

# Chapter 2

## The History of Family Therapy in Norway

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

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

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

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

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

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

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

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

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

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

## **Overarching Themes—Trends and Headlines Seen as Historical Processes**

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

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

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

## **Family Therapy in Norway Through the Decades**

### ***Family Therapy in the 1960s and 1970s***

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

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

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

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

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

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

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

## ***The 1980s***

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

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

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

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

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

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

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

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

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

## ***The 1990s***

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

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

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

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

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

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

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

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

### *After 2000*

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

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

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

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

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

## **The Important Working Contexts for Family Therapists**

### ***Family Counseling Services***

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

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

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

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

### *Child and Adolescent Psychiatry*

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

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

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

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

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

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

### *Adult Psychiatry*

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

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

## **Modum Bad**

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

## **History**

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

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

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

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

## **The Treatment**

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

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

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

## Evaluation and Research

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

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

## Diagnostic Challenges

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

## International Contacts and Inspirations

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

## The Research Institute

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

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

## **Publishing About Family Therapy**

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

## **Norsk Forening for Familierapi (NFFT)**

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

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

## **Family and Family Therapy Research in Norway**

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

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

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

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

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

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

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

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

## **Research Concerning Family Therapy with Children and Adolescents**

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

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

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

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

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

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

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

## **Educating Family Therapists**

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

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

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

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

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

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

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

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

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

## **Family Therapy in Norway—Is There a Future?**

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

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

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

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

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

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

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

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

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