to what the client appears to need from the therapist. It seems that tuning into what is required from clients requires skill from the therapist. Although only two therapists constructed curiosity as holding back from asking questions to let clients speak, this is thought to be useful to the understanding of curiosity.

Curiosity was understood as requiring "risk" taking, implying the need for skill in three interviews. Although this was not a pervasive construction, it illuminated a helpful understanding of curiosity. Extract 10 refers to the therapist taking a risk when working with a couple, in which the wife appears to feel a burden for relying on her husband to drive her to see her friend. The therapist describes taking a risk in following up on her

curiosity about whether it is actually a problem for the husband. It is a risk the therapist feels is worth taking, as he expresses that it is not a problem, as long as he doesn't have to go in and talk with them both.

Table 4
Curiosity is a personal quality: "naturally curious" 5/5

Illustrative extracts from the interview data
<p>Extract 11: C10</p> <p>you haven't seen a client or clients for four to six weeks so you're kind of naturally curious about what's being going on</p>
<p>Extract 12: B4</p> <p>I think I'm just naturally nosy anyway so you know that helps (.) it's not too much of an effort to maintain a curiosity</p>
<p>Extract 13: E2</p> <p>a quality of wanting to know what an experience is like for a person (.) wanting to know what makes them tick how (.) patterns work in their family (.) um what's important to them (.) and I think without that I think it's very important for us to have that (.) and for us to reflect on when we're not having that and think why</p>

A discourse was also drawn upon by participants to understand curiosity as something naturally inherent in a person. This was expressed explicitly and implicitly in all five interviews, although it was not as recurrent as the other two main discursive patterns identified. It has been focussed on as it demonstrates a contrast, helping to illustrate a variety of patterns from the data. Constructions comprising this pattern include curiosity as linked to being naturally nosy, a desire for the therapist to be connected with clients, spontaneous curiosity that happens in the moment in therapy by surprise, and having a personal interest and investment in what clients have to say.

Conflicts and paradoxes within the data

This section identifies and unpacks the conflicts and paradoxes within the discursive patterns identified. New constructions are included to depict further conflicts. How the discourses position therapists and clients is also explored, alongside implications for their subjective experience.

The model allows “flexibility”

But... the model is rigid

Although there was some talk about how the systemic model facilitates a flexible way to work with clients, there was one illuminating example in the text that appears to draw on an assumption that the model's principles are actually quite rigid.

Extract 14: B74

Therapist B: that's quite interesting me saying why because (.) systemically you **you never ask why** (.) well you don't tend to ask (.) solely that you you put it in I don't know a more kind of relational context or () ask a more circular question but at that point I just say (.) why and I (.) I kind of checked it out beforehand and I thought I wanna say why shall I say why yeah I'll say why huh (.) um I thought it fitted into the pattern that we'd been talking about and (.) I just allowed myself

The therapist describes how she broke a seemingly important rule of the systemic model, emphasised by humorously whispering “you never ask why” in a serious tone. The way she whispers this phrase suggests that the systemic model is powerful and inflexible, as she mimics a threatening tone to suggest the importance of never asking such a question. However, the therapist appears to feel comfortable in breaking this perceived rule as it still seems potentially therapeutic and overall, still in keeping with the model's principles. From the extract, the therapist appears to be in a skilful position enabling her to know that it is non-problematic to break the systemic rules and ask “why”. This may be symbolic of the therapist's established experience in this model.

Thus, the systemic model may be constructed as influential and rigid. When constructed in terms of skill and flexibility however, the model appears to allow increased freedom. It is possible that this more flexible representation of systemic working can only be accessed by therapists who can establish that experience and expertise in the eyes of others.

Curiosity is terminology: "terminology could be a bit distancing"

The word curiosity was constructed as "terminology" by one interviewee who was a trainee clinical psychologist. Although this occurred in only one interview, it provides a clinically relevant contrast to the other interviews which did not overtly discuss curiosity in this light.

Extract 15: E4-E8

- Therapist E: but the terminology I don't know it's almost I wonder if it's a bit disrespectful if it's not used correctly
- Interviewer: and how might that terminology not be used correctly could you give me an example of what you're thinking
- Therapist E: well I suppose if a therapist says oh I'm curious about (.) to a client who's described some experience they've had (.) I don't know they might be thinking I'm telling you how hard things are and you're curious you're curious (.) you know it's very well for you being curious
- Interviewer: so it might be received in that way
- Therapist E: I do wonder whether for some (.) or some circumstances

The interviewee expresses that the word "curiosity" could be a form of terminology and suggests that it could be distancing to clients when used in the wrong circumstances. As a trainee, she may have a useful outside perspective, identifying words as terminology that may feel less so following systemic training, which may normalise frequently used terms. The word curiosity, although used in talk outside of the realm of family therapy, may be experienced as distancing and disempowering to some clients if it is used in the wrong context or if it is not a word they regularly use. Alternatively, the word curiosity may be experienced as an accessible term, helping clients to engage with therapists and feel the therapy is worthwhile. Interestingly, the word "curiosity" was not actually used by the therapists when conversing with clients in any of the therapy DVD extracts used in the IPR interviews (which were transcribed for a future study). This suggests that curiosity can be put into practice or expressed without use the use of the systemic term "curiosity".

The extract may tap into the pattern of discourse of “curiosity requires skill from the therapist”, which includes the idea that “curiosity is not always appropriate”. Therapist E appears concerned that if a client is sharing a painful experience, curious questions from the therapist would be inappropriate to their needs. Extract 8 neatly illustrates this hypothetical possibility, when it actually occurred in the therapy session with therapist A. She describes tuning into the need for empathy with the couple she is working with, instead of curious questions.

To summarise, these extracts demonstrate constructions that position the therapist as needing to be very sensitive to the requirements of clients when they are distressed. They convey that using curiosity inappropriately might lead to clients disengaging, and to be aware of using terminology that might compound this.

*The therapist needs to manage the dance between therapist “intention” and client “agenda”
But...curiosity may be disempowering for the client if the direction of the session is controlled too much by the therapist*

A possible conflict in constructions made by participants is between descriptions of the need for therapists to facilitate the dance between therapist intention and the client agenda, and the need to not disempower clients by controlling the focus of the sessions too much. The excerpt below demonstrates this point.

Extract 16: D78

Therapist D: um she does listen and er tries to answer the question but she has lots of her own questions and lots of her own um ideas and thoughts that um (.) that she’s rushing to get to get onto (.) so it’s quite hard to keep her it feels sometimes you know quite **punitive** to keep coming back to something er when she’s wanting to move on

The therapist describes the challenge of wanting to explore a topic with the client, but that the client appears to have a different agenda. As the client does not seem to want to focus on the therapist’s topic interest, the therapist describes her action of repeatedly bringing the client back to what she is interested in as feeling “punitive”. This is a strong word associated with the action of control and disciplining. The talk positions the therapist as

working hard not to be punitive, but at the same time, trying to facilitate the focus of the session so that it is beneficial.

Competing constructions are expressed about what effective therapy is, which appears to lead to a perceived threat to the therapist's identity. Pursuing a potentially fruitful curiosity leads to feeling punitive, which is contradictory to the therapist's intention, which illustrates some of the dilemmas posed to family therapists in their work. The use of discursive patterns linked to skill and flexibility contribute to understanding how therapists express tackling these dilemmas.

Commitment to the systemic model: curiosity is "led by the theory"

But...client "agenda" may not be what the model offers

There was evidence in the data suggesting that clients' agendas did not always match the remit of the systemic model of which therapists illustrated a commitment to. Extract 5 suggests this conflict through discussing clients who want the therapist to tell them what they need to do. The quote below, following on from themes in Extract 16, is referring to how the client Pauline had noticed improvements in her life. The therapist was curious about her agency in that, but Pauline does not appear interested in spending time discussing this.

Extract 17: D98 & D102-D106

Therapist D: I'm wanting to come back to it but she's not obviously so and I've put that I feel frustrated [cut]

Therapist D: I think she grasps the nagging thing and then she she's saying yes she's agreeing with me yes there is less (.) um but there's a but there (.) but this still happens so um and I wonder about whether that (.) is something about her idea about what you bring to therapy and what kind of conversations you have and (.)

Interviewer: in terms of you bring

Therapist D: what's still not going (.)

Interviewer: ()

Therapist D: yeah yeah and there's more to learn from that than there is from what's going well

It seems that the therapist is using principles from the model to focus on exceptions to the problem and "what's going well" in Pauline's life, which is that the "nagging" has

reduced. However, the therapist suggests that Pauline might feel it is more useful to explore what is not going well in her life. Maybe the systemic approach does not feel familiar or comfortable enough for Pauline who is possibly drawing from a medical discourse, focussing on negative symptoms in the therapy session. This excerpt illustrates that the Pauline is able to have agency in the sessions to decide what she does and doesn't want to talk about.

In summary, there is a conflict in agendas between the systemic model's assumptions and the client's. This raises questions about the suitability of clients for systemic therapy if over time, they continue to have persistently contrasting views about what is helpful to discuss compared with the model's core principles. It may be that the therapy can still be productive, or it may be too poor a fit to be beneficial.

"Client as the expert"

But...curiosity requires skill from the therapist: "quite a skilful thing"

There is a contrast in the data between how the client is constructed as the expert, but how curiosity is constructed as requiring skill from the therapist. It can be argued that if the therapist is constructed as skilful, this may be linked to expertise; therefore is the client or the therapist the expert? In the excerpt below, the therapist is discussing the "skilful" meta-process of being curious with clients about interactions in the "here and now" in therapy.

Extract 18: A222

Therapist A: I've seen other people do it do it very effectively (.) but I think it's quite a skilful thing to be able to do um (.) to kind of notice it you know (.) clock it understand it enough to ask a ques a helpful question (.) um to get people to reflect on on what's happening

Here, therapists who are able to use curiosity in this manner are positioned by the interviewee as skilful, which may be associated with placing them in a potentially influential position. This skilful position may be respected by clients who value their skills to help them and clients may be positioned as less powerful and dependent on the therapists skills to help them with their problems. Alternatively, seeing the therapists as

very skilful may be distancing to clients who may not feel able to relate to them. In contrast, the extract below emphasises the role of clients as experts in the therapy process, in keeping with the pattern of discourse linked to therapists being committed to principles of the systemic model.

Extract 19: B120

Therapist B: I think I'm I'm throwing it out to them I'm hoping that they (.) can come up with an answer because I haven't got one for them really (.) so I'm I'm I really am trusting them to sort it out

Valuing the clients' knowledge and problem solving abilities might position the client in a more powerful position, rather than being directed by the therapist towards what they need to do to help with their difficulties. Alternatively though, if clients are coming to therapy expecting the therapist to tell them what will help, they may feel their ideas about what will help are not valued. This could lead to them feeling less in control with this approach, which could feel unsettling for them, as inferred by extract 5. One participant constructed therapists as having "expertise" which was "in the process rather than the content" suggesting that the skill of therapists is in managing the process of interactions and possibly facilitating the expertise of clients. Therefore the constructions of "client as the expert" and "curiosity requires skill" may also be complementary.

To sum up, "curiosity requires skill" may position the therapist as having expertise, appearing to contradict the construction of "client as the expert". However, if the therapist's skill is constructed as facilitating the therapy process, this helps these two constructions to be harmonious. The talk demonstrates that therapists and clients can each have their different expertise that can work together collaboratively and therapeutically in the right conditions.

"You always remain curious"

But...curiosity is not always "appropriate"

A contrast arose in the talk about curiosity not always being appropriate in therapy and opposing talk drawing on assumptions that curiosity is necessary in therapy all the time.

In the following extract, the therapist discusses how the IPR process illuminated curiosity in a different way to her, in relation to how much it should be used.

Extract 20: B70

Therapist B: when you set out on something like this you think oo I hope I'm gonna be curious enough you know what will [interviewer's name] think if I haven't been curious at all and oh my god and I have to remember to be curious and then (.) when you look watching you notice that actually your your curiosity is being very targeted and you're holding back quite a lot of the time

The assumption the therapist utilised about being curious all the time may link into the discourse pattern about being committed to implementing the systemic model, which values curiosity. This suggests that the model holds power to shape and guide the therapists' ideas about therapy and hints that there may be pressure on therapists to follow principles of the model, otherwise they will be negatively judged. Therapists' sense of identity may also be comprised of being a systemic therapist, feeding into their commitment.

To summarise, there was evidence of curiosity constructed as necessary all the time, reflecting commitment to the model. Following participating in the IPR research and analysing their practice, curiosity was also constructed as "not always appropriate", which seemed to surprise some of the participants. These constructions suggest that therapeutic actions sometimes take place outside of the therapist's awareness. This finding has implications for using IPR as a possible supervision tool, to raise awareness of and enhance clinical practice.

Being curious is "strategic"

But...being curious is a personal quality

Another contrast that occurred in the patterns of data was between curiosity constructed as strategic and constructed as a natural personal quality. The extract below provides evidence for this difference.

Extract 21: E20

Therapist E: I suppose something else that came out for me was (.) I've got this feeling that I could have a curiosity which is strategic or a curiosity which was genuine an interest that was genuine knowing what it's like for the person (.) and as I I reflect back over the session sometimes I ask things which I think is **clever to know**

When curiosity is constructed as strategic, therapist E explains that this is related to asking things that are "clever to know", positioning the therapist as knowledgeable, educated and powerful and the clients as less educated knowledgeable and powerful. When curiosity is constructed as a natural quality and desire, this conjures up an image of the therapist having more of a personal investment in the wellbeing of his/her clients, with more of an egalitarian relationship between them.

The extract below conveys how curiosity as a personal quality and curiosity as strategic are not separate, as suggested in Extract 20, but intertwined.

Extract 22: D4

Therapist D: the theory leads me to want to firm up that thing that she's said and for her to understand how that process has happened and her own agency in that so that's what leads me to be curious about it but I really don't know what she's gonna have to say (.) so I'm **fascinated** actually

The therapist is using curiosity, guided by principles of the model, positioning her as knowledgeable. She describes feeling fascinated, which is a strong natural feeling of wanting to know, also positioning her as having a personal investment in the answer and the client. This raises interesting questions about the nature of the varying identities of different therapists in relation to their use of curiosity and how that influences client experience. Being committed to the model's principles and also using natural human qualities have been constructed as being quite separate and also overlapping in a corresponding manner.

Discussion

From the data, three main discursive patterns have been drawn out and examined.

Curiosity was constructed in terms of commitment to the systemic model, requiring skill from the therapist and being a personal quality. There were conflicts within these patterns which highlighted implications for the positioning of clients and therapists, alongside their subjective experience. A common dilemma for therapists was balancing the remit of the therapeutic approach and the client's agenda. The clinical and political implications of the findings, reflexive comments, critical evaluation and ideas for future research will now be explored.

Clinical implications

In Western society, the medical model is dominant in all forms of health care including mental health services (e.g. Colombo, Bendelo, Fulford & Williams, 2003). Thus, it is understandable that clients may come to psychological therapy and focus on what is wrong with them, rather than what they feel is going well, as depicted by the results. Their assumptions of what is discussed in psychological therapy may be accessed from discourses linked to the medical model which focuses on treating negative symptoms. As the systemic model may feel very different to clients, "scaffolding" (Bruner, 1978) from the theory of the Zone of Proximal Development (Vygotski,1978) may help to engage clients. Scaffolding aims to help an individual to gradually build their knowledge and skills within their accessible repertoire. Scaffolding can be applied to help clients gradually become more familiar and comfortable with the systemic approach. If systemic therapy continues to feel to alien and inaccessible for clients, it may be appropriate to sign post them to a more appropriate service.

Cecchin (1987) promotes a curious stance in family therapy, although he does not explicitly suggest that therapists should or should not be curious all the time. As the results have demonstrated a discourse about curiosity being linked to skill, and knowing when and where to target curiosity, this has enhanced an understanding of how to practice it. Curiosity has also not been directly discussed in the literature in terms of it

being a natural personal quality. This finding raises the question of whether it is possible for therapists to easily cultivate curiosity in themselves, as the construction of curiosity as a natural personal quality suggests that you either possess it or you do not. Participants constructed curiosity as managing assumptions, which links to ideas from Cecchin et al. (1994) who write about prejudice, which they define as ideas, biases, assumptions, feelings and models of understanding. They consider it important for therapists to reflect on their prejudices and how these affect therapeutic interactions, and an account is provided of how to manage prejudices. The authors theorise that it is acceptable for therapists to have prejudices as long as they are flexible to change, and other ideas in the therapy room are given equal value.

Participants' talk constructed the need to be flexible to clients' needs, which sometimes meant not being curious and instead, attending to the need for empathy. Further to Wilkinson's (1992) and Flaskas' (2004) discussion of empathy and curiosity, Perry (1993) provides a detailed account of the essential role of empathy in family therapy. He states that families can become confused or frustrated if systemic techniques are applied in the absence of empathy from the therapist. He claims that in systemic work, empathy may be used in the context of relationships, family stories and themes rather than towards understanding an individual's internal experience.

Burnham (1992) provides a framework named Approach- Method- Technique so that systemic therapy can be practiced in a non "restrictive" and "creative" manner. John Burnham delivers systemic training to therapists in the district of the research setting and it is interesting that two of the most experienced therapists describe systemic therapy as providing a flexible framework and one of the therapists said it allows "creativity". It may be that ideas from local training contribute to a part of a discourse about the systemic model and its flexible nature that facilitates creativity. Using a model that enables flexible creative working may allow therapy to feel more rewarding for therapists and clients, as the therapist's judgement and problem solving skills are being utilised and it is possible to shape the therapy to client need.

Curiosity was constructed by one participant as terminology, which draws attention to work by Anderson and Goolishian (1988). They propose that for new therapeutic narratives to emerge, therapists must understand and use the client's language, as it represents a metaphor for their experience. Thus, if the word curiosity is in the client's vocabulary, then it makes theoretical sense for the therapist to also make use of this term, and to avoid the word curiosity if it is not meaningful to the client. One participating therapist constructed the therapist's expertise in managing the process not the content of sessions. Weingarten (1998), Anderson and Goolishian, (1992) and Duncan and Miller (2000) theorise about this point, suggesting the therapist's expertise is in facilitating the therapeutic conversation, incorporating the client's resources and priorities. As the analysis demonstrates that therapists are in a position of elevated power and influence at times, a review (Perryer 2011) provides relevant information for therapists to facilitate a more egalitarian relationship with clients. This aims to improve the quality of the therapy through helping clients feel more in control of the process.

Political implications

The primary care service in which the research took place was under threat and being reorganised during the research period. This may have contributed to the large proportion of the interview talk covering principles of the systemic model. Although there is growing empirical evidence to justify the use of systemic therapy (Jones & Asen, 2000; Stratton, 2010), the evidence base of Cognitive Behavioural Therapy (CBT) (e.g. Norton & Philipp, 2008; Okajima, Komada & Inoue, 2011) is more extensive. This may be because in CBT, it is more straightforward to measure therapeutic outcomes, in protocol driven research, compared with systemic approaches. CBT is also more dominantly promoted in recommendations from the National Institute of Clinical Excellence (NICE), an organisation that provides guidelines for the NHS. Therefore therapists participating may have feared a change in the systemic ethos of the service due to political pressures taking into account NICE recommendations. The interviews may have been used to promote the systemic approach in light of the threats to its continued predominant use in the service.

Reflexive comments, critical evaluation and future research

As a trainee clinical psychologist myself, I may have aligned more with the trainee participant's comments, although I hope that an even representation of quotes and analysis has been included from all participants' data. As my literature review is examining power and family therapy, I formed opinions about the nature of power relations between clients and therapist which may have made me more likely to analyse the therapist as being in a powerful position in this study's FDA. Another possible limitation is that therapists were aware that they were going to be interviewed about curiosity, so they may have been primed when they carried out the therapy session, influencing their use of curiosity, affecting the validity of the data. Participants were asked if they felt this could have had an effect and they all responded saying that once they were in the therapy session, their full focus was on the clients and not on the goal of the research, suggesting it had minimal influence. It can also be argued that a limitation of FDA is that it sees people as positioned by discourses in society and it does not believe that people have agency in using language and discourses to achieve goals, which may undermine people's abilities.

As illuminated in the introduction, there is a large gap in empirical research into curiosity, and this also applies to the family therapy sphere in general. Thus, further research is imperative to provide evidence to develop the effectiveness of this approach and justify its use, given the political threats to its continued role in the NHS. As participants in the current study were all from the same NHS site, it would have been interesting to compare ideas and assumptions about curiosity with other family therapy services, and also services that implement different psychological models. Ethical approval has also been obtained for a further two phases to the study. The next phase is to transcribe and analyse the family therapy sessions used in this study to understand how curiosity is performed by therapists. The following phase is to use IPR to interview couples and families receiving systemic therapy about their experience of curiosity during therapy. As therapists in the current investigation reported finding the IPR process helpful to raise their awareness about how they practiced curiosity, research could also take place into how this method could be used as an effective supervision tool. In

addition, as empathy was found in this study to be an important element in systemic therapy, a point echoed by Perry (1993). Further research is also required to develop understanding of its role in this arena.

Conclusion

In conclusion, this study has provided empirical evidence to support the use of the systemic approach and add to the understanding of how curiosity is constructed and practiced by family therapists. The findings demonstrate how curiosity can be constructed as part of a flexible and creative model of working with clients. Therapists also constructed the need for skill in order to use curiosity sensitively and appropriately, while also attending to the needs and agenda of clients. In addition, curiosity was understood as a natural personal quality. Further empirical research is required in the sphere of systemic therapy to enhance the understanding curiosity and different components to the model, and support its continued valuable use in the NHS.

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Public Domain Briefing

This briefing details a summary of a literature review investigating power and the therapeutic relationship in family therapy. In addition a qualitative interview study investigating the understanding and use of curiosity in family therapy is described. The overall aim was to enhance the knowledge and skills of family therapists in context of reducing power differences in the therapeutic relationship, and also in practicing curiosity. These papers were completed as part of the degree of Doctor of Clinical Psychology at the School of Psychology, University of Birmingham.

Review paper: What can be learnt about power relations in family therapy, to reduce power differences in the therapeutic relationship?

It is argued that family therapists, (alongside all therapists using different approaches) are in a responsible, influential position when working with clients, with elevated power and status. Therefore it is important that therapists reflect on the nature of power relations in the therapeutic relationship. The family therapy literature was surveyed to investigate how power is understood and the ways in which therapists can reduce power differences. No previous literature review was found that specifically focuses on power relations between therapists and clients in family therapy, other than a comparative review of the role of power in three family therapy approaches (Sutherland, 2007). The current review is different as it is not comparative, but draws out common applicable therapeutic practices to help reduce power differences, across a wider range of family therapy approaches previously investigated. From the literature obtained, seven were purely conceptual and five were conceptual with some anecdotal evidence reported from the authors' clinical practice. There was one qualitative study, one quantitative study and one literature review. The literature discussed power in relation to a number of different approaches under the Family Therapy umbrella. Power was defined as occurring in relationships in which people have influence over others. It was also discussed in relation to control, domination, authority, resistance, hierarchy and powerlessness. Therapists were theorised to have superior power and status due to being positioned by cultural, social and political influences. Most of the literature claimed it was possible to reduce, but not fully remove the power inequity between clients and therapists.

Helpful ideas were put forward to try and reduce the power differences present in the therapeutic relationship. Working collaboratively and also valuing the knowledge and expertise of the client with clients were common suggestions to achieve this aim. Helping clients become aware of unhelpful norms in society that are hard to achieve, leading to distress was also proposed. In addition, encouraging client agency which can be understood as helping clients take ownership of working towards their goals, was also suggested. Finally, the literature endorsed the need for therapists to have an awareness of the power imbalance in therapy and to reflect on this in different Clinical Practice Development forums. It was concluded that creative ideas had been asserted that appear to be clinically helpful in undermining the power and status of the therapist, although there is limited evidence to back up claims in the literature. Therefore, further research is required to develop and understand the concepts discussed and justify their use in family therapy.

Research paper: Curious about curiosity in family therapy

Curiosity is a commonly principle used family therapy. It is defined by Cecchin (1987) as a stance that helps the therapist to facilitate uncovering as many different ideas and explanations to help make sense of family relations as possible. The therapist is not searching for a true explanation, but is interested in how they all fit together. If the therapist is too closely committed to their own ideas, this is thought to limit the discovery of new potentially valuable ideas. Despite the widespread use of curiosity in family therapy, there is very limited research investigating this principle. Thus, family therapists were interviewed about how they conceptualise and practice curiosity. The intention was to gain information to improve therapists' understanding of curiosity, to benefit clients receiving family therapy. In the interviews, family therapy DVD recordings were used to prompt ideas and conversations using Interpersonal Process Recall (IPR) (Kagan, 1990). These were sessions in which the participating therapists had been working with couples and families.

Curiosity was understood in relation to therapists having a commitment to the family therapy model, demonstrated by their use of language linked to theory for example "led by the theory". Curiosity was also understood through a collection of ideas and

assumptions, as requiring skill and being “quite a skilful thing”. A contrasting conceptualisation constructed curiosity as a natural personal quality, for example participants described being “naturally curious”. Conflicts in assumptions and ideas within the data were examined to understand some of the implications of curiosity. The family therapy model was discussed as restrictive, but curiosity was also perceived to contribute to flexibility of the model. In addition, a common dilemma arose for therapists when their therapeutic intentions were different to the intentions of the client. This involved one client who did not wish to focus on the positive changes in her life, which the therapist was curious about. There were other examples in which curious questions from therapists had to be put “on the backburner” to attend to the need for empathy. Curiosity was also constructed as necessary all the time and in contrast, as targeted and not always appropriate.

In conclusion, the findings suggest that curiosity contributes to a flexible, potentially rewarding model of therapy. It seems that skill is required to use curiosity sensitively and appropriately, taking into account the changing needs of the client, which may not always correspond with the therapeutic aims of the therapist. Curiosity is also perceived as a natural personal quality, and it is unclear whether therapists simply do or do not possess it, and whether it is possible to cultivate curiosity in themselves. This study has provided evidence to demonstrate the value of curiosity in therapy and furthermore, develop understanding of it for therapists to consider in their family therapy practice.

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Appendix 1

Search Strategy

The PsychINFO database was searched from 1967 to January week 2 2011, the Ovid MEDLINE (R) database was searched from 1948 to January week 1 2011 and the ASSIA database was searched on 14/01/11.

The search strategy is described below:

- A. Keyword search "family therapy"
- B. Keyword search "systemic therapy"
- C. keyword search "narrative therapy"
- D. Combine A or B or C
- E. Keyword search "power"
- F. Combine searches D and E

Results= 953 references

- 931 references were excluded as their key focus were not power issues between therapists and clients in family therapy
- 5 references in which feminism was a primary focus were excluded, as examining this number of articles could be a literature review in itself
- 3 references were removed for focusing on a specific diagnosis
- 1 reference was excluded for being in a language other than English

= 13 left

2 articles were added from examining the reference lists of the articles included from the search

=15 references in total

Appendix 2

A comparison of a therapy of certainty versus a therapy of curiosity (Amundson et al., 1993)

A therapy of Certainty	A therapy of Curiosity
<ul style="list-style-type: none"> • Is uncomfortable with ambiguity; needs to have structure and clarity • Quickly insists in a diagnosis and adheres to descriptions from those diagnoses • Relies on problem-saturated descriptions of client behaviour • Clients who don't "get it" are seen as "resistant" and this resistance must be subverted, broken through etc. • Is concerned with asking and answering "why" questions • Closes space by narrowing observations to one's constructions/predispositions • Assumes that a symptom serves just as a function, or is a restraint, or is a solution • Operates from a first-order perspective and does not consider the therapist-client system • Is concerned with teaching, explaining, disseminating "expert knowledge" • Discounts or overlooks the resources of the client 	<ul style="list-style-type: none"> • Can tolerate confusion and ambiguity without moving to premature closure • Moves more slowly in defining the problem, taking time to consider the experience in the room • Takes care to discover exceptions to the problematic behaviour • When it seems that clients don't "get it" it may be that we haven't asked the kind of questions that will move the therapy forward • Asks circular questions and examines the effects of the problem • Opens space by considering observations from many system levels • Does not assume symptoms to be doing anything in particular and may fit many theoretical explanations • Operates from a second-order perspective, always considering the therapist client system • Asks questions, looks for the special indigenous knowledge of the client • Takes care to discover what strengths are present, seeing even problematic behaviour as a potential resource

Appendix 3

A comparison of a therapy of power versus a therapy of empowerment (Amundson et al., 1993)

A therapy of power	A therapy of empowerment
<ul style="list-style-type: none"> • Will tend to be more hierarchical • May be tempted to act as an agent of social control rather than choice • Seeks to get the client to respond to the therapy • May tend toward rescuing the client, doing for them what they might do for themselves • May inadvertently foster dependence • May use treatment jargon to sell the client “expert knowledge” of the therapist • May frame the client as uncooperative or unaware • Will tend to create a context of passivity • When frustrated, will tend to drift toward less therapeutic variety and resort to “more of the same” • Under the influence of urgency, agency policy, or court mandate, may unilaterally “set goals for the family” 	<ul style="list-style-type: none"> • Will tend to be more collaborative • Carefully considers the consequences of control • Seeks to get the therapy to respond to the client • Sidesteps temptations to rescue clients and instead calls forth special knowledge and competencies of the client • May foster independence, a sense of competence, and self-confidence • Avoids jargon, instead uses the client’s language and metaphors • May frame the client as restrained or oppressed • Will tend to create a context of discovery • When frustrated will tend to drift toward more therapeutic improvisation • Has a cautious eye for tendencies towards urgency, exercising patience and co-constructed definitions of solution

Appendix 4

Questions for therapists to use to reflect on issues of power in therapy (Piper & Treyer, 2010)

1. How does privilege influence your work with clients?
2. What types of privilege do you experience (in relation to gender, race, sexual identity, class, able-ism, culture, etc.)?
3. How might this affect your clinical work?
4. Do you believe you are an agent of social change? Why or why not? Should your agency of social change extend both inside and outside the therapy room? Why or why not?
5. What might make it difficult for you to discuss issues of privilege?
6. Are there issues of oppression that influence your work with clients? What are they?
7. How do you know if you are using your power or privilege in therapy? What type of feedback might you get from clients?
8. If you see another person acting in a powerful or privileged way, what would your response be? What could or should your response be?
9. When one party in therapy is being suppressed based on unequal power allotted to him or her by society, what should the therapist's response be?
10. What type of "isms" are relevant to your life (e.g., racism, classism, sexism, etc.)? How do you respond to these?
11. How would you respond to a client using a racial slur in session?
12. Do you consider yourself to be a feminist? Why or why not?

Appendix 5

Instructions for participants to watch the family therapy DVD

Instructions for watching the DVD to explore curiosity

Task 1

Briefly think about what curiosity means to you before you start watching the DVD.

IMPORTANT- please note the time references for points of interest on the DVD for the tasks below. Then we can easily find them during the interview.

Task 2

Look for around 2-6 occasions that you feel are meaningful regarding **your** curiosity in the session. For example:

- Times you were putting curiosity into practice
- Times you felt particularly curious
- Times you were exploring a curiosity

Ideas for aspects to consider:

- What were your intentions?
- What were your thought processes?
- How did you feel?
- How were the interactions in the room affected?
- How do you know when you have achieved “curiosity”?

Task 3

Look for around 1-3 occasions when **your** curiosity was challenged. This may link into occasions from Task 2, or they may be separate occasions. For example:

- Times you struggled to be curious
- Times you lost curiosity

Ideas for aspects to consider:

- What were your intentions?
- What were your thought processes?
- How did you feel?
- How were the interactions in the room affected?
- Is it possible to know when your curiosity is challenged, and if so, how?

Appendix 7

Participant information sheet for family therapists Version 1 (20/12/09)

PARTICIPANT INFORMATION SHEET- FAMILY THERAPISTS

Title of Project: - Curious about curiosity in systemic family therapy.

Researchers: Liz Perryer (Trainee Clinical Psychologist), Sara Willott (Clinical Psychologist)

We would like to invite you to take part in a research study. It is important that you know why the study is taking place and what it would involve before you decide if you would like to participate. Please read this information carefully.

What is the purpose of this research?

The purpose of the study is to investigate the family therapy principle of “curiosity”. As you will be well aware, this is when family therapists are genuinely interested in each family member’s perspective. The therapist will ask questions without having a particular answer in mind. They will also not be too closely wed to their hypotheses, recognising that there are multiple explanations. The aim of curiosity is to help the family generate lots of ideas and meanings, to help them move forward with their difficulties. We are interested in what curiosity looks like in practice and challenges to achieving/maintaining curiosity. This study is being conducted as part of a Clinical Psychology Doctorate at The University of Birmingham.

Why have I been invited to take part?

You are being invited to take part as you are a family therapist who practices at [research site] where the research study is taking place. We would welcome your participation to help us learn about the therapeutic principle of curiosity.

Do I have to take part?

No, it is up to you whether or not you choose to take part. Choosing not to participate will not lead to any negative consequences for you.

What will happen to me if I agree to take part?

1. A video recording of a family therapy session that you are involved in will be qualitatively analysed by a researcher to investigate the use of curiosity.
2. You will be asked to watch the same 1 hour video recording of the family therapy session and think about your practice of curiosity in the session. This will take about 1 hour 30 minutes.
3. You will meet with Liz Perryer to be interviewed about the session recorded on the video and your views about curiosity. You will be asked to point Liz towards segments of the video you find relevant to prompt conversations about curiosity. This will last about 1 hour 30 minutes. This interview will be audio recorded.
4. Once the results have been analysed, they will be fed back to all the family therapists who participated, as a group. Then a focus group will be run to generate ideas about what questions to ask families to research their experience of curiosity during family therapy. This will inform the next phase of this study. The duration of this part will be about 1 hour 30 minutes.

What will happen if I do not want to carry on with the study?

If you participate, you are free to withdraw from the study at any time before the results are analysed, without needing to give a reason. This will not lead to any negative consequences for you.

What will happen to the results of the research study?

The results will be written up and submitted for the Clinical Psychology Doctorate. They are also aimed to be published in academic journals. Your name will not appear in any reports or publications. Anonymised quotes from you may feature in reports and publications.

What are the possible disadvantages and benefits of taking part?

You may find participating tiring, therefore breaks will be provided if required. Participating will provide the opportunity to take valuable time to reflect on and improve your practice as a family therapist. You will also help develop knowledge about the practice of family therapy which may benefit families receiving it.

What is there is a problem?

You can direct any concerns about the way the research has been conducted towards the researcher, Liz Perryer on [REDACTED], Sara Willott (Clinical Supervisor) on [REDACTED] or Michael Larkin (Academic Supervisor) on [REDACTED]

What happens now?

If you agreed for Liz Perryer to contact you, she will telephone or email you a few days after meeting. This will be to answer any questions you have and find out if you are interested in taking part in the study. You are also welcome to get in touch with Liz using the contact details below.

Liz Perryer (Researcher and Trainee Clinical Psychologist)

Tel:

Email:

Post: Clinical Psychology, The University of Birmingham, Edgbaston, Birmingham, B15 2TT

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION

Appendix 8

Participant information sheet- adult family members Version 1 (20/12/09)

PARTICIPANT INFORMATION SHEET- FAMILIES

Title of Project: - Curious about curiosity in systemic family therapy.

Researchers: Liz Perryer (Trainee Clinical Psychologist), Sara Willott (Clinical Psychologist)

We would like to invite you to take part in a research study. It is important that you know why the study is taking place and what it would involve before you decide if you would like to participate. Please read this information carefully.

What is the purpose of this research?

The purpose of the study is to investigate the family/couples therapy principle of "curiosity". If a therapist has been curious during a session, if you asked the family/couple whose side the therapist had been on, they would not be able to name a side. Curiosity is when therapists are genuinely interested in each person's perspective. The therapist will ask questions without having a particular answer in mind. The aim of curiosity is to help the family/couple generate lots of ideas and explanations to help them move forward with their difficulties. We are interested in what curiosity looks like in practice and challenges to achieving/maintaining curiosity. This study is being conducted as part of a Clinical Psychology Doctorate at The University of Birmingham.

Why have I been invited to take part?

You are being invited to take part as you are a member of a family/couple receiving therapy at [research site], where the research study is taking place. We would welcome your participation to help us learn about the use of curiosity in therapy.

Do I have to take part?

No, it is up to you whether or not you choose to take part. Choosing not to participate will not lead to any negative consequences for you or affect your therapy in any way.

What will happen to me if I agree to take part?

A video recording of one of your routine therapy sessions will be analysed by a researcher to investigate the therapist's use of curiosity. The researcher will also meet with the therapist that led the session to watch sections of the video together and discuss their use of curiosity during the session. If you would like to take part, you will be asked to sign consent forms. Either your therapist will ask you to sign the consent forms in the session, or you will be asked to send the forms back by post in a stamped addressed envelope. If you have any questions about the research you can ask your therapist or contact Liz Perryer (researcher) using the details over the page.

What will happen if I do not want to carry on with the study?

If you choose to participate, you are free to withdraw from the study at any time before the results are analysed, without needing to give a reason. This will not lead to any negative consequences for you.

What will happen to the results of the research study?

The results will be written up and submitted for the Clinical Psychology Doctorate. They are also aimed to be published in academic journals. Your name will not appear in any

reports or publications. Anonymised quotes from you may feature in reports and publications where any details that may identify you will be changed.

What are the possible disadvantages and benefits of taking part?

You may not want a video of your family therapy session to be watched and analysed for the use of curiosity, as you may feel sensitive about this. There is no direct benefit to you participating, but your involvement will help develop knowledge about the practice of family/couples therapy which may benefit people receiving it in the future.

Ethical Approval

Before any research takes place, it has to be checked by a Research Ethics Committee to check it is fair. This project has been approved by South Birmingham Research Ethics Committee.

What is there is a problem?

You can direct any concerns about the way the study has been conducted towards the researcher, Liz Perryer on, Sara Willott (Clinical Supervisor) on or Michael Larkin (Academic Supervisor) on. If you are still unhappy, you can contact the Patient Advice and Liaison Service on 0800 953 0045, who are not linked with this research.

What happens now?

Your therapist will discuss the research with you during a therapy session. He/she will try and answer any questions you have. If you would like to discuss the research further, your therapist may ask if you agree to be telephoned by Liz Perryer (researcher) who will aim to answer any extra questions. If you would like to take part, you will either be asked to sign consent forms with your therapist or Liz will post them out to you to send back in a stamped addressed envelope. You are also welcome to contact Liz using the details below.

Liz Perryer (Researcher and Trainee Clinical Psychologist)

Tel: [REDACTED] (and leave a message with Joyce, University secretary, for Liz to ring you back)

Email:

Post: Clinical Psychology, The University of Birmingham, Edgbaston, Birmingham, B15 2TT

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION

Appendix 9

Information sheet- child (6-10 year old) Version 1 (20/12/09)

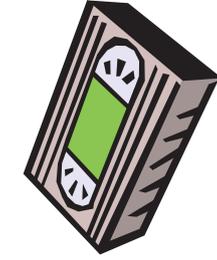
Hello, my name is Liz Perryer. I am a student at the University of Birmingham.

When you and your family came to [research site], you all had family therapy. I would like to know how the family therapist tried to help you.

I am interested in how family therapists use curiosity to help families. If a family therapist has been curious, at the end of a family session, if you asked the family whose side the family therapist was on, the family would say no one's side.

Curiosity is when the therapist is really interested in what each family member has to say. It aims to help the family come up with lots of different ideas about things. Hopefully, these ideas help them to be a happier family.

This project aims to improve family therapy to help families



I would like to watch a video with your therapist of one of your sessions. Then I would like to

to talk to them about how they put curiosity into practice. I will also look at the video by myself to think about curiosity.

What will you have to do?

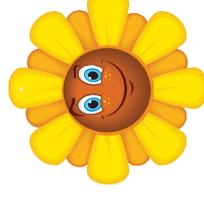
You are being asked if you agree for me and your family therapist to meet. We will look at one of your family therapy videos. We will discuss how your therapist put curiosity into action with you and your family.

Will anyone else know what I say on the video?

I will write up this project for people to read. In this, I may write some of the things you said in the family therapy session. I will change your name so no one will know it was you that said it.

What if I don't want you to meet with my family therapist, look at the video and talk about it together?

You can decide whether you want to help me. This is not something you have to do! If you do not agree to take part, this will not affect your family therapy in any way. All members of your family would need to agree to take part. It is up to you to decide as a family whether this is something you would like to do.



Contact details for parents:

Liz Perryer
Clinical Psychologist in Training

E-mail Liz Perryer on:

Write to:
School of Psychology
University of Birmingham
Edgbaston
Birmingham
B15 2TT



Or
telephone:
(secretary)

For independent advice contact
the Patient Advice and Liaison
Service by telephone:
0800 953 0045

**INFORMATION
LEAFLET**

(for 6-10 years old)

How do family
therapists use
curiosity with
families?



This research is being supervised
by:

Sara Willott
Clinical Psychologist
[research site details]

and

Michael Larkin
Academic supervisor
School of Psychology
University of Birmingham
Edgbaston
Birmingham
B15 2TT

Appendix 10

Information sheet- child (11-16 year old) Version 1 (20/12/09)

I would like to invite you to take part in a research study. My name is Liz Perryer, a student from the University of Birmingham. It is important that you know why the study is taking place and what it would involve, before you decide whether or not to take part. Please read this leaflet carefully. Talk about it with your family, friends or doctor if this would be helpful for you.

What is the study about?

When family therapists work with families, they aim to take a curious approach. If a family therapist has been curious, at the end of a session, if you asked the family whose side the therapist had been on, they would not be able to say a side. Curiosity is when the therapist is genuinely interested in what each family member has to say. They will ask questions without having a particular answer in their mind. The aim of this is to help the family generate lots of different ideas and explanations for things. This hopefully helps them to move forward with their difficulties.



I would like to know how your family therapist used curiosity during one of your family therapy sessions at [research site].

I would like to watch a video with your therapist of one of your sessions and interview them about how they used curiosity. I will also look the video by myself to explore my own ideas about how curiosity was used. This research aims to improve our knowledge about family therapy to help the families receiving it.

What will I have to do?

You are being asked whether you agree to me interviewing your family therapist about their use of curiosity. During the interview, we would be watching a video of one of your family therapy sessions. I would also look at the video alone to analyse the use of curiosity.

Will anyone else know what I say on the video?

I will write up this research in an essay for the University and in articles that may be published. I may quote some of the things you said in the family therapy session. I will

change your name so no one it was you that said it.

What if I don't want to take part?

It is totally up to you whether you would like to participate. This is not something you have to do. If you do not agree to take part, this will not affect your family therapy in any way.

What next if I would like to take part?

Your therapist will talk to you and your family about the study when you meet. You are also welcome to get in touch with me using the contact details over the page if you would like more information about the study.

All members of your family having therapy would need to agree to take part. It is up to you to decide as a family whether this is something you would like to do or not.



If you would all like to be involved, you will be either asked to sign consent forms with your therapist, or I will post them out to you with a stamped addressed envelope for you to send back.

You can change your mind at any point up to when the study is being written up. Again, this will not affect your therapy.

Are there any disadvantages or benefits to taking part?

There are no disadvantages or benefits to yourself in taking part. The information you provide will help improve our knowledge about family therapy to help the families receiving it in the future.

Ethical approval

Before any research takes place, it has to be checked by a Research Ethics Committee to check it is fair. This project has been checked by South Birmingham Research Ethics Committee.

This research is being supervised by:

Sara Willott- Clinical Psychologist
[research site details]

Michael Larkin- Academic supervisor

School of Psychology
University of Birmingham
Edgbaston
Birmingham
B15 2TT

Contact details for further information

Liz Peryer
Clinical Psychologist in Training

E-mail Liz Peryer on:

Write to:

School of Psychology
University of Birmingham
Edgbaston
Birmingham
B15 2TT

Or Telephone:
and leave a
message with
(secretary)



For independent advice contact
the Patient Advice and Liaison
Service by telephone:
0800 953 0045

**INFORMATION
LEAFLET**
(11-16 years old)

Interviewing family
therapists to explore
how they use “curiosity”
with families



Appendix 11

Consent form- family therapists Version 1 (20/12/09)

CONSENT FORM- FAMILY THERAPISTS

Research site:

Participant Identification Number:

Title of Project: - Curious about curiosity in systemic family therapy.

Researcher: Liz Perryer

Please initial box

- 1. I confirm that I have read and understood the information sheet dated 20/12/09 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research process. If I withdraw, I do not have to give a reason and I understand there will be no negative consequences.
- 3. I understand that the research interview and focus group will be audio-recorded
- 4. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.
- 5. I understand that direct quotes from my family therapy session and interview may be published in any write-up of the data, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments.
- 6. I agree to take part in the above study.

.....
Name of participant Date Signature

.....
Name of researcher Date Signature

If you would like to receive a written summary of this research written in layman's terms by post, please complete your address below:

.....
.....
.....
.....

Appendix 13

Consent form- child (6-10 years) Version 1 (20/12/09)

**Agreement form for taking part in the project called:
How do family therapists use curiosity with families?**



I have read the leaflet about the project called- how do family therapists use curiosity with families? I understand it.

I have had the chance to ask questions about the project and these have been answered well enough.

I know I do not have to take part in this project if I do not want to. I can change my mind about taking part. This will not affect my family therapy.

I know that things I say in family therapy may be written up for this project. My name will be changed so no one will know it was me that said it.

I agree to take part in this project.

My Name

Signature

Date

Please fill in your address if you would like to receive a written summary of this study by post:

.....
.....
.....
.....

Appendix14

Consent form- child (11-16 years) Version 1 (20/12/09)

Consent form- Interviewing family therapists to explore how they use “curiosity” with families



- 7. I have understood the information sheet dated 20/12/09 (version 1) for this study. I have had the chance to think about the information, ask questions and had these answered well enough.
- 8. I understand that I do not have to take part if I do not want to. I can change my mind about taking part, at any time up to when the results are being written up. If I change my mind about taking part, I do not have to give a reason. This will not negatively affect my family therapy.
- 9. I understand that quotes from my family therapy session may be written up for this study. My name will be changed so no one will know it was me that said it.
- 10. I agree to take part in this study.

My Name

Signature

Date

If you would like to receive a summary of the results of this study by post, please fill in your address below:

.....
.....
.....

Appendix 15

Transcription symbols

Extracts

Extracts are coded for example “Extract 1: D10”. Extract 1 refers to it being the first illustrative extract in the study. The letter refers to which therapist is being interviewed in the extract. The number after the letter refers to the section of talk taken from the transcript.

Symbols used in extracts

- (.) a pause in the talk
- [cut] a section of talk has been removed
- () inaudible

Words in bold have been highlighted to draw the reader’s attention to them.