



The Multi-epistemological Systemic Therapist: A Qualitative Study

Lennart Lorås¹  and Johan Sundelin²

¹ Western Norway University of Applied Sciences, Bergen Norway

² Sundelin Consulting AB, Lund Sweden

The purpose of this article is to explore how experienced systemic therapists who work in child and adolescent mental health position themselves within epistemology. The article is based on a grounded theory re-analysis of 12 qualitative in-depth interviews with six experienced systemic family therapists and fieldwork observations of the same therapists. The specific research question for this article is: *How do you position yourself as a systemic therapist in child and adolescent mental health care in relation to epistemology?* The analysis identified the overarching finding: *the multi-epistemological therapist*. The experienced systemic therapists' descriptions of their epistemological stance are discussed alongside the context of child and adolescent mental health care and systemic therapy's theory and practice.

Keywords: epistemology, systemic therapy, child and adolescent mental health care, social constructionism, constructivism, critical realism

Key points

- 1 The participants expressed a general scepticism towards all stringent theories that attempt to embrace human complexity.
- 2 The epistemological stance of the participants was identified as multifaceted, consisting of social constructionism, critical realism, and constructivism.
- 3 A future multi-epistemological perspective appears to be a natural extension of the development of systemic therapy.

The so-called epistemology debate accelerated in the field of family therapy in 1982 after the March issue of the magazine *Family Process*. This issue contained several articles that addressed a fundamental criticism of systems theory in the family therapy tradition (Allman, 1982; Dell, 1982; Keeney & Sprenkle, 1982). The main message was that systemic family therapists should take their thoughtful thinking into consideration and, among other things, reassess how they have positioned themselves in relation to epistemology and the concept of power (Wifstad, 1997).

Connected to the epistemology debate, Lynn Hoffman's (1985) article 'Beyond Power and Control' is central and considered one of the milestones of second-order cybernetics in family therapy (Hertz, 2003). The topic of power has held a central position in the history of systemic family therapy for years (Hertz, 2003). Hoffman (1985) claims that power was retained as a core concept of systemic therapy: 'Thinking back, it seems clear that the cold-war years set a pattern that was informed by a fascination with control' (p. 382). Hoffman (1985) argues for a new epistemological paradigm that is characterised by being collaborative rather than hierarchical and that enters the process of a co-created therapy.

Address for correspondence: Lennart Lorås, Associate Professor, Western Norway University of Applied Sciences, Bergen, Norway. lennart.loras@hvl.no

The epistemology debate brings forth a richness of developments in the field of systemic therapy. For instance, narrative practices, the work of Tom Andersen, and collaborative and dialogically oriented therapies. Even though these can't be fully described as versions of social constructionist practices, after the epistemology debate systemic therapies have primarily been described from the perspective of social constructionist theory (Lorås, 2016a, b; Pote et al., 2000). However, in child and adolescent mental health care, the positivistic tradition with an increased focus on diagnosis has continued to grow stronger (Brinkmann, 2014). The number of children and young people diagnosed with a psychiatric condition has also risen drastically over the past 15–20 years (Thomsen, 2015). Currently, diagnosis can be said to be a dominant culture in child and adolescent mental health care, in which so-called objective diagnostic examinations are viewed as representative of 'the Truth' with a capital T (Hertz, 2003).

Systemic therapists have never theoretically been aligned with ideas of linear causality and the focus on diagnoses in the field of child and adolescent mental health care (Hertz, 2003). The systemic idea counterbalances the tendency towards a reliance on bio-psychiatry and pharmacology, which is too easy (Bertrando, 2009). However, the systemic therapist's wish to be 'beyond power' has created a situation in which central areas in the field of mental health, such as diagnosis and to some extent evidence-based approaches, have been left to other analysts (i.e., cognitive therapists) (Hertz, 2003). Instead of adhering to the positivist epistemological stance and the greater focus on research in human sciences, systemic therapists seem to have almost exclusively focused on their own social constructionist theory (Larner, 2015; Lorås, 2016a, b). Systemic therapists seem to have neglected placing themselves in influential positions within the mental health field. Instead, systemic therapists seem to have emphasised a focus on stories and constructions, with a basis in resources and opportunities, without attempting to build bridges between positivism and social constructionism (Hertz, 2003; Lorås, 2016a, b, c).

The increased positivistic epistemological focus in child and adolescent mental health care is considered to be an essential reason for the marginalisation of systemic therapy (Bertrando, 2009; Lorås, 2016a, b). There may be several reasons for this. One reason can be viewed in connection with the inclusion of social constructionist ideas in systemic family therapy of the 1980s (Lorås, 2016a, b) and the *not-knowing position* put forth by Anderson and Goolishian (1988). Therapists working from a social constructionist stance argue that an exact replication of what is 'out there' does not exist; instead, representations are variably mediated according to socially or communally shared meanings through language (Ness, 2011). Social constructionists emphasise that people's beliefs about the world and what constitutes reality are social constructs. A common understanding of reality is developed through an interactive process of negotiation through language (Ness, 2011). However, the social constructionist approach to research is a marginalised position in the current evidence-based discourse, with randomised control studies (RCTs) considered the gold standard for research methodology.

Another reason for marginalisation could be whether systemic therapists' dichotomous operationalisation of social constructionist ideas and the *not-knowing position* has led to an assumed fear of positioning oneself as a knowledge- and research-based systemic therapist in the field of mental health (Rober, 2005). One of the dichotomous operationalisations is how the perspective of the *not-knowing position* has not been sufficiently distinguished between the therapist's ethical position as a respectful

conversational partner and their knowledge about the processes of therapeutic change and other sources of knowledge (i.e., bio-psycho-social models and well-known risk- and protection factors). This has created challenges in dealing with the tensions between social constructionism and realism with flexibility.

However, the marginalised position of systemic therapy cannot simply be explained by the epistemological position taken by these ways of working. This overlooks the political, ideological, and economic forces that drive and support the evidence-based and positivistic-oriented ideology and epistemological positions. From a basis in social constructionist epistemology, systemic therapists are faced with a choice – to either develop their approach within a complex multi-epistemological society and develop tools for a more integrated collaboration within the ‘positivistic and diagnostic culture’ or to work from a marginalised position within their mental health care organisation. Alternatively, they can look for other organisations to work for.

The purpose of this article is to explore how experienced systemic therapists who work in child and adolescent mental health care position themselves within epistemology.

Based on the purpose and aims of the study, the research question is the following:

How do you position yourself as a systemic therapist in child and adolescent mental health care regarding epistemology?

Methods

This article is based on a re-analysis of the interview transcripts and fieldwork observation notes from one of the author’s doctoral thesis (Lorås, 2016a). The methodology chosen for the re-analysis is inspired by Kathy Charmaz’s (2006, 2014) version of constructivist grounded theory (GT). Constructivist grounded theorists prioritise the phenomenon of study and view both data and analysis as created from shared experiences and the relations between the participants and other sources of data (Charmaz, 2006). The lack of theory concerning therapists’ positioning with regard to epistemology makes GT suitable for this research project.

Research context

Our participants worked in three different institutions in the field of child and adolescent mental health care in Norway. Eleven of the interviews and all the fieldwork observations were conducted at their respective workplaces, which were dispersed from northern to southern Norway. The last interview was conducted through Skype®. All institutions were obligated to work under the Norwegian Directorate of Health’s guidelines and, among other services, had their own family units (where the participants worked).

Recruitment

In GT, the researcher actively and strategically seeks participants who can reveal something concerning the object of interest (Charmaz, 2006). Respondents for this research were chosen to obtain a strategic and heterogeneous range, which is a characteristic of GT and qualitative studies (Charmaz, 2014; Thagaard, 1998). A strategic range means that the participants are chosen based on the characteristics or qualifications that are strategic relative to the research questions and the study’s theoretical perspectives (Thagaard, 1998).

The inclusion criteria were based on Rønnestad and Orlinsky's (2006) criteria for experienced therapists, which states that experienced therapists have more than 15 years of clinical experience. Based on their criteria, all participants had more than 15 years of clinical experience, either as systemic therapists or as therapists in mental health, or both. Although gender is not the subject of this research, both men and women were represented.

Details of the participants

Six experienced systemic therapists, four men and two women, participated in this study. Their professional backgrounds included four psychologists, one social worker, and one professional with an education as a health care worker. All participants had additional education and were trained in systemic family therapy. All participants worked in the Norwegian child and adolescent mental health care system. Two of the participants also worked as educators in family therapy and mental health. The participants worked in three different geographically located child and adolescent mental health care institutions.

To ensure their confidentiality, we have used pseudonyms in the presentation of the findings. The ages of the participants ranged between 50 and 65 years and included: (1) *Martin*, psychologist, 29 years of experience in mental health care, 28 years of experience as a systemic family therapist; (2) *Nora*, social worker, 25 years of experience in mental health care, nine years of experience as a systemic family therapist; (3) *Tuva*, psychologist, 30 years of experience in mental health care, 11 years of experience as a systemic family therapist; (4) *Stein*, health worker, 24 years of experience in mental health care, 10 years of experience as a systemic family therapist; (5) *Einar*, psychologist, 27 years of experience in mental health care, 17 years of experience as a systemic family therapist; and (6) *Roar*, psychologist, 30 years of experience in mental health care, 35 years of experience as a systemic family therapist.

Data collection: Semi-structured interviews and fieldwork

This study consists of two qualitative sources: in-depth semi-structured interviews and fieldwork observations. Semi-structured interviews are neither an open conversation nor a closed questionnaire-based conversation. They are conducted according to an interview guide that revolves around specific topics and that may include suggestions for questions (Kvale & Brinkmann, 2015). The interview questions were co-constructed with the doctoral supervisors of the original research project. The interview guide was further changed according to GT sampling procedures.

Fieldwork observations were used to gain a broader understanding of the participants' therapeutic practice and to provide a fuller and more nuanced picture of clinical practice than that offered by the interview alone (Timmermans & Tavory, 2007). The fieldwork observations were limited to six to eight hours of clinical practice with each of the six participant therapists. Based on the fieldwork notes and reading of the initial interview transcripts, new questions were developed, and the follow-up interviews were conducted shortly after the initial interview. The fieldwork observation notes were included in the grounded theory analysis process.

Data analysis

To make sense of the raw data material and to follow the GT methodology, we used constructivist GT analysis to evaluate the interview transcriptions and fieldwork

observation notes (Charmaz, 2014). Shortly after implementation, the analysis began with repeatedly listening to the audio-recorded interview and reading and re-reading the fieldwork notes. Thereafter, the key techniques of GT were adhered to (Charmaz, 2014), which included initial coding, focused coding, and categorising (see Table 1).

In Table 1, we present an example of the building and merging of the master category, *the multi-epistemological therapist*.

Research ethics

In the process of obtaining informed consent, all participants were given appropriate information at different stages regarding their participation. An invitation letter that described the purpose and objectives of the study was sent to the participants after a verbal introduction (phone call). The participants also received an information letter and consent form describing the presence of the researcher (Lorås, 2016a), in addition to copies of the ethical approvals for the doctoral project. All the families were recruited by the participants and were informed about the project at an early stage.

TABLE 1
Example of Coding

Text transcripts	Initial coding	Focused coding
<p>Circular questioning is for me more than asking triadic and relational questions. I think circular questioning is about asking questions that challenge the linear ideas, which guides the family. This is of course Batesonian inspired.</p> <p>My intention is to ask questions which represent what Bateson would have called the difference that makes the difference, contribute to new information.</p> <p>I'm not asking to be informed, but I ask questions which I think can have an effect on the family's system of beliefs.</p>	<p>Circular questioning is about more than relations. It should challenge the linear understanding of the family.</p> <p>Asking to make an effect on the family's system of belief.</p>	<p>Challenge the linear understanding through circular questioning.</p> <p>Aim to make an effect on the family's system of belief.</p>
Focused codes	Sub-categories	Master categories
<p>Challenge the linear understanding through circular questioning.</p> <p>Aim to make an impact on the family's system of belief.</p>	<p>Being circular.</p> <p>Working on the family's system of beliefs.</p>	<p>The multi-epistemological therapist.</p> <p>The multi-epistemological therapist.</p>

The families also received a verbal description of the goals and focus of the project before the fieldwork observations were conducted.

Important considerations at the start of this project were how the research process would affect the participants' identities and interests. A careful process of ethical considerations was necessary (Denscombe, 2002). All participants in this research largely belonged to the same network because they were chosen through strategic criteria, and the Norwegian family therapy community is somewhat small. Whether this small community also enables the participants to be identified or allows participants to identify one another are relevant questions. However, all private and other identification information regarding the participants was omitted from the research. This research does not initially address sensitive information because the focus is on the therapist's competence rather than patient information. No identifying information regarding the families and their members is included.

Findings

In this section, we will present the findings that were identified through the GT analysis of the interview transcripts and fieldwork observation notes. The research question at the starting point for the analysis was: *How do you position yourself as systemic therapist in child and adolescent mental health care regarding epistemology?* The findings will be presented in the following section.

The multi-epistemological therapist

The term most frequently used by the participants when discussing epistemology was *the multi-epistemological therapist*. This refers to how the participants positioned themselves in their clinical work. Although systemic therapy is primarily described from the perspective of Batesonian ideas and social constructionism, the participants expressed a general scepticism towards all theories that attempt to embrace human complexity. It is important to note that the participants' scepticism in relation to theories was directed towards their relationship with only one epistemological position. As Martin explained:

There is something reductionist about being able to arrive at a true and valid understanding of a phenomenon. For example, at a mechanic's workshop, it can be OK to arrive at the right way to do things, but in our work with persons with troubled relationships, it helps to think: "There's always another way."

The participant emphasised a certain scepticism towards defining and limiting one' approach too much because of the danger of promoting reductionist thinking that cannot easily embrace human complexity. As described by Roar:

I have always been sceptical of social constructionism, as I feel it's reductionist to reduce everything to social constructions.

For the most part, the participants positioned themselves in a *not-knowing position* and referred to Anderson (2005), who emphasises the client's expertise, shared meaning making, and an increased focus on dialogue. The participants expressed disbelief that instruction from an 'expert' regarding their difficulties was useful. Instead, the need to create security and a good climate of collaboration was emphasised. As expressed by Einar, *my systemic conviction creates little faith in my own power of*

persuasion or instructing others. Instead, the therapist asks for the family's own perspectives (without taking the expert role in the family).

Although the family's own knowledge is preferred in therapy, there are situations in which families ask for normative, 'expert' knowledge and specialist competence. Several of the participants explained that they occasionally take up normative positions or relate to so-called normative knowledge, such as developmental psychology and that which gives children and young people healthy opportunities for their development. Typical examples that the participants discussed were when families describe that they are 'stuck' or in a crisis, and their repeated attempts at a solution have not led to a resolution. In crisis situations, the participants claimed that therapy can be characterised as being more instrumental and/or manualised. As Nora and Tuva explained:

I am inspired by developmental psychology regarding normative functions in children. I also think that one must be normative if one has thoughts about parental behaviour/functioning that is harmful for the child's development.

Developmental psychology makes it so that we have with us some thoughts about what is good for a three-year-old, for example, and what one can expect regarding the mentalisation of the child.

The participants also described that families occasionally come with expectations that the therapist should 'fix' and 'repair' their 'damaged' child. Nora argued that if parents do not want a systemic approach, a limited individualistic focus can still be facilitated, although in a somewhat more 'multifaceted' manner:

If we get a family that is in no way interested in a systemic understanding, we can take an individualistic perspective, but we will nevertheless facilitate a more multifaceted view of the difficulties they have come in with. However, if the family's demands become too different in relation to our systemic base, we refer the case on.

In situations in which the therapists and the families consider a diagnostic assessment to be necessary, the participants indicated that the experience of the process of assessment impedes therapy. Several of the participants claimed to believe that both diagnostic assessments and treatment can (and sometimes should) occur in parallel. However, the participants stated that organisational reasons, such as local deadlines for assessment and access to therapists with the necessary assessment competence, often make it difficult to achieve such parallel processes.

Although the child should perhaps undergo a diagnostic assessment, the participants emphasised that this does not exclude the opportunity for a systemic approach. The therapists will then use this opportunity to make the 'normal tools of diagnostic assessment' family-oriented by including them in the process of assessment. Receiving a diagnosis by itself does not make anyone healthy; therefore, participants described that they sought invitations from the family to discuss what type of help the family needed based on the given diagnosis.

Discussion

Based on our findings, Bateson's ideas of systems (Batesonian) and social constructionist ideas are still the most relevant theoretical perspective for systemic therapists. However, the participants in this research also expressed a general scepticism towards all stringent theories that attempt to embrace human complexity, because of the

danger of promoting reductionist thinking where everything can be reduced to only linguistic meanings and possible simplicity.

Based on this research, the participants' epistemological stance was identified as multifaceted, consisting of social constructionism, critical realism, and constructivism. We think that there are several reasons for this.

For one, we think that the social constructionist idea that everything can be considered as a construction is inaccurate (Lorås, 2016c). Even if it is impossible for people to know what is real, we must realise that there is something that is unreal. As expressed by Eco (2012), *we cannot say what is right, but all of us can tell what is wrong* (p. 105). We think the same reflections are relevant regarding families. We cannot say how 'right' a family interaction is, but we can say when there are unhealthy family interactions, for example, when discipline is so inconsistent within/between parents that a predictable response to the child's misbehaviour is lacking (World Health Organization, 1996). We agree with Pocock (2013) who, arguing for a critical realist position, stated that if one follows a strong social constructionism, for example, Gergen's (1998) claim that social constructionism is 'ontologically mute,' then one is unable to criticise family interactions at all.

According to our findings, the participants argued that they occasionally take up normative positions or relate to so-called normative knowledge, such as developmental psychology and that which gives children and young people healthy opportunities for their development, which is inconsistent with a strong social constructionist stance. From this perspective, even relational diagnosis is considered normative knowledge because it somewhat defines unhealthy family interactions (e.g., abnormal intrafamilial relationships, abnormal qualities of upbringing).

We argue that it is important to include both constructivism and critical realism in the systemic 'portfolio.' By this we mean that to acknowledge only a social constructionist stance as the foundation for systemic therapy is insufficient regarding the complexity in child and adolescent mental health care. For example, although systemic therapists cannot define what the 'correct' family interactions are, they can instead say that family violence is wrong and illegal (Lorås, 2016a, c). The social constructionist idea that everything can be re-constructed is not actually useful when working with vulnerable children and adolescents living under adverse conditions. It is also incorrect because, in practice, systemic therapists make choices between competing constructions, both those of the family that we either support or at some point hope to see explored/or challenged and the therapist's own competing ideas of what is going on. The systemic therapist's 'both-and' stance is supported by a philosophical stance of social constructionism, but the systemic therapist's 'either/or' practices seem to be a hidden but well-documented dichotomy (Pocock, 2013). *Moderate* social constructionism in the systemic therapy portfolio seems necessary, both in order to ensure a tentative stance towards so-called 'objective' knowledge and to acknowledge each family member's understanding as equally important.

Social constructionism and constructivism have for decades been described as interchangeable, even though there are both differences and similarities between the two perspectives (Jensen, 2008; McNamee, 2004). This is probably a result of their shared focus on meaning-making processes (McNamee, 2004). From this perspective, one could say that the constructivist ideas have been viewed as identical to social constructionism with its almost exclusive focus on language and discourse (Jensen, 2008). By using the 'umbrella term' constructivism as the epistemological basis for systemic

therapy, the constructivist's focus on biological processes seems to have been neglected and marginalised.

It can be argued that the focus on inner and cognitive processes is based on a linear understanding (Schjødt & Egeland, 1993). Hence, we argue that it is important for therapists to be concerned with both the linear and circular models of understanding to grasp the development and continuation of human problems. All participants also noted that they had experience with individual clients who wanted diagnostic assessments. The participants were not critical of relating to biology or diagnostic assessments per se (repeatedly referring to Maturana), but they were critical of all knowledge that claimed to be objective truth, resulting in generalisable understanding and approaches. In therapeutic terms, a diagnosis can contribute to the removal of guilt and/or shame or have the aim of marking significant deviations from normally expected development (e.g., autism) (Rimehaug & Helmersberg, 1995). Given the organisation of modern society, a specific diagnosis can even release a person from the right to receive specific forms of treatment, medicines or aid (e.g., anti-psychosis medicine, audiobooks for school). Depriving a child or adolescent and his/her family the right to a diagnosis that can help them in understanding, reunification, and mastery and provide potential helping aids or interventions can also be understood as an expression of therapeutic authoritarianism and an abuse of power (Rimehaug & Helmersberg, 1995). The problem with the dominant diagnostic culture is the idea that once you have made the diagnosis, you have identified the essence of the suffering and solved the problem (Lorås, 2016c; Rose, 2015). Instead, a more useful distinction was made by Bertrando (cited in Lorås, 2016c), that once you have made a diagnosis, you have made a somewhat useful distinction if it gives meaning to the involved persons. The problem is perhaps not the technological aspect (e.g., ICD-10) of 'traditional' psychiatry, but its values (Lorås, 2016c).

Diagnostic assessment is not necessarily in opposition to systemic therapy's epistemological basis, and it is possible to use it within a systemic framework as 'guides and maps' rather than as instructive manuals (Lorås, 2016a). The use of dialogical practices could be particularly relevant in order to create acceptance of the different perspectives for both clinicians and clients, that is, when a diagnosis is required (Bertrando, 2009). If a diagnosis is required, it is important to include the family's 'significant others' as part of the empirical material for an eventual diagnostic conference. In the diagnostic conference all members of the relevant system around the problem have their own say about the presenting issue and the process, without necessarily searching for a final agreement (Lorås, Bertrando, & Ness, 2017).

The participants also described repeated examples in which clients had experienced receiving a diagnosis as a valuable contribution to the removal of shame and guilt (i.e., in the case of 'mental retardation') (Rimehaug & Helmersberg, 1995). In this manner, the actual result of receiving a diagnosis can have the paradoxical effect of removing guilt and shame and creating distance between the individual and the problem, which is the same result that one attempts to achieve through externalising conversations from narrative therapy (White, 2007). Simultaneously, in contemporary society, a diagnosis can also grant rights (e.g., assistant teachers, access to treatment) (Sundet, 2015).

It is time to discuss whether constructivism, with its extended focus on other significant aspects of life, such as the internal cognitive processes of individuals, should be included and acknowledged as part of the systemic therapy portfolio, instead of only as the idea of social constructionist epistemological purity (Pocock, 2013).

Knowledge about internal, cognitive processes, normal development, and lopsided development were also described by the participants as one of the areas that must be considered.

Critical realist ideas became apparent through the participants because of their need for normative and somewhat expert knowledge at certain times in therapy. Although the participants in this research did not use the phrase 'critical realism,' we consider the way they positioned themselves regarding knowledge to be within a critical realist stance. This is in opposition to the 'both and stance' in social constructionism, which offers a safe container for the tension between the different perspectives offered, those of family members and our own as therapists (Pocock, 2013). The critical realism-inspired systemic therapist acknowledges taking a position as an expert in the therapeutic process, with simultaneous professional knowledge regarding unhealthy family interactions and child development but is humble about what he knows and is open to other possibilities. Critical realist ideas do not seem to exclude social constructionist ideas because they share an experience of the world as a place where it is difficult (if not impossible) to achieve true objective knowledge (Pilgrim, 2000).

The inclusion of critical realist ideas is a response to and supports the participants' wishes for some precise descriptions of the systemic competences that they are expected to cover or that may be valuable working in child and adolescent mental health care. Hence, moderate critical realists claim that some social phenomena (i.e., unhealthy family interactions) should be considered in terms of somewhat normative or objective knowledge and should be treated differently from so-called constructions (Andersen, 2007). Given the ideas of Bateson (1972), we will argue that critical realist ideas can be considered as already included in the diversity of perspective that the cybernetic epistemology includes. The postmodern descriptions of systemic therapy as a social constructionist approach has reduced systemic therapy to focusing solely on meaning-making through social interactions (Lorås, 2016a). Thus, a clinical perspective can move the systemic perspective to a meta-perspective (Bateson, 1979). In this way the therapist can access different validated psychotherapeutic theories and methods under a systemic umbrella, for example from developmental psychology; attachment needs, affect regulation, mentalisation (Fonagy, Gergely, Jurist, & Target, 2002). From family sociology (Dencik, 2002) research we can integrate knowledge about the form, needs, and challenges for the family in our society of today.

To practice a therapy influenced by moderate critical realism, systemic therapists must take a stance regarding how they position themselves in relation to somewhat 'semi-objective' knowledge, for example, diagnoses. Otherwise, systemic therapists are in danger of offering a covert version of social constructionism that only borrows the name of 'moderate critical realism' and only appears to have considered the changing society. We consider such a covert approach to be in danger of presenting systemic therapy as being even more indistinct than it already is today. We argue that it is necessary for systemic therapists in child and adolescent mental health care to take a multi-epistemological stance that consists of moderate social constructionism, constructivism, and moderate critical realism. For example, from a multi-epistemological stance, a diagnosis can be useful for identifying abnormal or unhelpful behaviours (which are contextually defined), but that these are dynamic, relational, and subject to change and not just identified with the individual's biology but also as patterns.

The inclusion of moderate critical realism in systemic therapy can serve as a valuable contribution to and 'disruption' of the antagonism towards research and an

assumed fear that therapists have of positioning themselves as knowledge and research-based therapists, a fear that is ravaging the systemic field. A future multi-epistemological perspective on therapeutic change, in combination with established knowledge from other relevant fields, appears to be a natural extension of the development of systemic therapy.

Possible limitations of the research project

Although 12 interviews with six experienced systemic therapists were conducted, the research project is based on the practice of a relatively small number of practitioners. However, qualitative research is not dependent upon numbers. We also consider that the idea of saturation in qualitative research functions more as a goal than a reality.

As relational reflexive researchers, we recognise that the identified epistemological positions of the participants occur because of a dynamic process among us as researchers, the participant, the clients, and the text (Finlay, 2012). Therefore, the findings are somewhat subjective and cannot be expected to satisfy everyone. Nevertheless, we consider that it is possible to obtain a certain agreement on the identified epistemological positions to account for a transparent, fair, and reproducible research process (Daniels & Sabin, 2002).

Concluding Comments

We argue that if systemic therapists base their epistemology in moderate social constructionism, constructivism, and critical realism, then an opening is created for a more nuanced and useful stance in relation to diagnosis and research than what systemic therapists have today. In this manner, both diagnoses and research can be viewed as useful for practice, and vice versa, instead of being viewed as a dichotomy. The multi-epistemological systemic therapist will ‘speak’ a range of therapeutic languages, including those of biological psychiatry and DSM-5 while giving priority to speaking the language of the client (Larner, 2015).

References

- Allman, L. (1982). The aesthetic preference: Overcoming the pragmatic error. *Family Process*, 21(4), 43–56. <https://doi.org/10.1111/j.1545-5300.1982.00415.x>.
- Andersen, S.A. (2007). *Kritisk Realisme som Perspektiv i Socialt Arbejde. En Introduksjon og Forskningsoversigt [Critical Realist Perspective in Social Work]*. Aarhus: Den Sociale Højskole i Aarhus.
- Anderson, H., & Goolishian, H.A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 27, 371–394. <https://doi.org/10.1111/j.1545-5300.1988.00371.x>.
- Anderson, H. (2005). Myths about “not-knowing”. *Family Process*, 44(4), 497–504. <https://doi.org/10.1111/j.1545-5300.2005.00074.x>.
- Bateson, G. (1972). *Steps to an Ecology of Mind*. New York, NY: Ballantine Books.
- Bateson, G. (1979). *Mind and Nature*. Chicago, IL: University of Chicago Press.
- Bertrando, P. (2009). Surviving in psychiatry as a systemic family therapist. *Australian and New Zealand Journal of Family Therapy*, 3(30), 160–172. <https://doi.org/10.1375/anft.30.3.160>.
- Brinkmann, S. (2014). Languages of suffering. *Theory & Psychology*, 24(5), 630–648. <https://doi.org/10.1177/0959354314531523>.
- Charmaz, K. (2006). *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis*. London: Sage Publishing.

- Charmaz, K. (2014). *Constructing Grounded Theory* (2nd ed.). London: Sage Publishing.
- Daniels, N., & Sabin, J.E. (2002). *Setting Limits Fairly: Can We Learn to Share Medical Resources?* New York, NY: Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780195149364.001.0001>.
- Dell, P.F. (1982). Beyond homeostasis: Towards a concept of coherence. *Family Process*, 21(1), 21–42. <https://doi.org/10.1111/j.1545-5300.1982.00021.x>.
- Dencik, L. (2002). *Living in Modern Times: Implications for the Lives of Children and Their Families*. Roskilde: Roskilde Universitet.
- Denscombe, M. (2002). *Ground Rules for Good Research: A 10 Point Guide for Social Researchers*. Philadelphia, PA: Open University Press.
- Eco, H. (2012). Di un realism negative, in M. Ferraris (Ed.), *Bentornata Realta. II Nuovo Realism in Discussion* (pp. 91–112). Torino: Einaudi.
- Finlay, L. (2012). Five lenses for the reflexive interviewer, in J.F. Gubrium, J.A. Holstein, A.B. Marvasti, & K.D. McKinney (Eds.), *The Sage Handbook of Interview Research: The Complexity of the Craft* (pp. 317–332). London: Sage Publishing. <https://doi.org/10.4135/9781452218403.n23>.
- Fonagy, P., Gergely, G., Jurist, E.L., & Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self*. New York: Other Press.
- Gergen, K.J. (1998). Commentary on Lannamann: The Palace of Material in a Constructed World. *Family Process*, 37(4), 415–419. <https://doi.org/10.1111/j.15455300.1998.00415.x>.
- Hertz, S. (2003). At arbejds systemisk i et diagnostisk felt [Working systemic in a diagnostic field]. *Fokus På Familien*, 42(1), 1–11.
- Hoffman, L. (1985). Beyond power and control: Toward a “second order” family systems therapy. *Family Systems Medicine*, 3(4), 381–396. <https://doi.org/10.1037/h0089674>.
- Jensen, P. (2008). *The Narratives Which Connect. A Qualitative Research Approach to the Narratives Which Connect Therapists' Personal and Private Lives to Their Family Therapy Practices*. Doctorate of Systemic Psychotherapy, University of East London University in conjunction with the Tavistock Clinic.
- Keeney, B.P., & Sprenkle, D.H. (1982). Ecosystemic epistemology: Critical implications for the aesthetics and pragmatics of family therapy. *Family Process*, 21(4), 1–20. <https://doi.org/10.1111/j.1545-5300.1982.00001.x>.
- Kvale, S., & Brinkmann, S. (2015). *Learning the Craft of Qualitative Research Interviewing*, (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Larner, G. (2015). Ethical family therapy: Speaking the language of the other. *Australian & New Zealand Journal of Family Therapy*, 36(4), 434–449. <https://doi.org/doi.org.10.10002/anzf.1131>.
- Lorås, L. (2016a). *The Map of Competences in Systemic Therapy. A Qualitative Study of the Systemic Competences in Child and Adolescent Mental Health That Target ICD 10 Axis 5 Associated Abnormal Psychosocial Situations*. Doctorate thesis of Systemic Psychotherapy, awarded by the University of East London in conjunction with the Tavistock Clinic.
- Lorås, L. (2016b). Systemisk familierterapi og helsedirektoratets krav innen barne og ungdomspsykiatrien i Norge [Systemic family therapy and the Norwegian child and adolescent mental health demands]. *Fokus På Familien*, 02(2), 93–112.
- Lorås, L. (2016c). Paolo Bertrando: “To some extent” an interview with the Italian systemic family therapist. *Fokus På Familien*, 2(1), 8–26. <https://doi.org/10.18261/issn.08077487-2016-01-03>.
- Lorås, L., Bertrando, P., & Ness, O. (2017). Researching systemic therapy history: In search for a definition. *Journal of Family Psychotherapy*, 28(2), 134–149. <https://doi.org/10.1080/08975353.2017.1285656>.

- McNamee, S. (2004). Relational bridges between constructionism and constructivism, in J.D. Raskin & S.K. Bridges (Eds.), *Studies in Meaning 2: Bridging the Personal and Social in Constructivist Psychology* (pp. 37–50). New York: Pace University Press.
- Ness, O. (2011). *Learning New Ideas and Practices Together. A Co-operative Inquiry into Learning to Use Johnella Bird's Relational Language-Making Approach in Couples Therapy*. Ph.D. dissertation, Tilburg University.
- Pilgrim, D. (2000). The real problem for postmodernism. *Journal of Family Therapy*, 22(1), 6–23. <https://doi.org/10.1111/1467-6427.00135>.
- Pocock, D. (2013). A philosophy of practice for systemic psychotherapy: The case for critical realism. *Journal of Family Therapy*, 37(2), 167–183. <https://doi.org/10.1111/14676427.12027>.
- Pote, H., Stratton, P., Cottrell, D., Bostion, P., Shapiro, D., & Hanks, H. (2000). *The Leeds Systemic Family Therapy Manual*. Leeds: Leeds Family Therapy Research Centre.
- Rimehaug, T., & Helmersberg, I. (1995). Barnepsykiatrisk utredning: Fra produkt til prosess. Veien mot rollen som med-ekspert [Child psychiatric diagnostic assessment: From product to process]. *Fokus På Familien*, 23(2), 145–156.
- Rober, P. (2005). The therapist's self in dialogical family therapy: Some ideas about not knowing and the therapist's inner conversation. *Family Process*, 44, 477–495. <https://doi.org/10.1111/j.1545-5300.2005.00073.x>.
- Rønnestad, M.H., & Orlinsky, D.E. (2006). Terapeutisk arbeid og profesjonell utvikling: En internasjonal studie [Therapeutic work and professional development]. *Tidsskrift for Norsk Psykologforening*, 11(1), 6–24.
- Rose, N. (2015). Hvad er diagnoser til for [What's the meaning of diagnosis]?, in S. Brinkmann & A. Petersen (Eds.), *Diagnoser: Perspektiver, Kritik Og Diskussion [Diagnosis: Perspectives, Criticism and Discussion]* (pp. 17–36). Aarhus: Forlaget Klim.
- Schjødt, B., & Egeland, T.H. (1993). *Fra Systemteori Til Familierapi [From System-Theory to Family Therapy]*. Oslo: Tano.
- Sundet, R. (2015). Kunnskap i evidensens tid [Knowledge, in the time of evidence]. *Fokus på Familien*, 43(1), 6–24.
- Thagaard, T. (1998). *Systematikk og Innlevelse. En Innføring i Kvalitativ Metode [An Introduction to Qualitative Methods]*. Bergen: Fagbokforlaget.
- Thomsen, P.H. (2015). Børne og ungdomspsykiatriske diagnoser [Child and adolescents diagnoses], in S. Brinkmann, S. & A. Petersen (Eds.), *Diagnoser: Perspektiver, Kritik Og Diskussion [Diagnosis: Perspectives, Criticism and Discussion]* (pp. 129–154). Aarhus: Forlaget Klim.
- Timmermans, S., & Tavory, I. (2007). Advancing ethnographic research through grounded theory practice, in A. Bryant & K. Charmaz (Eds.), *Handbook of Grounded Theory* (pp. 493–512). London: Sage Publishing. <https://doi.org/10.4135/9781848607941.n23>.
- White, M. (2007). *Maps of Narrative Practice*. New York, NY: W.W. Norton.
- Wifstad, Å. (1997). *Vilkår for Begrepsdannelse og Praksis i Psykiatri. En Filosofisk Undersøkelse [A Philosophical Examination]*. Oslo: Tano Aschehougs Fonteneserie.
- World Health Organization (1996). *Multiaxial Classification of Child and Adolescent Psychiatric Disorders. The ICD-10 Classification of Mental and Behavioral Disorders in Children and Adolescents*. Cambridge: Cambridge University Press.