JYVÄSKYLÄ STUDIES IN EDUCATION PSYCHOLOGY AND SOCIAL RESEARCH 247

Aarno Laitila

Dimensions of Expertise in Family Therapeutic Process

Esitetään Jyväskylän yliopiston yhteiskuntatieteellinen tiedekunnan suostumuksella
julkisesti tarkastettavaksi yliopiston vanhassa juhlasalissa (S212)
syyskuun 17. päivänä 2004 kello 12.

Academic dissertation to be publicly discussed, by permission of
the the Faculty of Social Sciences of the University of Jyväskylä,
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UNIVERSITY OF JYVÄSKYLÄ

JYVÄSKYLÄ 2004

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Publishing Unit, University Library of Jyväskylä

Cover design Sauli Heikkilä

URN:ISBN 9513919188
ISBN 951-39-1918-8 (PDF)

ISBN 951-39-1817-3 (nid.)
ISSN 0075-4625

Jyväskylä University Printing House, Jyväskylä 2004

ABSTRACT

Laitila, Aarno
Dimensions of expertise in family therapeutic process
Jyväskylä: University of Jyväskylä, 2004, 54 p.
(Jyväskylä Studies in Education, Psychology and Social Research,
ISSN 0075-4625; 247)
ISBN 951-39-1918-8
Yhteenveto: Asiantuntijuuden ulottuvuuksia perheterapeuttisessa prosessissa
Diss.

This study focused on family therapeutic expertise as one specific area of expertise research. The empirical background of this study consists of qualitative clinical case studies which were published as four articles. The framing of the questions addressed in these case studies was connected to therapeutic process, therapeutic change, and preconditions of therapeutic change, the therapist's actions, and the methodology of family therapeutic research. The methodology employed in these qualitative case studies consisted of theory-informed case methodology, the assimilation analysis method, two studies applying the micro-analytic narrative research method, and the specific Narrative Processes Coding System (NPCS). This report consists of 1) a theoretical review of the question of expertise, expertise research and expertise in psychotherapy in general and in family therapy in particular, 2) a summary of the four above-mentioned published articles, and 3) a synthesizing discussion, in which the concepts of expertise research were used as tools of dialogue concerning the main results of the empirical studies. According to the results of the case studies, the research methodology applied directs the findings obtained. This was apparent in case studies I and II, in which the same clinical case was studied. The same process could be studied either as the therapeutic development and change of the family or the joint therapeutic development of the entire therapeutic system. Reflexivity and reflectivity were highlighted (I, III, and IV) since therapists have to be able to deliberate, reflect, and question the premises of their own thinking, ongoing interaction, and acting, as well as integrate the verbal and experiential tools of clinical work. The therapist's expertise was manifested more in the role of a facilitator of interaction and opener of conversation and dialogue than in that of an observer and diagnostician. As the report makes clear, the different reflective and reflexive therapist's techniques and practices for participating in the process of horizontal expertise were highlighted. The family therapy session was described as a crossroads of individual/vertical and interactive/horizontal expertise in which the resources of all the participants of the session can be activated for the purposes of therapeutic change. Notice was taken of issues of theoretical development in family therapy, which has been dominated by the modern - post-modern debate. The third wave of science studies, namely the study of expertise and experience is shown as making a serious challenge to this debate.

Key words: family therapy, expertise research, case study, assimilation analysis, Narrative Processes Coding System, horizontal expertise, vertical expertise

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ACKNOWLEDGEMENTS

I wish to express my deepest gratitude to my supervisor, Professor Jukka Aaltonen, who has guided and encouraged me throughout the course of my research. In addition to his professional expertise, his patience was needed more than once.

I am indebted to the Department of Psychology, and I want to personally thank the present head, Professor Tapani Korhonen, for his contribution as the scientific editor of the research series, and for his tolerance of a stubborn researcher with sometimes too flexible timetables.

I am grateful to the reviewers of my thesis, Professor Pekka Larivaara and Professor Anssi Peräkylä for their comments and constructive criticism, as well as to the members of my supervisory group, Associate Professor Lynne Angus, Professor Risto Eräsaari, and Professor Jarl Wahlström. Professor Wahlström has also provided me with remarkable data, for which I cannot thank him enough. I wish to thank two Lecturers in English who have proof-read my published articles and this thesis, Michael Freeman, and Michael Peacock. I would also like to thank my long-time friend Sauli Heikkilä for the cover.

The late professor Eila Räsänen, from the University of Kuopio, and Hannu-Olavi Piilinen, M.D., the head of child psychiatry from the Health District of Central Finland, both deserve my gratitude, as they kindly provided the research context out of which the first part-study, and later the first article, arose. I also want to express my gratefulness to Kaija Pänkäläinen, Sirkku Salminen, Raija Keski-Petäjä, and Riitta Nevalainen from Family Guidance Center of Jyväskylä, and Raija Mehto from the department of Psychology for keeping things going smoothly. Their help was very valuable to me.

There are also a number of persons who have had an important personal role in this process. Among them I wish to thank by name Docent Mikael Leiman, Ph.D. and Professor William B. Stiles, who organized the "Semiosis in Psychoterapy"; an intensive two-week seminar which provided encouraging experience in qualitative psychotherapy research and was more or less the unofficial starting-point of the project that reaches its end here. I am deeply grateful also to Juha Holma, Ph.D., whose friendship, practical advice, and sense of humour have carried me over innumerable obstacles. I also thank Professor Päivi Tynjälä for her kind and generous help in providing me with a remarkable number of useful references for various areas of expertise research.

Jukka Vapaavuori, Ph.D., and Tapio Ikonen, M.A., with whom I took the first cautious and hesitating steps in using a narrative coding system deserve my gratitude. Those steps we took have proved to be significant.

I should also mention a group of practising clinicians, and fellow trainers of family therapy who deserve to be acknowledged here by name for their support, kindness, and just being there. Annaliisa Heikinheimo, Ps.Lic., Kaija Lajunen, M.A., Sirkka Tasola, Ps.Lic., and Jukka Harmainen, M.A., have all shared my interest in family therapy and enriched my professional life with their joy and wit. I also want to thank my nearest workmates by name, clinical psychologists Eija

Himilä-Mälkki, Kari Kiianmaa, Elina Lätti and Kirsi Äikäs, clinical social workers Anu Huovinen and Marja-Leena Ollikainen, and physician Leila Oksanen.

There are many friends who have given me something else to think about, their friendship, support, and last but not least their respectful distance from this project. Here I want to mention by name Timo Ahonen, Ph.D., Jukka Kaartinen, Ph.D., Arto Leppänen, M.A., Sirpa Leppänen, Ph.D., and Pekka Tiempo, M.A. Thank you all.

Finally, I want to express my gratitude to my post-traditional family. My wife, Marianna Savio, M.D. has never lost sight of the completion of this dissertation, and her supportive attitude has been unequalled and of unique value to me. I also want to thank my sons, Eero and Valtteri, and my stepdaughters, Anna, Darja, and Kira. Be serious!

This study was financially supported by the University of Jyväskylä, the Eemil Aaltonen Foundation, the Foundation of Child-Psychiatric Institute of Haukkala, the Nordic Academy for Advanced Study (NORFA), and The Academy of Finland. I wish to express my gratitude to all these organizations and foundations for this.

CONTENTS

LIST OF ORIGINAL PUBLICATIONS

I Laitila, A., Aaltonen, J. Piilinen, H.-O. & Räsänen, E. H. (1996). Dealing with negative connotations in family therapeutic treatment of an enmeshed family - a case study. Contemporary Family Therapy, 18(3):331-343.

II Laitila,A., Aaltonen, J. (1998). Application of the assimilation model in the context of family therapy - A case study. Contemporary Family Therapy, 20(3):277-290.

III Laitila, A., Aaltonen, J., Wahlström, J. & Angus, L. (2001). Narrative Process Coding System in Marital and Family Therapy: An Intensive Case Analysis of the Formation of a Therapeutic System. Contemporary Family Therapy, 23(3):309-322.

IV Laitila, A., Aaltonen, J., Wahlström, J. & Angus, L. (2003). Narrative Process Modes as a Bridging Concept for the Theory, Research, and Clinical Practice of Systemic Therapy. Submitted.

1 INTRODUCTION

"You don't need a weather man
To know which way the wind blows" (Dylan, 2003, 639).

Human beings have been developing their expertise ever since they first came into existence as a species. People have always striven to gain control over the surrounding world in order to make their living conditions more tolerable. In the early history of the species the means for doing this were limited; and so people used magic to fill the gap between their efforts and their expectations (Bernal, 1965). Science was born out of those first conscious efforts to develop the tools and means with which to enhance life, agriculture, hunting and work.

In the early history of science, the means used to control the environment varied according to the view taken of the material world: was it something alive, or simply dead matter? For modern science this distinction is no longer valid. It is assumed that scientific activity has an effect on its object in any case (Bernal, 1965; Giddens, 1990): Scientific progress has made earlier views of the material world almost meaningless (Fleck, 1935). In spite of this, the object of expert activity and expertise determines whether this object is assumed to possess the subjective character of agency (as often in the human sciences), or has only the objective character; having no will or agency of its own, as in the application of engineering and technology.

Thus the position of the expert in the field of social and (mental) health services (particularly in a primary health care setting) is a complicated one. Considerations of status, power, and position in the hierarchy are somewhat ambiguous today: and experts have to take into consideration questions of accountability, transparency, and human rights. The same ambivalence also characterizes the lay attitude (Giddens, 1990). This can be understood as being due partly to changes in the whole of society, partly to the development of science, and partly to the complex interaction of society and science (Collins & Evans, 2002; Nowotny, Scott & Gibbons, 2001). The rise of reflexivity in the social sciences also reflects the desire of ordinary people to have a voice in any decisions which concern their personal lives. At the same time, the need for experts and expertise is

not disappearing, but rising and expanding, and working life offers ever greater challenges.

The challenge of responding to the non-expert voice has been answered in different ways, depending the area concerned (Collins & Evans, 2002). In some cases, scientists and experts have a continuing aversion to the opinions of laymen, while in other cases the non-expert voice has been regarded as providing a valuable contribution, or as a valuable participant in the process of dialogue, e.g. in certain client-centred therapy practices (Aaltonen et al 2000; Andersen, 1997; Anderson, 1996; Anderson & Goolishian, 1992; Anderson& Levin, 1997; Friedman, 1995; Seikkula, 2002; Seikkula, Arnkil & Erikson, 2003; Smith & Nylund, 1997) or in applications of constructivism in education (Tynjälä, 1999). These fields recognize the dual role of their object. As an object of expertise, a human being always has a subject-object character and an agency of her/his own. Thus, from the expertise research perspective, this non-expert client voice can be seen as an expertise of its own kind. It brings into the negotiation knowledge of the client's unique and individual life experiences with all its nuances (Engeström, 1992) and experience-based expertise (Collins & Evans, 2002). This kind of information is not available in any other way; nor can it be ignored without influencing the object and the working relationship of the professionals with the object.

Family therapy as a helping profession has been conceptualized by family therapists themselves. The situation is very similar in all areas of psychotherapy. So the concepts used to describe and evaluate family therapy as an expert practice might be expected to be clinically informed for the most part. This is not the case, however. The theories applie by family therapists are not necessarily the same as those espoused by them, (Argyris, Putnam, & McLain Smith, 1985), and academic theory and the level of the abstraction are often distant from the clinical practice. Clinical innovations in the practice of family therapy have often been based on concepts derived from very different fields, such as physics and mechanics. This phenomenon has been apparent in psychology and in various kinds of psychotherapy. It has been criticized since quite early on in the history of psychology (Vygostky, 1997), while its possible worth and advantages have also been discussed (Fonagy, 2003; Ricoeur, 1981). The relationship between the theory, research and clinical practice of family therapy has remained tenuous (Pinsof & Wynne, 2000; Sprenkle & Ball, 1996).

This study is a move towards dialogue with the more theoretical perspectives of expertise research; a research into the nature of family therapy as an expert practice. The language of family therapy and the language of family therapeutic expertise and expertise research are studied in their practical context. “Speaking practically” (Shotter, 1986) is an attempt to learn from within this practical context. The expertise research perspective is used as a cultural anthropological tool in this task of evaluating family therapeutic practices (Latour & Woolgar, 1986). This is achieved through a new reading of the original case studies in order to provide a double description of family therapy (Bateson, 1979), which has lately been dominated by the post-modern critique of modern practices. The aim is more inclusive than exclusive, since the aim is to promote new dialogue which is clinically informed in addition to being philosophically informed.

The course of development of family therapeutic expertise, as well as of other modes of psychotherapy reflects at least some developmental lines of expertise and expertise research in general. In this thesis family therapy is studied in order to find new perspectives in clinical practice, training, and research into family therapy.

This thesis consists of two parts. The first part begins with a theoretical review of the issue of expertise from three differing perspectives; 1) that of expertise research, and expert knowledge; 2) the question of how the expertise is described and understood in the area of psychotherapy in general and, 3) the question of how the expertise is described in the area of family therapy in particular. After these follows a brief summary of the original published articles and one article manuscript and the outlining of the research task for the present study. The last part of this first section consists of a re-reading of the articles through this lens of expertise, and it also includes the empirical part of this study.

In the second part, consisting of four articles, the field of interest is mostly focussed on clinical practice, and the processes of family therapy; a helping profession which deals with the well-being and the suffering of families and family members. These four case studies were carried out to throw light on the family therapeutic process, the nature of change, the role and actions of the therapist, and the application of different qualitative research methods.

2 EXPERTISE RESEARCH

2.1 The changing concept of expertise

Expertise as a noun refers, according to the thesaurus (1994), to expert knowledge or skills. "Expert" as an adjective refers to someone thoroughly skilled or knowledgeable through training and experience. As a noun it refers to a person with special skills or training in any art or science. Thus expertise is something connected with speciality, and involves the gradual development of skills acquired over a period of time through increasing experience. The definition also emphasizes individuality. Expertise is a characteristic of a single person, an individual capacity or quality highlighting the agent and agency of the expert. The same individuality is also highlighted by Giddens when he writes: "An expert is any individual who can successfully lay claim to either specific skills or types of knowledge which the layperson does not possess" (Beck, Giddens & Lash, 1994, 84). The relationship to the object of the expert or expertise is not included in these definitions at all; which implies some kind of universality of the object and/or the superfluity of this kind of consideration. Giddens' definition also makes a distinction from the layperson. There's a difference (of quantity and quality) of knowledge between the expert and the layperson.

According to Collins & Evans (2002) there have been three waves in sociological studies of science. During the first wave there was no "expertise problem", and the focus of the research was to explain and reinforce the success of the sciences. The second wave was defined as "social constructivism" and one major element in this wave was the sociology of scientific knowledge. The main focus was to conceptualize science as social activity, and this has led to a situation where scientific knowledge is like other forms of knowledge, which is contrary to the thesaurus definition or the definition made by Giddens. The third wave is about to take shape as a study of expertise and experience, which should, according to Collins & Evans (2002), develop into "knowledge science". As a result of this development, expertise research is a multidimensional and multidisciplinary area of interest for psychologists, sociologists, educational researchers, philosophers, and researchers of science.

These successive waves in the sociological studies of science are also evident in the development of expertise research. The focus of expertise research was for a long time on the top performances in special skills, chess, for example. This quite accurately reflected the thesaurus definition. This kind of research further characterized expertise as the superb cognitive ability of an exceptional individual, cf. technical expertise. From that kind of interest, the scope of research has widened to include more practical working expertise and everyday working contexts. The original emphasis is somehow present in the domination of technical expertise. Simultaneously the definition of the concept has changed and acquired new dimensions. To provide an outline of expertise research and the concept of expertise, some clarifications and conceptual distinctions have to be made.

Hakkarainen, Palonen & Paavola (2002) combine the various views of expertise in three main approaches: 1) the traditional cognitive perspective (the acquisition view), 2) the perspective of situated cognition (the participation view), and 3) expertise acquired through a process of knowledge creation (the knowledge-creation view). The first approach combines the elements of individuality and the cognitive character of expertise as well as large amount of personally-gathered information (Tynjälä, 1999). The development of expertise starts from the rigid application of knowledge and principles (i.e. closed-context expertise) (Eräsaari, 2003) and proceeds to the flexible use of different means of problem-solving, and an independent attitude toward rules (i.e. open-context expertise) (Eräsaari, 2003); the developmental line being from novice to expert.

According to Tynjälä et al's review (1997) experts: 1) perceive a large meaningful pattern in their own domain; 2) focus on the relevant cues of the task; 3) represent problems at a deeper level than novices; 4) have better self-monitoring skills than novices; 5) have knowledge structures that are hierarchically organized and have more depth in their conceptual levels compared to those of novices; 6) categorize problems within their own domain according to abstract high-level principles; and 7) have more coherence in their knowledge structures than novices have.

This individual and traditional (modern) concept of expertise, according to Engeström (1992), represents a Cartesian view of expertise, which emphasizes its universal and invariant character. It suggests an unproblematic relationship between expertise and experience; as if a more experienced person would always (other things being equal) be a better practitioner of tasks requiring expertise than a beginner. This belief, however, has been questioned by research findings. This view is also present in Giddens' (1990; 1991) idea of the dis-embedding character of expertise: modern expertise is actualized outside the context, and this is possible since there is a trust in abstract systems.

The participation view of expertise emphasizes the interactive, historical, and cultural, that is, contextual nature of expert knowledge (Engeström, 1992; Hakkarainen, Palonen & Paavola, 2002). This means that the methods used to solve problems and perform tasks of various kinds differ from one occasion to another, and depend on the context of the actions taken as well as on the role of the object. This view has become more widely emphasized through the organization of multi-

professional team work, and different approaches using the potential resources of networks.

Engeström (1993) has classified the development of interactive team-work as 1) coordination, 2) co-operation, and 3) communication. Aspects that define this kind of expertise are its poly-contextual character and tendency towards boundary crossing, discussed in the context of family therapeutic applications by Seikkula, Arnkil & Erikson (2003). The detailed contents and the usefulness of these three concepts of interaction in a family therapeutic context will be dealt later in Chapter 4.2.

In fact, both the individual/acquisition and interactive/participation perspectives have been emphasized in family therapeutic literature and the need for both perspectives is evident. The specific role and use of the therapeutic team has been emphasized in systemic family therapy (Selvini Palazzoli et al, 1978; Papp, 1983), in the need-adapted approach (Alanen et al, 1991), and in the reflecting team approach (Andersen, 1991; Friedman, 1995). The role of a single therapist has been central in, for example, the writings of Satir (1967), Minuchin (Minuchin, Lee & Simon, 1996), Andolfi (Andolfi, Angelo & De Nichilo, 1989), Epston (1997) and Byng-Hall (1995).

The two above-mentioned views of expertise (the acquisition view and the participation view) have also been described using the spatial metaphor of vertical and horizontal expertise (Aaltonen, 1999; Aaltonen et al, 2000; Launis, 1997). Vertical expertise refers to individually deepening capability and the gradual accumulation of knowledge. Horizontal expertise as a community-oriented phenomenon refers to the interactive ability of the experts to use their collaborators, teams and networks (also including the non-expert clients) as a resource and a means of problem-solving in carrying out the expert task. What is of importance in horizontal expertise is the crossing of the professional boundaries and barriers that characterize different sectors of expertise (Aaltonen et al, 2000).

The newest view on expertise is to recognize knowledge-creation as an approach "in its own right", which regards knowledge-creation as a mediating tool between the individual-cognitive and the social-interactive understanding of expertise (Hakkarainen, Palonen & Paavola, 2002). This is needed since all expert action should, in theory, include knowledge-creation, and the finding of new solutions to new problems, problems which have not existed before. The independence of this perspective can be questioned because of this mediating role, and because of the inherent creativity of all expertise as well as of problem solving. This perspective seems to highlight the context of discovery (Reichenbach, 1938; Paavola, 1998) and the specific form of scientific reasoning involved, namely abduction (Hintikka & Hintikka, 1998; Paavola, 1998; Peirce, 2001). Abduction here refers to attaining knowledge through hypothesizing and asking questions, or to detective methodology (Paavola, 1998).

From the family therapeutic perspective this third view of expertise is the one that has been of interest in the texts of therapeutic change (e.g. Hoffman, 1981; Wahlström, 1992): therapeutic change has been variously conceptualised as emotional /affective, behavioural/interactive, or semantic/cognitive. What seems to be a constant factor is the fact that the change in itself is unpredictable, or even

surprising; unique, and contextual; and it cannot be calculated or derived from the actual premises, that is from the basic circumstances of the client's condition and the treatment applied. Thus therapeutic change is both a context of discovery and a context of justification (Reichenbach, 1938), as the meaning, and significance of change is discussed and validated here and now.

Theoretically the acquisition view is based on cognitive psychology, and research is carried out in the tradition of individual psychology. The participation view leans on one hand towards activity theory, and towards social construction on the other. The proponents of knowledge-creation view aim to overcome the dichotomy separating the previous two.

2.2 Expert knowledge

Expertise, whether it is cognitive/individual or interactive/team-work based, consists of various kinds of knowledge (some of which is formal and operative, and some tacit, personal and cultural), and ways of using this expert knowledge. Thus expertise in action has these two dimensions of 1) substance, and 2) action. The substance dimension consists of the special knowledge of the subject which accumulates as a result of various learning experiences and through the conscious acquisition of knowledge in an academic context. Technical expertise (e.g. the information professions) is a good example of a field where the substance dimension is dominant. The action dimension in the human science context consists of different interactive and communication skills, parts of which are the achievement of normal individual development, and parts, of the special and conscious learning of these skills. The action dimension of expertise is dominant in the various fields of social expertise and human relationships. The action level is, however present in nearly every expert practice. This means that the expert has to have at her or his command the means to communicate and act in human networks.

Expert knowledge has been seen to have three different components: 1) the knowledge of facts, formal knowledge, answering the question of "what"; 2) the knowledge of means, practical knowledge, answering the question of "how" and; 3) the knowledge of how to evaluate knowledge; self-regulating reflective knowledge, the knowledge about the knowledge (Tynjälä, 1999). It is possible to see how for example, the diagnostic and therapeutic tradition of medical science is emphasized if the first two components of expert knowledge are the only ones highlighted in therapy practice. It is, however, knowledge of the third kind which is typical of different therapies; and especially of person-oriented therapies and collaborative practices of therapy (Anderson, 2001). The very same emphasis on the need for case specific information "from within" the therapy relationship was implicitly reported by the original Milan team in endnotes to "The Paradox and Counterparadox" (Selvini Palazzoli et al, 1978, 179): "...we naively repeated the same intervention in the case of another male anorectic, with an entirely different family situation, without obtaining, as should have been expected, any result." In

the context of therapy, acquisition of the knowledge of facts (1) should include both the abstracting, dis-embedding process of modern expertise (Giddens, 1990) and knowledge of the third kind i.e. the knowledge obtained from within the relationship (3) (Shotter, 1986). The combination of these two kinds of knowledge represents a re-embedding process of high modernity.

The above-mentioned categorization does not explicitly mention or differentiate scientific knowledge, nor deal with the application of scientifically produced knowledge. The scientific character of knowledge is not an exclusive criterion, though expertise is seen as one form of the application of scientific knowledge. The field of psychotherapies has emphasized the evidence-based therapies, which without a doubt highlights the scientific character of the knowledge base (Castonguay et al, 1999; Norcross, 2002). Expert knowledge can be scientific knowledge but is not necessarily so: expertise does not presuppose science, but science and scientific progress presuppose expertise in the form of the capacity for abstracting and generalizing. Popper (1962) noted this paradox as he dealt with the issue of differentiating science from pseudo-science: science can give rise to errors and pseudo-science "may happen to stumble on the truth" (1962, 33). The issue of errors and faulty assumptions has also been dealt with by Fleck (1935).

The relationship of (natural) science and society has been dealt with by Nowotny, Scott & Gibbons (2001). Their main argument is to emphasize the role of the context, of contextualization, and of the rich interaction of science and society which is described in the context of co-evolution. This issue of reflexivity is dealt with further in 2.3.

Fleck (1935) heavily emphasized the role of the collective in the creation of new knowledge. Thus he was a forerunner of interactive expertise. In the beginning of the 1990's Gibbons et al (1994) published a book dealing with mode 2 of the production of knowledge, the emphasis being on trans-disciplinary knowledge production. The subject of the book was scientific knowledge, and the new trans-disciplinary attention given to the social context of this process as an alternative or evolved way of knowledge production. Horizontal expertise had thus also become a way of doing scientific research and producing knowledge. Gibbons et al differentiate between embedded knowledge and migratory knowledge. Embedded knowledge is tacit, experiential, and not available as a text; being personal and not very rapidly transferred. This concept of knowledge is based on Polanyi's (1962, 1966) idea of tacit knowledge as the form of knowledge which cannot be articulated: "we can know more than we can tell" (1966, 4). Migratory knowledge is codified, often in a written form as a text, and it is also mobile and rapidly transferred.

Traditionally, expert practices were hierarchically organized. This meant that a position of power was attached to the position of expert. The role of expert included a variety of rituals in delivering the expert information, which highlighted the asymmetry of the setting. Expertise was bound to time (e.g. office hours) and place (e.g. clinics, bureaus); dis-embedding the time and space of the client. "Second expertise", as Giddens terms the new forms of expertise, or migratory knowledge, according to Gibbons et al (1994), is not based on trust in abstract systems, but on the person. This re-embedding is visible in the fact that

expertise is actualized separately from specific times and places; giving up the rituals without giving up the expertise. The same emphasis was already present in Polanyi's presentation of personal knowledge (1962), when he criticized modern science for producing detached knowledge and marginalising the personal element. It is worth noting that Polanyi (1962) does not refer to Vygotsky; who had expressed the view that consciousness and reflection come after skills have been acquired (Shotter, 1989; Vygotsky, 1931).

While discussing expertise Nowotny, Scott & Gibbons (2001) have also been "re-thinking science in an age of uncertainty". Tolerance and dealing with uncertainty has been one central focus in the changing position of expert knowledge. Scientific progress has been unquestionable but in spite of all the progress, new and unexpected risks have become evident. The progress made cannot cancel the uncertainty. On the contrary, scientists have to be more aware than ever of all the possible implications of their work.

While discussing interactive expertise, Engeström (1992) has also emphasized the disadvantages and weaknesses of team-work. One of these is the social conditioning of thinking in group-work, noted by Fleck as early as in 1935; which leads to self-reassuring rhetoric and makes it difficult for people to critically evaluate their own actions. Engeström's examples are from multi-professional teams (1992, 1993) (Engeström's own research areas have been court practices and public health care; that is to say, the emphasis has been on the 'social'). The collaborative, client-centred orientation of family therapy is not present in these analyses, but we can ask if the constraints of change are similarly behavioural, interactive, and cognitive, as they are in multi-professional teams.

2.3 Reflexivity and reflection

These changes in the concept of expertise are not simply a matter of semantics, since they are also visible in the expert practices employed at many levels of society. Since the expert's role is no longer merely hierarchically constructed; not, at least, in the areas of human life, there is no more safety left in the ivory tower: "the context speaks back", as Nowotny, Scott and Gibbons put it (2001, 50). Faceless commitment has been replaced with facework commitment, and trust is no longer placed in abstract systems, but in persons (Giddens, 1990); and these reflect the re-embedding tendency as a counter-force to dis-embedding. This is visible in the areas of social welfare, social services, mental health services, and psychotherapy: the client's voice and participation are not to be ignored. The knowledge of a vast quantity of facts does not justify the expert's position. There is a constant demand for accountability, transparency, and operating in public: openness has become an essential part of expertise, and expertise cannot be put into practice without negotiation (Anderson, 2001; Eräsaari & Jokinen, 1997). Collins and Evans (2002) see this as the result of changes in the structure of society which are also reflected in the second wave of science studies, when science was studied as a social activity. It's a result of the new epistemology of the sciences, and the discursive turn taken

by the social sciences. When multi-voiced conversation became the dominant guiding metaphor, it became important to be able to reflect on the basis and usage of knowledge, and to articulate it. This is especially clear in the field of family therapy, and the subject will be dealt with in detail in Chapter 4.

The concepts of 'reflective' and 'reflexive' have been used optionally and synonymously (Alvesson & Sköldberg, 2000) to describe the process of critically thinking about the premises of one's own thoughts and knowledge. In the history of science and in epistemology these concepts have different meanings, however. "Reflection" refers primarily to critical and speculative thinking in general. "Reflexivity", on the other hand, refers in a more limited way to self-referral; and consideration of the premises of one's own thinking. Lawson (1985) has dealt with this question in detail, in connection with the roots of post-modern thinkers such as Nietzsche, Heidegger, and Derrida. In the area of research this approach can be taken to such extremes that language is seen as referring only to language, and words as referring to other words (or the texts of social science, as referring only to the texts of social science (Latour, 1988)); so that reality cannot be reached through linguistic means. To use words is to enter into an endless reflexive loop. From another point of view, the practicality of words, the practical context for the use of signs offers the possibility of abandoning or overcoming this non-representational stance (Leiman, 2000), or on the other hand, of emphasizing the moral choices embedded in our conceptions of human nature (Pinker, 2002) and the context of implication (Nowotny, Scott & Gibbons, 2001).

As regards the question of the interaction between research and reality, Gergen (1973) and Giddens (1990) have emphasized the reflexive nature of the relationship: knowledge of social life attained by experts impinges on the subject matter, i.e. social life and social reality; altering it. Thus the continuously changing character of the basis of knowledge shows the impossibility of even science reaching certainty. According to Giddens, this reflexivity is typical and an essential characteristic of high modernity.

What is curious, in view of the reflexivity of psychotherapy in general and of family therapy in particular, is the fact that theorists seem to repeatedly forget that the things they say about human behaviour apply equally to themselves (Amundson, 2001; Spence, 2002).

Sometimes this distinction between reflexivity and reflection is blurred; giving rise to confusion as to the exact meaning of these terms. To clarify this point I use the terms 'reflexive' and 'reflexivity' to refer to phenomenon of self-referring activity; and the term 'reflection' to refer to (critical) thought processes in general; whether these are self-referring (thus "reflexive") or not.

3 EXPERTISE IN PSYCHOTHERAPY

3.1 In what way is psychotherapy an expert task?

Psychotherapy deals mostly by verbal means with the problems of living, and the phenomena of psychic disorders, symptoms, and the various questions of personal meaning-making. It uses a variety of directing theories in order to organize the flow of information during the therapeutic encounter. This definition emphasizes the therapeutic means used, and the underlying theory; which are based on scientific research. Theories provide an orientation for the therapy process. Nonetheless, during each therapy process the therapist needs to adapt to the situation in unique ways; co-constructing new solutions, new ideas, and new questions out of her/his personal experience, theories, and the ongoing interaction with the client. As an expert task, psychotherapy demands the constant application of different interventions and theories, as well as constant evaluation of the interaction. Psychotherapy also demands evaluation of the therapist's own position in relation to that of the client/s, and evaluation of the therapeutic process; this evaluation to be carried out jointly with the client or clients.

Therapeutic interaction progresses mostly through verbal means; words are the tools by means of which the meanings are most often communicated. This is not, however, always the case; and there are also therapies which rely principally on non-verbal means; for example, art therapy and music therapy. Whether verbal or non-verbal, in psychotherapy there is also a need for interactive skills, some of which, it has been claimed, are based on deeply personal tacit/ unarticulated, experiential/pre-narrative knowledge, rather than on science or the results of scientific research.

An account of a mode of therapy usually includes a presentation both of the theory and of the techniques associated with that mode. In some cases the most common fields of application, as well as some supporting research results are also included in these accounts. Theories are usually closely linked to the theory of change, that is, the developmental theory and psychoanalysis, or the cognitive theory of psychological disorders. In psychoanalysis the process of change follows the lines of the psychological development of emotions and personality: each

psycho-analysis is a context for research into basic psychological processes. In cognitive theory, on the other hand, development is not emphasized in the same manner. The problems are seen in the light of symptomatic behaviour; the emotions connected to it as well as the beliefs. In this tradition it is possible to produce change through any of these ways.

The attitudes among psychotherapists towards the idea of psychotherapy as an expert practise are not, however unanimous. In the tradition of humanistic psychology, on the one hand, psychological growth is emphasized, and so the theory of therapy does not focus on development or highly specified techniques. Rogers (1957) detailed the necessary and sufficient conditions of therapeutic change, and his list is not highly theoretical or based on developmental theory. On the contrary, Rogers emphasizes qualities or dimensions of interaction that are theory-free, and as such not therapy techniques. The same theme is highlighted in the field of family therapy as described by Anderson (2001): therapy is seen more as a philosophical stance and attitude than as a theory or a set of techniques. And simultaneously there is an expert position: "A therapist can say anything, but critical to their expression is intention, manner, timing, and tentativeness. It is also important to realize when and how these kinds of therapist ideas or knowing risk building roadblocks, or, to use Rogers' word, *retard* collaborative relationships and dialogical conversations" (Anderson, 2001, 351). This is quite similar to Patterson et al's (1998, 110) definition of the considerations of importance: "…issues of process and content, timing, and even clients' anxiety levels when selecting specific interventions."

The asymmetry of psychotherapy is in the end unavoidable: Anderson (2001) emphasizes that therapy always takes place in a certain context and with an agenda. The participants in the therapeutic conversation or discourse come to the situation from very different backgrounds: the client asks for help from a professional, the therapist and the therapist offers her/his outside perspective for the client's use. This asymmetry arises from the fact that therapy can serve to promote empowerment and engagement, as well as re-appropriation and dependence and passivity (Giddens, 1991). The asymmetry has to be dealt with somehow, and it is the theory of the applied mode of therapy which gives the outline of the things to be done. Ways of dealing with the asymmetry and defining the positions and the relationship are, e.g., the therapy contract, and the internal rules of therapy; experiential work with the feelings provoked in the situation, and joining with the conflict-free-sphere of the ego as well as decentralizing and empowering practices from the therapist's side in order to alleviate the conflicts of the client's agency in these phases.

As a representative of high modern expertise and of a reflexive project (Giddens, 1991), psychotherapy is typically reflexive. Reflexively the continuously intertwining processes of understanding and confusing keep changing each other during the entire course of therapy: successful therapeutic intervention produces therapeutic change, providing new therapeutic challenges or an opportunity to end the therapy. Giddens connects this with the idea of life-planning, simultaneously omitting all the descriptions of the reason for seeking therapy. Psychotherapy was developed in order to help people in dealing with different

types of personal suffering and meaning-making. The definition of psychotherapy (only) as a means of life-planning, even in the post-traditional society of multiple choices, is narrow and impoverished when viewed against the background of suffering.

3.2 Three perspectives on expertise in psychotherapy

Therapeutic expertise represents a domain-specific dimension in the totality of expertise research. As such it has been conceptualized directly in therapy manuals, textbooks, case histories, and other accounts of the therapy process. Parts of this expertise are grounded in scientific research, and parts are based on clinical experience. Often these accounts and conceptualizations are closely connected to the therapeutic approach in question (Leiman & Stiles, 2002). The same concepts have different meanings in different approaches, and compatibility is not self-evident. Here expertise in psychotherapy will be approached from three differing perspectives: 1) How the question of expertise is seen through different focuses of psychotherapy research; 2) what kind of knowledge is needed in psychotherapy; and 3) knowledge as a tool for reflecting and reproducing the theory of psychotherapy. The aim of this paragraph is to present some key ideas bearing on this question, and to deal with the general and common factor of expertise in psychotherapies, i.e. 'non-specific factors'; but not to compare different modes of psychotherapy. Psychotherapy has been viewed as an autonomous discipline apart from psychology and psychiatry, merely as a pre-paradigmatic one (Deurzen-Smith & Smith, 1996). In this presentation the aim is not to argue for or against this view, but to look for the common factors which are present in at least some of the approaches of current psychotherapy. These views bring the abstract expertise question closer to psychotherapy, as well as showing some of the complexity involved in applying general principles and knowledge in psychotherapy.

3.2.1 Research focuses as a guide to expertise

Psychotherapy research has focussed on three main areas (Norcross, 2002; Wynne, 1988): those focussing on variables of therapy/therapist; on variables of disorder/client; on variables of therapeutic alliance/interaction/collaboration. These areas dominate both outcome research and process research. The dominant guiding metaphor has been the drug metaphor, i.e. therapy is seen as an independent variable in a scientific experiment or in a quasi-experimental setting. This has resulted in research where the focus is on specified therapeutic techniques and disorder-specific knowledge, while all the various relational aspects are marginalized. However, the setting, and the explanatory power of the three groupings of variables detailed above has been heavily criticized (Norcross, 2002). The context of psychotherapy is seen by the critics as an ideographic and reflexive one, so that group comparisons are problematic both scientifically and ethically (Alanen et al, 1991).

Research focuses concentrated on the diagnosis/classification dimension and the therapy techniques dimension are based on the ideal of experimental research in which the relationship aspect is neglected or bracketed. This means also neglecting the subject character of the object of psychotherapy. In alternative modes of research there is an attempt to find a different guiding metaphor, as the therapeutic change and developmental process in therapy is seen as learning or adopting a new view. The relationship aspect of psychotherapy is highlighted, and research data is collected in a natural setting, i.e. as various kinds of recordings taken from therapeutic sessions. This kind of research leans more on qualitative methodology and ethnography (Kvale, 1999; Lincoln & Cuba, 1985; Stiles, 1993, 1996).

3.2.2 Different types of expert knowledge in the field of psychotherapy

The ways in which knowledge is used is also a handy route to understanding expertise whose value is problematic and in doubt in psychotherapy. A division into three categories has been used: Knowledge of how things are/ factual knowledge; knowledge of what to do/ know-how; and knowledge of the third kind, the knowledge arising from within the relationship (Shotter, 1986; Tynjälä, 1999). These three categories can be theory-informed, clinically-informed, or based on research. These categories are reminiscent of the perspectives of expertise as Hakkarainen et al (2002) described them: the first category refers to recognizing and differentiating clinical phenomena (both for diagnostic and therapeutic purposes); the second, to the variety of therapeutic options and interventions in use and the ability to choose between these; and the third, to unexpected or unpredicted formation or creation of new knowledge, as well as the ability to make contact with people and share meanings with them.

3.2.3 Reflecting and reproducing theory through therapeutic expertise

Therapeutic work in its secondary role of scientific activity also has the potential to reflect, reproduce, evaluate, and question already-articulated models and existing theory (Fonagy, 2003; Spence, 2002). This is often done within the case-study tradition based on the possibility of falsifications: a single case running counter to an articulated theory or model is enough to show that the generalization behind the model is flawed (Deurzen-Smith & Smith, 1996). Freud is maybe the most durable example of this kind of work with his own findings, even though Popper claimed that psychoanalysis was not scientific because its propositions could not be falsified (1962). In the field of psycho-analysis there is an ongoing debate as to whether psychoanalysis should be seen only as a therapeutic approach, or as a method for carrying out basic research into personality (Aisenstein, 2003).

Therapy as a context for science and scientific research represents the Mode 2 means of knowledge production (Gibbons et al, 1994): knowledge is produced in the context of application; and the first evaluation of it, or the first quality control takes place reflexively, and publicly in a transparent manner, during the therapy process carried on jointly by the therapist and the client/s (Kvale, 1999). To

differentiate between basic research and the application of research becomes more difficult, and unnecessary.

Using psychotherapy as the context of scientific activity in an experimental context presupposes that the therapist is able to articulate her/his way of doing psychotherapy, and has some basic theory for her/his way doing it; and that therapy is conducted coherently according to the theory. If these preconditions are met, then it is possible to evaluate whether the therapy has at least partly produced the expected change. It often happens, however, that a therapist can be seen to be doing other than what s/he herself / himself, or the manual prescribes. It must be noted that even though it might sometimes be useful to do manual-based psychotherapy for experimental research purposes, this does not inevitably lead to an improved outcome (Castonguay et al, 1999).

The above-described situation in which clinical practice serves as a laboratory in which to test theory would be possible if the clinical practices of psychotherapy were manual-based, and the theories-in-use in accordance with espoused theory (Argyris, Putnam & McLain Smith, 1985) and could therefore legitimately feature in experiments of the kind evisaged. There is, however, a constant need for more distinctions, and the analysis of existing modes of psychotherapy, not least in the area of family therapy (Pinsof & Wynne, 2000; Sprenkle & Ball, 1996). Among possible solutions are 1) to do discovery-oriented research in order to identify the curative factors of therapy (Mahrer, 1988; Mahrer & Boulet, 1999), 2) to define therapeutic change differently; giving up the drug metaphor, and emphasizing the learning aspects of change (Pinsof & Wynne, 2000; Stiles, 1996; Stiles et al 1990, 1992), or 3) to develop the methodology for research into the therapeutic relationship (Norcross, 2002).

Therapeutic theories are, in principle, not exclusive but open-ended, reflexive, and liable to change as dictated by the gradual accumulation of professional knowledge. Spence (2002) criticizes psychoanalysis for the conservative tendencies of the research, which are apparent in the continued prominence of Freud's original model. The assimilation model applied in this study is one example of theory, where a concept of more general applicability, namely the concept of assimilation taken from the cognitive psychology of Piaget, has been used to describe a single change in therapy. The present research is conducted in order to develop the model, and evaluate it in different therapeutic contexts (Stiles, 1996), without making the model exclusive. The assimilation of problematic experiences can thus be applied with different modes of psychotherapy as the model of therapeutic change.

4 FAMILY THERAPY AS AN EXPERT TASK

4.1 With and without the one-way screen

How has expertise been described during the written history of family therapy? The development of family therapy has gone through some major phases (Dallos & Draper, 2000; Goldenberg & Goldenberg, 1996); first, from individual therapy to the idea of seeing family members together in joint sessions and abandoning the idea of an identified patient (the roots and course of this development have been described e.g. by Goldenberg & Goldenberg, and challenged and questioned as "the official history" by Beels (2002)). This first change signified the shift from just concentrating on the intra-psychic to concentrating also on the interpersonal level.

The leaning towards systems theory and cybernetics emphasized the development of strategic approaches employing a variety of therapeutic techniques. This led to the birth of different schools; including, for example, brief therapy (Watzlawick, Weakland and Fisch, 1974); problem-solving and strategic therapy (Haley, 1979; Madanes, 1981); Milan-systemic therapy (Selvini Palazzoli et al, 1979); and solution-focussed therapy (de Shazer, 1985). The discursive phase entered upon by the social sciences and psychology, and the narrative phase in therapy were reflected in family therapy as a revival of more conversational approaches and the birth of so-called post-Milan systemic therapy; as well as various narrative approaches (Anderson, 1997; Dallos & Draper, 2000; Dallos & Urry, 1999; Jones, 1993; Real, 1990; Smith & Nylund, 1997; Wahlström, 1997; White & Epston, 1990).

The principles used to define the profession of psychotherapist are also valid for family therapy. One of these principles is to emphasize the role of theory and research. Thus the knowledge basis of psychotherapy is reproduced process by process. The problems that surround the use of these definitions are also valid in the case of family therapy.

The beginnings of systemic therapy can be seen in the work of Bateson's group during the fifties (Bateson, 1972). This group produced the concept of double bind, which has been durable both in the development of the systemic understanding of schizophrenia and in the development of the strategic

approaches used in family therapy. The models and tools of work set a standard for family therapeutic sessions for a long time. In the systemic era of family therapy there were at least three dimensions in the therapy and the therapy setting that highlighted the traditional therapist-centred scientific expertise in preference to interactive expertise: 1) Therapy sessions were conducted in the context of a one-way screen, a setting which emphasized the laboratory-like nature of the therapeutic setting. This clearly connoted science and scientific observation. This setting also ignored the perception that the object changes as a result of the process of observation. 2) The subject-character of the family as the object of therapy was emphasized by the fact that family brought the information through their story and non-verbal action into the setting. The object character, on the other hand, was emphasized by the fact that the family was the target of intervention made from a hierarchical expert position. 3) The problem-definitions in systemic family therapy were concentrated on the subject's observed behaviour, marginalizing the semantic dimensions of feelings and meaning as well as developmental perspectives (Erickson, 1988).

The birth of reflecting, and narrative therapy can be seen as a response to this above-mentioned emphasis on observable behaviour. After the Milan phase of family therapy there were various efforts to redefine family therapy. Among others, chaos theory, biological ideas of structural coupling, and cognitive constructivist ideas were tried as a possible new orientation basis for therapy. It was, however, social construction theory which was most widely accepted, and used in the study not only of observable behaviour, but of invisible feelings, interpretations of reality, meanings, and the interactive social process of negotiating these issues in relation to each other. It is Salvador Minuchin and his associates who have most emphasized observable in-session behaviour, and made the claim that "therapy should be oriented toward action" (1996, 12).

Flemons, Green and Rambo (1996) have attempted to classify and differentiate different levels of family therapeutic skills, from basics to the level of expertise. Their starting point was to ask how it is possible to classify expertise if there is no privileged expert position left, in the era of social constructionist and post-modern epistemology. Through joint processing the authors ended up with a model of 32 levels of therapeutic skills. The teamwork nature of family therapy is largely ignored in this model, as well as the role of the client system, even though it was present in the construction of the original levels. This model is representative of the acquisition model in its classification: from novice to expert, again. The character of the family, or some other human system, as the object of therapeutic work is also largely ignored in the classifications employed by this model. The very same emphasis is also present in Patterson et al (1998) when they describe the different means of developing expertise. The question of the development of teamwork and horizontal expertise will be dealt with in more detail in the next chapter.

Sensitivity to changes in the client system has been a central feature of family therapeutic expertise, whether in the form of problem solving, relief of symptoms, more open patterns of communication, clarified family and subsystem boundaries, or the expression of feelings. These changes, either minor or major, may be

observable and behavioural or subjective, experiential and semantic. This sensitivity must be highlighted, since the diagnostic classifications of clinical phenomena tend to over-emphasize stability. Thus psychotherapeutic and family therapeutic reasoning has always a curious Galileian (Lewin, 1931) interest in details that do not conform to the general rule: in psychotherapy one exceptional situation or unique outcome, even if momentary, is enough to call in question the power of the problem; and to challenge the client's personal rule or law (behind the dysfunctional behaviour) (Minuchin, 1966; de Shazer, 1985; White & Epston, 1990). The uniqueness of a deviant event is not seen as diminishing its significance. On the contrary, it may be all that is needed in order to start an inquiry into the client's resources (Shotter, 2002). To take notice of an exception or a unique outcome is to conduct an abductive reasoning process in order to form an alternative hypothesis (Peirce, 2001; Rober, 2002). Thus a single therapy provides a valid setting for possible discovery or innovation.

4.2 Attitudes towards expert positions in present-day family therapy

Since the ways of relating to the object of the expertise have been important in making earlier distinctions, it seems reasonable to start this evaluation from the same point, with particular reference to family therapy. The systemic schools emphasized the subject-object character of the family: the client family and family members provided the therapeutic team with necessary information, and the team was responsible for the intervention.

If the interactive nature of expertise is highlighted there is a very clear difference in the role of the object during the strategic era and during the post-Milan era. Through the development of post-Milan schools (reflective and narrative therapy) of family therapy the family as a subject-object of the therapy acquired a participant position which had not been previously available. The difference is also highlighted in the concept of "therapeutic system" i.e. a system which includes both the client system and the therapeutic team.

One specific issue has been the role and the position of the therapist, which has fluctuated from that of a very active proponent of change to that of a more passive interviewer. Minuchin, Lee & Simon (1996) have categorized the roles of the therapists of different schools into two main types: the restrained therapist and the interventionist therapist. The question of the therapist's position is connected with the question of the expert's power as opposed to the client's agency; which has been a robust theoretical and clinical subject since the early days of family therapy (Goolishian & Anderson, 1992). Part of this discussion can be condensed in the dichotomies of linear - systemic, interventionist - restrained, therapy of certainty - therapy of curiosity, logico-scientific mode of therapy - narrative mode of therapy, and modern – post-modern.

From the family-therapeutic perspective the issue of reflectivity is of interest. The reflecting team approach, and the reflecting processes, as Andersen (1987, 1991) has conceptualized them, was a part of the development of the family-

therapeutic setting. This served the purpose of making the asymmetry of therapy less sharp, and the situation more multi-directional as a countermove to the original Milan approach. This allowed the client system a participant role in the therapeutic process. The position of the team in the Milan approach was different from that of the reflecting team. From the perspective of hindsight the Milan approach can be seen as a developed phase of strategic therapy (Real, 1990) and as such it stood for anonymous and hierarchically-organized expertise with a one-way-screen, an unchanging course of the session, and the unapproachable "faceless" team. The difference in interview practices and other details of the setting, i.e. the break, screen, and specific use of the team led to different developments in the method, as was seen in the work of Cecchin and Boscolo as well as Tomm on the one hand, and Selvini Palazzoli and Prata on the other.

In the above discussion many of the authorities cited are seen to be critical of systemic therapy. This does not mean that the therapeutic praxis is unable to profit from any of the innovations of the systemic therapy era. On the contrary: as Dallos and Urry (1999) have pointed out, there is no need to throw away those tools that have already been developed simply because the theoretical context in which they will be used has changed.

Now we may ask if the reflectivity of family therapy necessitates reflecting practices in the form of a reflecting team, or whether it may be possible to achieve reflection without the team. Reflection in itself is not the invention of reflective therapists. The philosophical roots of the concept were dealt with in chapter 2.3., and here I shall only deal with reflection in the context of family therapy. The simplest answer to the question seems self-evident: therapy must always include reflectivity and reflection if it is intended to be productive.

Engeström (1993) has classified the development of interactive team-work as 1) coordination, 2) co-operation, and 3) communication. His aim was to combine the instrumental-object and social-interactive sides of the action of a team. All these concepts are also familiar in the field of family therapy, but their application is quite different, and cannot be transferred to the family therapeutic context without the danger of confusion. In order to develop understanding of these concepts I will briefly describe Engeström's ideas.

Coordination is the first phase in the development of team-work. In this phase it is typical for team members to concentrate on bringing out their own opinions, interests, and individual points of view. This kind of interaction Engeström regards as self-evident and routine, and governed by an unwritten script. In the coordination phase of interaction the participants also make clear their own limited interests and professional affiliations.

In the second phase of the development of team work, co-operation, the problem is seen jointly. There is a need to solve the problem in such a way that the solution can be approved by all. The solutions can be qualitatively new, and their development has required crossing the boundaries of the assumed script. The script, however, is not fundamentally challenged or changed. This means that the co-operation phase is typically quite a short, intensive period of interaction, and the changes in interaction are typically temporary.

Communication is the concept that defines the third phase of the development of team-work. Engeström sees this as a process whereby participants reflexively turn their attention both to the object task and to the script, and reflect on their own interaction. This allows the team to define its own long-term developmental aims.

How should we use these ideas when we deal with the processes of family therapy? It is obvious that these issues have also been dealt with in the family therapeutic context, even though the concepts involved have been different. I give two examples here as an illustration to highlight both the instrumental-object side of team action and its social-interactive side.

In order to treat psychotic disorders and especially schizophrenia effectively there have been developed treatment models which allow combining different modes of therapy and medical care. One of these models is the need-adapted model (Alanen et al, 1991). The model is based on long-term research into schizophrenia and its therapeutic treatment. The object of treatment, i.e. schizophrenia, is seen as a multidimensional disorder which, to be treated effectively, demands taking note of both the individual and the social development of the patient, both her or his physical-somatic and her or his psychological well-being, and both psychological therapies and medication; all of this to be carried out in the context of the therapeutic attitude, facilitating the continuity of psychological understanding. The model is also reflexive in the way that Gergen (1973) and Giddens (1990) described it: the needs of the patient change as a result of the treatment, and this means that the treatment must be adapted to suit these changing needs.

In this case the effort to exclusively apply Engeström's concepts of coordination, co-operation and communication is a complex one. The agents of the different treatment modalities have to be able to use their own professional skills, to speak with their own voices (coordination) as well as be ready to try out new combinations of therapies and treatment modalities (co-operation) and also to challenge and question the order of therapeutic progression and the roles of the team members (communication). Thus what is highlighted in these models is the reflexive development of the model itself, adapting continuously to the patient's changing needs in a case-specific way. A new finding in the Finnish project for the treatment of acute psychosis also emphasised horizontal expertise in conducting a successful treatment process (Aaltonen et al, 2000).

The social-interactive side of team action is highlighted in the work of Andersen (1991) and Seikkula (2002; Seikkula, Arnkil & Erikson, 2003). Andersen originally published the idea of the reflecting team as an alternative to the way the therapeutic team was used in Milan family therapy. The session was organised in such a way that the client family had the opportunity to listen to the team's conversations. (This was something completely contrary to the principles articulated for the original Milan approach). Seikkula, on the other hand, has been developing the open dialogue approach to therapy. Both these approaches emphasize following the client's lead, careful listening to what is said, linguistic coupling to the client(s), and assuming a position of not-knowing so as to facilitate the emergence of the reflecting position. The focus of these approaches is more on

the therapeutic discourse itself, as in the clinical phenomenon. The therapeutic aim is defined as the promotion of dialogue which is defined as an open and multi-voiced process; and it is envisaged as a therapy of curiosity which tolerates confusion and uncertainty (Smith, 1997), as an alternative to monologue, which is defined as exclusive and the therapy of certainty.

If we compare the concepts of coordination, co-operation, and communication with these ideas, it is tempting to see equivalence between the extremes of the development, namely coordination and communication, with the concepts of monologue and dialogue. Since monologue and dialogue are dimensions of communication and definitions for therapeutic interaction it is important to remember the specific content of Engeström's concept of communication.

5 THE NEW RESEARCH TASK

5.1 Summary of original communications

The empirical basis of this study consists of a series of four case studies (I, II, III, and IV) which exist as separately-published articles. These studies are applications of qualitative case research methodology which were carried out in order to study therapeutic change and change in therapeutic interaction. Research interests varied from the process of change and the role and actions of the therapist and therapy team, to the preconditions of change and to family therapy research methodology; all these interests are closely connected to family therapeutic practice. Most of the theoretical discussion in the context of family therapy has been about social construction theory and post-modern thinking. Here the expertise perspective is taken in order to enrich dialogue about therapy, and enable dialogue between these differing approaches to therapy practice. The articles as a whole are the second part of this dissertation, and here I shall present only a brief summary of the findings.

5.1.1 The process of change in family therapy

The "global" therapeutic change which is taking place in the family therapy process is a multi-dimensional phenomenon. Each of the above-mentioned articles deals with partial changes, and parts of the overall outcome. The research was oriented towards the therapeutic process, and therapeutic interaction; not to the outcome as a quantitative variable.

Articles I and II are concerned with the same clinical case and two alternative perspectives were taken in looking at the therapy process and therapeutic change. In article I research was carried out as a theory-informed case study. The research task was to observe how the therapists and therapy team dealt with the negative connotations of different diagnostic remarks in a case of childhood psychotic reaction. The family-diagnostic concept of "enmeshment", and its (non)therapeutic use was studied. The main results gained from the process-of-change perspective were 1) the moments when the negative connotations of diagnostic remarks

become apparent are also the moments when change takes place; 2) therapists have to adopt an inquiring approach and attitude to therapeutic work; and 3) therapists have be able to integrate nonverbal experiential technique with the verbal reflective approach.

In article II the same therapeutic process, and the same data was looked at through the lens of the therapeutic assimilation model (APES). In this model the global therapeutic change is seen to consist of a number of processes of partial change. In the course of these processes the client's different problematic experiences are dealt with in such a way that their assimilation is possible; the experience of negative affect is lessened and neutralized; and the client has adaptive ways of dealing with the experience available for her/his use. In the clinical case a single assimilation process was analyzed as a methodological triangulation. Without transcribing all the treatment process sessions it was, however, possible to use the usual clinical data with the addition of some research data in the assimilation analysis. From the assimilation perspective the process of change was added to with developmental and family historical information which were obtained in a condensed form through an experiential family therapeutic technique of family sculpting: 1) The non-verbal therapeutic technique (family sculpting) and the verbal reflecting team approach were used jointly, enabling the use of different communicative channels. This made it possible to develop the pre-narrative experiential contents into narrative form, 2) the nearness/enmeshment topic (highlighted in article I) became more considerable, with some key experiences in the family history connected with it assisting their assimilation.

Thus the above-mentioned articles I and II give a double description of the expertise deployed during a family therapy process. Depending on the perspective of the research methodology, the emphasis is either on the here and now of the therapy or on the developmental family history. The shift of perspective highlights the presence of both traditional/vertical expert knowledge (in the use of specific therapeutic techniques) and interactive/horizontal expertise (in promoting dialogue and providing conversational space for the clients).

In articles III and IV the process of change perspective was less present than in the first two articles, and the emphasis was more on the preconditions of change (5.1.3).

5.1.2 The role and activities of the therapist and the therapy team

The role of the therapy team has been central and important during the entire course of systemic family therapy, starting from the Bateson group and continuing to the Milan approach, the Greek choir and the reflecting team. In the Finnish family therapeutic context, teamwork has had a central role because of the importance of the multi-professional public sector as a central context of family therapy, and the role of the applications of the need-adapted treatment model of schizophrenia. In this study, however, the role of the team has been more marginal, in comparison with that of the individual therapist.

The role of the individual therapist, who has her/his own methods, were highlighted in articles I, III and IV. In article I one of the main findings concerning

the actions of the therapist was the finding that the therapist's failure to contain different aspects of nearness could be used for the benefit of therapeutic change by incorporating action-level phenomena in verbal reflection, thus facilitating the enrichment of the ecology of meanings. In article III the participating therapist had described her own orientation, and the analysis was a triangulation of the espoused theory and the theory in use. Basic actions were also reflected by the therapist, but the analysis made visible what the therapist did, quite apart from what was expressed in her own account of typical therapeutic actions.

The roles of the therapy team and co-therapist were analysed in article I. The team's way of discussing the nonverbal contents of different family sculptures, highlighting the positive connotation (introduced by the identified patient himself) instead of negative ones was emphasized in the reflecting process.

The consideration given to the role of the therapist, and of the team highlights the dimensions of expert knowledge used. Diagnostic information is typically knowledge answering the question "what". The various interventions, on the other hand, are part of the "how" -dimension. Change seems to be connected, according to the case studies, to the use made of knowledge of the third kind, the knowledge "from within" the therapeutic situation. Interventions based on accurate diagnosis may be necessary but not sufficient in order to promote change. As articles I and II showed, the identified patient's introduction of a positive connotation for the issue of enmeshment/nearness served to open up the problematic temporal-developmental themes of family history. This positive connotation created a dialogical dimension for the family-diagnostic category, expanding the hierarchical expert view of the situation into an interactive-horizontal view.

5.1.3 Preconditions of change

Each of the four articles postulates certain preconditions for therapeutic change, whether global change or one or other of the component processes of this. The outcome of the therapy was described in articles I and II, and articles III and IV dealt with the questions of joining, collaboration, and the construction of the therapeutic system. Thus parts of the preconditions are connected with macro-level processes and parts with micro-level interaction.

From the outcome perspective these preconditions of change, according to this study are: 1) the questioning of basic assumptions connected with clinical phenomena in order to investigate the semantic and meaning level of behaviour, 2) the interest in individual variation, and even minor changes, i.e. unique outcomes and exceptions to the problem-saturated story in the context of client-centred orientation so that the diagnostic conversation can be predisposed to bring about change, and assist in dealing with problematic experiences, and 3) the use of different therapeutic modes in order to assist change of perspective on the problem in hand, both for the clients and the therapist and therapy team.

The main focus from this perspective in both the latter two articles, III and IV, was the meaning of the beginning of therapy process for the formation of a joint effort to carry out therapeutic exploration, and to join together in a research project

in order to deal with delicate and private marital matters. Details of this process in the micro-level interaction include, according to articles III and IV, 1) all therapeutic interaction (and all interaction taking place during a therapy session) which serves the definition of the collaborative relationship, e.g. “We cannot not communicate”, 2) client-informed production of the therapeutic plot (also present in article I); 3) co-construction of therapeutic context; and 4) reflective contextualisation of the problematic relationship issues (between spouses and between the couple and the therapist), on account of which the social/interactive context of therapy changes constantly, and reflexively.

The above-mentioned questions are a part of expertise and imply expertise decisions and choices, even though the aim of these manoeuvres is to give up the expert position based on the ownership of “hidden” knowledge (which would possibly act to limit the client's agency); and to emphasize the outside therapy team as the source of help. Thus the focus of expertise is more on the interactive process of therapeutic discourse and conversation rather than on the contents of conversation (as a representation of internal world).

5.1.4 Family therapy research methodology

The research methodology applied in this series of case studies has consisted of different qualitative methods: 1) a theory-informed case study, 2) the application of an assimilation model, and 3) and 4) a micro-analytic case study using the Narrative Process Coding System (NPCS) method. The results have been presented in linguistic form and empathy has been a central observation strategy. The common denominator has been the effort to work in a clinically informed way, in contradistinction to applications of social-scientific methods such as discourse analyses or conversation analysis. This has been partly due to the research data; which included not only therapy transcripts, but also documentation of the treatment given, and verbal accounts of therapy sessions as well as two research interviews, one concerning the effectiveness of the treatment, and the other concerning the therapist's orientation. Partly it has been due to the effort to find and develop methods of analyzing family therapeutic research data using methods which allow both 1) data-based analysis and 2) dialogue between theory and clinical practice. This was done in order to avoid being stuck in empirical generalizations, and a too-general level of abstraction.

The relationships of clinical practice, theory and research have been thin, as if these areas were too autonomous to relate to each other: clinicians have not been able to use research findings in order to improve clinical practice; theoretical abstractions have been very general, and often philosophically informed. The measures described in articles II, III, and IV were designed to be contingent with the clinician’s experience of therapy sessions, and the classification categories of NPCS are the basic dimensions of therapeutic interviews: subjective experiences, external happenings and interpretations of both of these.

Validity issues of the interpretations of qualitative data have been dealt with according to the traditions of qualitative research (Lincoln & Guba, 1985; Stiles, 1993).These principles of openness (research procedures should be open to public

scrutiny) are also congruent with reflective and collaborative family therapy. Research interpretations are made open, i.e. transparent, in the original communications; and the continuing principle has been to submit all the interpretations to a dialectical relationship with the actual data: the data is consulted repeatedly throughout the interpretative process.

5.2 The renewed research task: the question of expertise

The original case studies all had research tasks of their own associated with the family therapeutic case material. In this re-reading the main task is to take another look at the four case studies, so that the expertise frame which has been outlined above will provide a new frame of reference for this task. The following questions are addressed and answered in Chapter Six.

(1) How expertise in the form of community-oriented and interaction-based action is actualized in family-therapeutic processes.

(2) The role individual expertise plays in the socially-constructed reality of family therapy.

(3) Whether these two above-mentioned dimensions of expertise can be described from the expertise perspective in a commensurable way.

6 SYNTHESIZING DISCUSSION

6.1 Implications for family therapy

In articles I and II the same clinical case is studied in an attempt to answer two different research questions. The clinical process was both therapist-driven (shown in the use of different therapeutic modalities) and client-centred (shown in the different family sculptures made by the family members). These therapeutic initiatives, embodying different diagnostic and therapeutic ideas, and with material provided by the sculptures, reveal both the asymmetry of the setting, and the collaborative aims - the intention to involve the client family as well as the therapist in searching for a solution – of the therapist. Articles III and IV describe cases which are in danger of ending up in a therapeutic impasse: and they suggest what the role of therapeutic techniques in situations of this kind might be. In this chapter these dimensions are looked at through the lens o expertise.

The expertise view of family therapy does not change the therapy itself. Instead it provides a new perspective for making an alternative, or so called double description, and the possibility of identifying certain questions of a challenging character for family therapy. Some of these questions are more of a practical, and some more of a theoretical character. These last include the synchronic and diachronic views of systems change, the context of implication, and the character of family therapeutic reasoning. Expertise perspective makes it possible to formulate therapeutic process on the basis therapeutic actions, instead of only therapeutic intentions, or the post-modern critique of modern practices.

The rise of systemic family therapy marginalised the time-bound developmental approach partly because the developmental approach was associated, in the minds of systemic therapists, with linear thinking (Erickson, 1988). Thus the developmental view was left as an issue which "kept knocking on the door" but was not allowed a place in the systemic thinking approach (Dallos & Draper, 2000). However, through the birth and existence of clinical problems the chronological-developmental view, even in an auxiliary role, is nearly inevitable.

Horizontal/interactive expertise provides an opportunity for family therapy to outline the actions of therapeutic teams, and develop collaborative client-

centred therapy. Simultaneously the concept of horizontal expertise makes it possible to bring the concept of the family (and wider social systems) back into family therapy. This is connected with the fact that during the development of narrative therapies, and essentially constructivist approaches; the emphasis was transferred to the individual at the expense of the interactive process. Nowotny, Scott & Gibbons (2001) emphasize the role of the individual as a rational decision-maker, which can be seen as one possible way in which the individual voice can be emphasized: the individual has a dual role as an informed and an information-seeking consumer and a citizen. The very same emphasis on subjectivity is also present in the anticipation dialogues (Seikkula, Arnkil & Erikson, 2003). This was visible in articles I and II, in which the identified patient, the child, provided the key to therapeutic change and introduced novelty into the meaning system. His sculpture was also defined by the father as the most creative one. This comment of the father also shows the significance of the interaction as validating the son's view, leading to the horizontal dimension: it was not the therapist who made this validation.

Horizontal expertise consists of all the resources of the participants in therapeutic discourse that are made use of for therapeutic purposes. Thus we can avoid using the controversial and internally incongruous concept of lay-expertise (Collins & Evans, 2002) and refer to experience-based knowledge and expertise as the client's specific contribution to the process. In this context the therapist's expert task is to create possibilities for interaction and comment, and to create space for everybody's experience to be articulated in a manner which allows therapeutic change and the dis-solving of problems. Thus the therapist's starting point is to to offer the therapeutic group (the therapist, and the client and the client's family) the opportunity of themselves determining the direction to be taken in the therapeutic session (the opportunity of joint leadership), and secondarily to reflect back his own ideas by being public (Anderson, 1997).

Vertical expertise, in the context of family therapy, refers more to a single therapist's personal knowledge in practice; including both experiential/ implicit/tacit knowledge and the individual/learned/ cognitive/integrated storage of knowledge. Typical of this knowledge is the fact that it can be at least partly articulated and activated as a resource in family therapeutic work. The therapist who emphasizes vertical expertise takes a position as an active agent of change (i.e. unbalancing and challenging the system, Minuchin, Lee & Simon, 1996), and moves secondarily into the horizontal interactive sphere and back. In case studies I and II this vertical dimension is visible in the therapists' decision to use a specific family therapeutic technique or tool, namely family sculpture, in order search for new possibilities for the therapeutic process.

Both these expertise perspectives are necessary, and take advantage of knowledge from within the relationship (that is to say, knowledge of the third kind). In this sense family therapy can be seen as a crossroads for horizontal and vertical expertise. According to articles I and II, therapeutic change as a process of semantic change is connected both with the synchronic view within a single session of interaction and with the diachronic process, the temporally-organized narrative of family members. In therapy this narrative is associated with pre-

narrative elements and details previously outside narration; the not-yet-said. What is interesting is the fact that the choice of the research perspective also dominates which view can be observed during the research process (the context of implication). This emphasizes the constructed character of research findings. Article I is dominated by the synchronic view, with the idea of how to organize the clinical data from the in-session interaction in a way that promotes change. This view keeps the emphasis on the interaction as it is described using clinical concepts. The more developmentally-oriented chronological perspective of the assimilation model in article II, on the other hand, emphasizes the connecting of in-session interaction with problematic joint-developmental themes in the family past. This methodological choice shifts the focus to the client system; abandoning the interaction with the therapist.

In articles III and IV the therapeutic impasse and the difficulties to be overcome in the formation of the therapeutic system are focussed on. The results show that the change of perspective was a key factor of interaction. As long as the therapist sticks to the therapy technique, and loses interactive cues, then, although the therapist may make "correct" interventions, the therapeutic conversation will end in monologue, and the client's voice will not be heard.

The context of implication is a concept which emphasizes the possible consequences that both clinical and research activities generate (Nowotny, Scott & Gibbons, 2001). Psychotherapy as the context for research has always been problematic since Reichenbach's (1938) original division into the context of discovery and the context of justification. Kvale has discussed the psychoanalytic interview as a prototype for qualitative research (1999). Thus the field of psychoanalysis (and possibly other conversational therapies as well) is seen as a research process where findings are arrived at jointly, and their validity (and usefulness) is negotiated in the analytic process. The same is also true in family therapy, especially in the post-Milan era when the negotiation of meanings has been highlighted in the therapy process. This validation process was emphasized in articles I and II, where the identified patient provided meaningful new perspective for the family, therapists, and the reflective team. In article II this validation process is taken even further, as the parents of the family are able to connect the newfound question of enmeshment/nearness to a significant situation in the family history.

Nowotny, Scott & Gibbons (2001) deal mostly with (natural) science, and their examples come from that field. In the field of social science the value of their findings is obvious. In family therapy this issue of the context of implication has been part of theoretical and historical development, as well as a part of the clinical process. An example of theoretical development is the view taken of systemic regulation in the context of violence. The feminist critique emphasized the power issues in such a way that systemic neutrality was no longer possible. This theoretical issue had immediate clinical implications. The therapists were forced to consider the consequences of their actions in relation to the possibility of increasing the probability of violence.

The issue of the context of implications was present implicitly in all the articles (I, II, III, and IV). It was present in the question of what kind of interaction,

detail of therapeutic narrative, or exception in the problem-saturated story is enough to direct the therapy discourse towards change. In article I this subject was also present in the diagnostic thinking and diagnostic concepts as well as in the possibility of regarding the symptoms as signs of illness. These findings suggest the question of how many choices are already made in the process of therapy, even before the client is met for the first time, and how these choices can be made visible through research, which is another process of choosing and constructing.

The character of family-therapeutic reasoning is a third topic which can be approached from the expertise perspective. Hargens and Grau (1994) claim that therapists are experts in interviewing and clients are experts on the subject of their lives. Interviewing has been a central area of the therapist's development through the course of systemic therapy (Brown, 1997; Haley, 1979; Penn, 1982; Tomm, 1988).

Interviewing in the family therapeutic sense must be differentiated from interrogating or narrowly just asking questions. Interviewing is the therapist's way of searching the relational conversational space using both questions, and comments or statements. Another way of describing this has been to speak of structural coupling in the linguistic sphere of the client, or following the client's lead. The aim in all this is not to reach exclusive deductions or inductions in order to diagnose or generalize. The aim is rather to create reflective space both for oneself and for the clientele. This reflection allows changing ones position towards the presented problem. This can be seen in all the articles in the series I, II, III, and IV. Therapists have to be able to change their ways of acting in order to allow their clients to act more collaboratively, or to reach a reflective position.

The big question for present-day family therapy is whether the conversation itself is the author; is all therapist's talk based on in-session client talk? Or is it still possible that there are other sources for therapist's talk, both reflected and outside of immediate reflection? According to these case studies, in order for dialogue to promote change, necessary and sufficient preconditions are that there should be interaction between the client and client family, and the therapeutic team, of the kind which succeeds in producing a rich conversation, here and now. For the therapist to be able to use all this contextual data, on the other hand, may require reflections and the reflexivity of the therapist's own experiences, i.e. experience-based expertise, drawn from other therapeutic situations in order to differentiate and recognize the uniqueness of the case in question. This may be tacit knowledge or knowledge which cannot be reflected or articulated immediately, either by the therapist or by the clientele.

It is also possible to look at a family therapy session as a context for knowledge-creation, as the third kind of expertise (Hakkarainen, Palonen & Paavola, 2002). Previously I mentioned the need to see the other possibilities for this process as traditionally deduction and induction. By this I refer to the concept of abduction, which refers to the questioning process as a means of hypothesis formation. Here the hypothesis and hypothesizing mean something other than what they mean in the context of scientific experimentation or statistical reasoning or even in the Milan approach to family therapy, and they are connected with the concept of the shared image guiding the treatment process (Aaltonen, &

Räkköläinen, 1993, 1994). A hypothesis is a reflexive, anticipatory, and open tool of the therapist orienting her- or himself in the interview, and it is a tool which enables the therapist to maintain an active responsive position in the therapeutic dialogue (Patterson et al, 1998; Shotter, 1993). The logic of abduction, as a tool of hypothesizing, is compared to the questioning method of Sherlock Holmes (Hintikka & Hintikka, 1998), or characterized as a detective methodology (Paavola, 1998). Every question asked either supports the direction the therapist has taken or re-directs him, enriching the inner dialogue of the therapist, but the aim is not to reach the truth or the correct diagnosis in the way Anderson suggests (1997). The emphasis on abduction makes more visible the therapist's role and the elements of her/his inner dialogue, in contrast to interventive questioning (Rober, 2002; Tomm, 1988) which emphasizes the role of questioning the clientele.

To sum up the implications for family therapy and the suggestions for therapists emerging from this study, I recommend that family therapists: 1) have a variety of personal, and individual, vertical expertise, learned and experiential, parts at least of which they are able to articulate; 2) are able to use their interactive and communicational skills, i.e. horizontal expertise in order to create space for everybody's experience to be articulated in a manner which allows therapeutic change and the dis-solving of problems; 3) are able to use the family therapy session as a crossroads for different kinds of expertise, both their own and their clients', and move between these positions; 4) are able to see therapeutic change as semantic change and are able to promote dealing with different negative connotations; 5) create conversational space for the-not-yet-said; 6) are able to see therapeutic impasse as a lack of dialogue, and narrowing of interaction; 7) are able to use their experiential expertise in different therapeutic situations and contexts; 8) are able to use the therapy session as the context of knowledge-creation i.e. social constructionism in action; 9) are able to create and use their inner conversation and abductive reasoning to form open-ended and tentative hypotheses for conversational purposes both in the conversation with clients and with the reflecting team; and 10) are able to see all therapeutic interaction as meaningful from the first second of the session to the last one.

6.2 Implications for family therapy research methodology

As scientific research works with different levels of abstraction and generalisation, and the exchange of meanings is carried out by different symbolic means, we can consider its possibilities as one special type of modern expertise. Thus research, if anything is a good example of a modern project, as Giddens observes. This has been visible in the scientific revolution. One product of this development has been the effort to apply natural scientific ideals in research into human and social sphere.

A repeated subject of concern in family therapy is the tenuous relationship between theory, research, and clinical practice (Pinsof & Wynne, 2000; Sprenkle & Ball, 1996; Wynne, 1988). The dis-embedded character of modern expertise is

present here (Giddens, 1990). Research is not directed towards anything close to the clinician's or the client's experience. If re-embedding were to be emphasized, then the situation would be quite different. Therapy itself can be looked at both as a process of knowledge creation and as a process of application (and through therapeutic aims the context of implication is present as well). The knowledge jointly created in therapy is also jointly thoroughly evaluated and validated, and is both of a re-embedding and a contextual character (Kvale, 1999). It is knowledge that "speaks for itself", as it is empowering both for the client and for the therapist/s, and the level of abstraction is decided contextually.

The articles discussed in this research are divided into two groups in relation to therapeutic change. Articles I and II focus on the global change of therapy, the change aimed at. The texts are anchored in the case-research tradition of psychotherapy research. Using the concepts of narrative research the interest can be seen to focus on the macro-narrative of therapy, in which the retrospective explanation often acts to legitimate the treatment mode employed. The orientation basis of the treatment mode can acquire new dimensions, or be left without further support. But actual falsification of theory is not possible with this approach. This is the form of research that Spence wrote about with cutting criticism within the field of psycho-analytic case report writing (2002). According to Spence, this kind of research can be very conservative, and prevent the development of therapeutic method and a widening of the area of applications. Qualitative research has long since also recognized the need for researchers to account for possible biases in order to evaluate validity and plausibility, and to discover the possible directing interests of the research. In spite of these criticisms, this kind of macro-analytic view has its place in the research. The family's role in the validation of therapeutic findings and the outcome of therapy are made visible in this kind of research.

In articles III and IV the focus is on the progress of the therapy process, and thus the therapeutic outcome (the global change of therapy) is not considered. Thus these articles are based on more disinterested research, and focus more on the question of efficiency than the question of effectiveness. The kind of research carried out in articles III and IV suggests the possibility for more immediate responsiveness to be taken into consideration in research. It opens up the therapeutic situation, examining the way therapists apply their knowledge in action, as well as their ability to reflect in action; narrowing the gap between application and research, and bringing the research results nearer to the clinician's experience. Thus further research could set out to look at key incidents in therapy, either from the therapist's or the client's perspective: what happens in therapy, and therapeutic interaction; what is the immediate micro-result of interaction, and does it have anything to do with the global outcome of the therapy?

To sum up the implications for family therapy research: 1) the knowledge created in therapy sessions is jointly thoroughly evaluated and validated; 2) the knowledge created, and the process of this knowledge-creation in therapy sessions can thus be used in qualitative clinical research; 3) there is the need both for macro-narrative and micro-narrative/micro-analytic research of psychotherapy in order to understand and to recognize both the preconditions and the process of change as well as the outcome; and 4) openness, typical of collaborative conversational

therapies, is a useful tool in qualitative psychotherapy research; allowing the participant client voice also to be heard in science.

6.3 The implications for family therapy training

This research was not carried out to study family therapy training. Nevertheless some questions emerge from a consideration of the research methodology used in this study on the one side, and from the concept of horizontal expertise on the other. But these findings are more speculative and tentative than the research findings just discussed above.

From the perspective of expertise family therapy training programs should be able to offer the possibility of developing therapeutic abilities both from the point of view of interactive/horizontal expertise and from that of experiential/vertical expertise. An important part of this is the need to acquire tools to articulate implicit/personal/tacit knowledge. There are no specific problems in considering the transferring of codified, migratory knowledge, and not even in the transfer of tacit knowledge. The training traditions combining theoretical readings, the practising of therapeutic skills, modelling, and supervision all allow for the process of personal integration. It is the problem of reflexivity and the use of reflection that is of interest here: how to proceed, if one wants to articulate one's own therapeutic skills and orientation.

From the point of view of family therapy training this research offers two possibilities. The first of these is connected with teaching and training methods. The measures used and reported in articles II, III and IV provide tools for organizing therapy-data in ways which can also be used as tools for the evaluation of therapeutic conversation. The second is connected with training philosophy, and the possibility of applying the principles of reflective work in training.

During the course of therapy training the trainee participates in a considerable number of therapeutic sessions of different kinds. In these situations the focus is mainly therapeutic, so that the clients can get what they are looking for. From the perspective of learning therapeutic skills a large amount of information must be ignored and cannot be thoroughly considered. Thus the feedback for the trainee may stay at a comparatively general level. Articles III and IV show how important interaction begins right from the beginning of the session.

A central question for the learning objectives is in what way training should be organized in order to facilitate the development of the trainee's self-reflexivity as a means of learning and as a tool for advancing and deepening professional skills. The tools of scientific research are generally considered to require such a deep expertise that they cannot be applied for training purposes. The target of analysis may also be too narrow for training purposes. Even in a simplified form the assimilation model provides a frame within which to evaluate and examine the trainees' own role in assisting the clientele to deal with different problematic experiences during the therapy process e.g. what kind of initiatives the therapist

makes in order to approach sensitive issues, or how does the therapist support family members when there are conflicting agendas among them in the session.

Narrative process modes, on the other hand, facilitate examining the therapist's role in the conversation. In my partial studies these analyses concentrated on the beginning of the therapy process, and the focus was on the research, not on training. However, taking advantage of the research method makes possible a change of the perspective on therapy data, both for the trainees and the researchers, in a way which allows more accuracy. As the therapeutic interview is focussed on dimensions of experiences, happenings, and meanings, it is informative to see, especially in "blocked" situations, if all these areas have been covered; or if the therapist is too eager to move to a different mode and bypass e.g. differing descriptions of external events.

In psychotherapy training this approach offers the possibility to reach for new kinds of expertise for ones own work, and to narrow the gap between the espoused theory and the theory actually being applied, in a way that serves the learning process. This kind of training is able to take advantage of the new learning and expertise concepts and the isomorphic relationship between therapy and training. This isomorphic relationship is evident in 1) collaboration, and joint action, 2) emphasis on resources, 3) active respect of agency, 4) reflectivity, and 5) social constructionism (Laitila et al, 2004). As the trainees are able to create double descriptions of their own actions in the therapy session, using different tools of psychotherapy research, they move into the zone of proximal development, as Vygotsky termed it. There it is possible to observe and reflect on one's own ways of acting from a reflexive outside position.

6.4 Conclusions and openings

The aims of this kind of research cannot be made too exclusive, if the work is to be carried out according to the principles it speaks for. Just as reflective family therapy leaves many doors open, and therapists uncertain as to the direction in which their clients shall move next, so the aim here is not to predict precisely in which direction family therapy will move. The scope for this research is wide: empirical articles focus on the internal happenings within therapy sessions, and theoretical reasoning takes the sociology of scientific knowledge as its starting point. And neither of these can be deduced unequivocally from the other. The aim has been to strive for a dialogue "which might make new perspectives possible".

Even though family therapy is a contextually oriented mode of therapy, it has been surprising to see the co-evolution of the social sciences and family therapy. The development and history of the concept of expertise parallels that of family therapy. And simultaneously a great deal of family therapy seems to have developed autonomously, or in accordance with the patterns followed in completely different areas of scholarship e.g. general systems theory, biology, and literature, according to which articles are considered.

In recent academic treatment of family therapy the expertise conversation has been overshadowed by the modern – post-modern discussion. It has been marginalized to the position of a facet of this modern – post-modern debate. This latter topic as a form of critique (Anderson, 1997) seems to have been ideologically more tempting, and it also opens up more theoretical horizons, as well as providing a yardstick for good and bad, right and wrong practice. The debate of expertise, on the other hand, is closer to everyday clinical practice, which includes a lot of integrated and disintegrated, organized and disorganized clinical information. There is, however, a need for the expertise debate also. One reason is that it represents a different level of abstraction, and maybe shows some other dimensions of family therapy than the modern – post-modern debate, which is somehow reminiscent of the linear - systemic debate, in dividing therapists into those that do it in the right way and those who do it wrong. And it is also reasonable to remember that the very concept of "post-modern" has also been criticized by social scientists, who prefer to use some other concepts in the context of science and society; for example, high modernity or reflexive modernity (Beck, Giddens & Lash, 1994; Giddens, 1990).

This modern – post-modern debate can be seen as a facet of the second phase of science studies, during which the sociological study of science has dominated (Collins Evans, 2002). Scientific findings have been looked at as social constructions (e.g. Latour & Woolgar, 1986). And the debate on expertise has ended with the same question that Flemons, Green and Rambo (1966) posed, when they were creating a scheme for evaluating therapists' practices: how to evaluate if the persons carrying out the evaluation do not have any privileged position from which to observe?

There are two tendencies in family therapy itself which justify a special interest in expertise. The first one is that the development of family therapy has been quite rapid since the 1950's. There have been many significant turns in the development of family therapy. Yet many clinical tools and innovations have maintained their usefulness irrespective of theoretical development and changes (Dallos & Draper, 2000; Dallos & Urry, 1999). This is interesting and challenging, and maybe shows some theoretical thinness in family therapy. This very phenomenon reveals how metaphors too distant from therapy practice do not become rooted in the theoretical base, but are replaced in the next theoretical shift. It seems that both the knowledge of interviewing skills and the number of therapy techniques and interventions is accumulating steadily, while theories rise and fall. From an expertise perspective the dichotomy dealt with by Anderson (1997), and Minuchin, Lee & Simon (1996) (i.e. the contrast between therapy as a relationship between an expert and people who need help, and therapy as a collaboration between people with different perspectives and experience) seems no longer valid because both these views on therapy are needed. Of interest is also the fact that nobody has declared him-/herself to be a representative or spokesperson of linear thinking, modern therapy, the therapy of certainty, or the logico-scientific mode of therapy; and no dialogue has ever evolved out of these definitions.

The second issue is the relational aspect of psychotherapy and family therapy. Psychotherapeutic work is based on therapeutic alliance and the joint

effort of the client and therapist to generate meanings. This is not an innovation of post-modern therapy or a result of paradigm shift. A part of psychotherapeutic "folklore" is the phrase that the best interpretation is the one made by the client her-/himself. This does not mean that all therapies are equally client-centred or collaborative, but that therapeutic alliance, cooperation, joint work and collaboration are important preconditions for successful therapy. In this way the development of conversational therapies has been partly the development of different kinds of joint action. Therapists position themselves differently in relation to expertise, depending on whether they emphasize its "vertical" personal side or its interactive horizontal side. Judging the work of previous generations of psychotherapists does not do justice to them, since they probably worked according to the best knowledge available at the time. If we, profiting from the knowledge now available, criticize previous work, this should be carried out in the light of the latest expertise, instead of adopting a post-modern view with its ideological emphasis. Would the answers be the same? These views imply the need for research in which the asymmetry produced in therapeutic systems by different approaches and therapy methods would be the object of research. Of interest are the questions of whether there are differences in therapists' ways of acting in different therapeutic modalities and therapeutic techniques, or if there are differences in clients' experiences.

Therapeutic impasse is a significant phenomenon in advancing understanding of this question. According to case studies III and IV, one explanation for impasses is relational failure; a failure of collaboration, empathy and understanding. And as article I showed, it is the negative connotations of diagnostic remarks that tend to be attended to when therapists find themselves at a loss to understand a problem. Therapists give up their curiosity, and their attempts to understand and end up labelling their clients, as falling into established scientific and diagnostic categories (Nylund & Corsiglia, 1994). This phenomenon, and the various possible solutions to it can be evaluated by means of expertise concepts, and making use of modern expertise without the need for post-modernism, which shifts the whole issue to a completely new level of abstraction.

We always did feel the same,
We just saw it from a different point of view,
Tangled up in blue. (Dylan, 2003, 646)

YHTEENVETO

Tässä tutkimuksessa on tarkasteltu perheterapeuttista asiantuntijuutta yhtenä asiantuntijuustutkimuksen erityisalueena. Empiirisen taustan tutkimukselle muodostavat tekijän artikkeleina julkaisemat neljä erityyppisiin perheterapiatilanteisiin liittyvää tapaustutkimusta, joiden kysymyksenasettelu on liittynyt terapeuttiseen prosessiin, terapeuttiseen muutokseen, terapeuttisen muutoksen ennakkoehtoihin, terapeutin toimenpiteisiin ja tutkimuksen metodologiaan. Väitöskirjatyö muodostuu 1) asiantuntijuuden kysymyksenasettelujen teoreettisesta käsittelystä sekä asiantuntijatutkimuksen että perheterapian näkökulmista, 2) artikkelijulkaisujen yhteenvedosta, 3) pohdintaosuudesta, jossa käydään vuoropuhelua asiantuntijuudesta nousevien käsitteiden ja kysymysten avulla perheterapian sisällöistä, teoriasta, tutkimusmenetelmistä ja koulutuksesta taustanaan artikkeleista nousevat löydökset, sekä 4) artikkelijulkaisuista.

Asiantuntijuustutkimuksen kehitykselle on leimaa antavaa ollut siirtymä erikoistuneiden huippusuoritusten tutkimisesta jokapäiväiseen työelämään ja työtehtäviin liittyvään osaamiseen. Tällaisena tämä muutos on samankaltainen kuin tiedetutkimuksessa, jossa Collinsin ja Evansin mukaan (2002) on ollut kaksi aaltoa, joista ensimmäisen aikaan “asiantuntijuusprobleemaa” ei ollut olemassa, vaan painopiste oli tieteen kehittymisen arvioinnissa. Toista aaltoa taas edusti sosiaalinen konstruktivismi, jonka yksi näkyvin edustaja tiedetutkimuksessa on ollut tieteen sosiologia. Tämän aallon aikana on korostunut tapa tutkia tiedettä sosiaalisena toimintana. Asiantuntijuuden probleema on tämän kehityksen tulosta, kun kaikki tieto nähdään samankaltaisena ilman erikoistumisen mahdollisuutta, jota jo asiantuntijatietoon, asiantuntijan käsitteeseen ja asiantuntijuuteen liittyvät sanakirjamääritelmätkin korostavat. Collins ja Evans ennustavat kolmannen aallon olevan tulossa ja nimeävät sen asiantuntijuuden ja kokemuksen tutkimukseksi. Tämän kehityksen pitäisi heidän mukaansa mahdollistaa myös asiantuntijuuden tutkimisen tavalla, jossa tiedon laatuun eri tiedon haltijoilla olisi mahdollista ottaa kantaa.

Tieteen sosiologinen tutkimus on osoittanut ja osittain tuottanut kehityksen, jossa asiantuntijuuteen aiemmin liittynyt hierarkkisuus ja abstrakteja systeemejä korostavat rituaalit ovat poistuneet ja tilalle on tullut selontekovelvollisuus, avoimuus, läpinäkyvyys sekä tietoon ja luottamukseen liittyvä neuvoteltavuus. Tiedon tuottamiseen, myös tieteellisen tiedon tuottamiseen ja toimintaan liittyy monitieteellisyys, joka tutkimusten valossa kertoo yhteiskunnan ja tieteen myötäkehityksellisestä vuorovaikutuksesta.

Asiantuntijatoimintaa on arvioitava sellaisenaan myös työn kohteen kautta. Ihmisten kanssa toimittaessa korostuu työn kohteen toimijaluonne, agenttisuus, joka tarkoittaa sitä, että toiminnan vaikutukset eivät ole ennustettavissa mekaniikan lakien mukaisesti, vaan toiminta ja kohde ovat refleksiivisessä suhteessa. Toiminta vaikuttaa kohteeseen, joka muuttuessaan vaikuttaa taas niihin toimenpiteisiin, joita ollaan toimeenpanemassa. Se, millaisena asiantuntijuus ottaa asiakkaan ei-asiantuntija-äänen, poikkeaa suuresti riippuen sovellusaloi-

ta. Asiakkaan ääntä pidetään erityisen merkityksellisenä erilaisten asiakaslähtöisten ja -keskeisten psykoterapioiden parissa sekä uuden oppimiskäsityksen mukaisissa koulutustilanteissa, jotka perustuvat yhteistyölle ja jatkuvalle keskinäiselle arvioinnille.

Perheterapian sisäinen kehitys on ollut ko-evolutionaarisessa suhteessa tieteen ja yhteiskunnan kehitykseen. Perheterapian sisällä voidaan havaita nämä kaudet, joita perheterapeutit itse ovat kuvanneet toisenlaisilla käsitteillä ja omalakisempina kuin ehkä olisi perusteltua, esim. siirtymänä modernin asiantuntijuuden sisältävästä terapiasta post-moderniin tai diskursiiviseen terapiaan. Tälle kehitykselle leimaa-antavaa on ollut terapeutin tai terapeuttien ja terapeuttisten työryhmien työskentelyyn liittyneiden asetelmien tieteellistä "laboratorio-luonnetta" ja tieteellistä perustaa korostaneiden yksisuuntaisten peiliikkunoiden ja niihin liittyvien havainnointijärjestelmien purkaminen. Tilalle ovat tulleet erilaiset avoimet työkäytännöt, joissa terapeutin asiantuntijuutta kuvataan vuorovaikutuksen ylläpitäjänä, keskustelun avaajana ihmisen psyyken tuntijan tai perheen vuorovaikutuksen mallien tunnistajan ja arvioijan sijaan. Samalla toiselle aallolle tyypillisesti myös kyseenalaistetaan terapeuttien asiantuntijuutta.

Ensimmäisessä ja toisessa osatutkimuksessa tutkittiin lapsuuden psykoottisen reaktion perhekeskeisen hoitoprosessin kulkua. Terapeuttisen muutoksen aikaansaamisessa osoittautui olennaiseksi se, että diagnostisiin kategorioihin liittyviin huomioihin kuuluvat negatiiviset sivumerkitykset pystyttiin tunnistamaan ja käyttämään hyödyksi prosessin kuluessa. Terapeuttien tulee voida toistuvasti arvioida omien alkuoletustensa vaikutusta työhönsä sekä tapaansa havainnoida vuorovaikutusta ja käyttää tätä arviointipotentiaalia erilaisten hoidossa käytettävien keskustelevien ja kokemuksellisten lähestymistapojen integraation palveluksessa. Ensimmäisen ja toisen osatutkimuksen tutkimusmenetelmät säätelivät selkeästi sitä, mikä tuloksissa korostuu: vuorovaikutukselliset käsitteet tutkimisen välineinä tuottivat terapeuttisen systeemin vuorovaikutukseen liittyviä havaintoja ja kognitiivisesta teoriasta tulevat käsitteet painottivat asiakkaan/asiakkaiden psykologista prosessia.

Kolmas ja neljäs osatutkimus painottuivat terapiaprosessin alkuun ja terapeuttisen systeemin syntyyn liittyviin kysymyksiin sekä narratiivisen analyysimenetelmän sovelluksen edelleen kehittämiseen perheterapeuttisen vuorovaikutuksen tutkimiseksi. Terapeuttisen vuorovaikutuksen kannalta ei tulosten mukaan ole olemassa merkityksetöntä hetkeä terapiassa, ei edes nk. sosiaalisen kontaktin luomisen merkityksessä terapian alussa. Terapia alkaa ensimmäisestä kontaktin hetkestä ja tämä edellyttää terapeuteilta vuorovaikutusasiantuntijuutta.

Arvioitaessa tuloksia erityisesti asiantuntijuuden näkökulmista korostuu horisontaalisen asiantuntijuuden merkitys so. terapeuttien kyky toimia asiakaslähtöisesti siten, että työskentelyn piiriin kuuluvien ihmisten mielipiteet ja ääneen lausutut ajatukset ovat kaikki potentiaalisesti tärkeitä. Tutkimuksen perusteella perheterapiaistuntoa on kuvattu vertikaalisen ja horisontaalisen asiantuntijuuden risteykseksi, jossa terapeutilta edellytetään avoimuutta sekä itses-

sään ja omissa mielikuvissaan aktivoituville asioille sekä vuorovaikutuksessa tapahtuville asioille siten, että näitä asioita voi ottaa terapiatilanteessa reflektion pariin sekä yksityisesti terapeutin sisäisessä keskustelussa ja terapeuttisessa päättelyssä että julkisesti yhteisesti jaettavassa terapeuttisessa vuorovaikutuksessa.

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