GROUP COHESION IN MULTIFAMILY THERAPY WITH MULTILINGUAL FAMILIES

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"Every heart sings a song, incomplete, until another heart whispers back. Those who wish to sing always find a song. At the touch of a lover, everyone becomes a poet."

Plato

"All experience aspires towards linguistic expression.
Language is the medium by which we affirm ourselves as social beings.
It binds individual subjects together.
It is the primary means of communication by which others are acknowledged over distance"
(Gross, 2018)

ABSTRACT

This study explores how Multifamily therapists create a context for group cohesion between monolingual and multilingual family members and what they might inadvertently do to hinder it. Group cohesion has been found to enable processes of change. I examine the intersection between group cohesion and language which is underrepresented in psychotherapy, MFT process research. Qualitative research methods were used to address the following research questions: 1*) What do Multifamily therapists do in dialogue to create a context for horizontal (between multilingual and monolingual families) and vertical (between family members and therapist) group cohesion?; 2) What do Multifamily therapists do in dialogue that inadvertently hinders the horizontal and vertical group cohesion between monolingual and multilingual families?; 3) What is the intersection between Multifamily therapy, group cohesion and language, including interpreters' roles?* Participants included families with children between 6 and 14 years old, from different cultural backgrounds, attending a Multifamily group in inner London for children who were at risk of being permanently excluded from school. For some, English was their first language, and for others English was their second language and some needed an interpreter. Therapists, students and interpreters also participated.

Two types of analysis, Dialogical Investigations of Happenings of Change (Seikkula, Laitila and Rober, 2012), and Thematic Analysis, were carried out on three data sources– 2 MFT sessions, a focus group with group participants, and an interview with therapists. A significant finding was that MFT therapists used a collaborative voice in dialogue, but also held an inherently powerful position influenced by how group participants positioned them, their own positioning (such as organising the room/activities, deciding topics and who talked, their work context) and by contextual/external factors (e.g. reasons for families' referral, societally constructed as experts), and their therapeutic task. Dialogical language seemed to create a space for 'withness' interactions between group members, and more group cohesion. I identified some factors which were likely to have impacted negatively on group cohesion and placed participants in a powerless/non-agentic position. Interpreters' roles and children's positioning as their 'mother's voice' were also considered.

Implications of the study are discussed as is its potential contribution to the practice, training and supervision of MFT and individual FT with multilingual and monolingual families. The importance

of creating a space where everyone's voices can be heard and in particular those of silenced/marginalised members is highlighted. Therapists' relational reflexivity and self-reflexivity play a crucial part in this in order to avoid unintentionally putting group members in shameful or powerless/non-agentic positions. The significance of, and processes involved in, creating a 'community of help' are identified.

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I would like to dedicate this dissertation to my grandmother, who has taught me the importance of families and has inspired me throughout my life, even at 100 years old.

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INTRODUCTION

The 2019 'International Migration United Nations' report states that the number of international migrants worldwide has continued to grow rapidly, reaching 272 million in 2019, up from 220 million in 2010 and 153 million in 1990. Worldwide, 3.5% of the population are international migrants. With migration, there is often an increase in the different languages spoken in the recipient country. It is estimated that more than half of the world's population is bilingual (Grosjean, 2012) due to migration and globalisation. More recently experts have estimated the percentage to be even higher (60-70%), depending on the chosen definition (Baker, 2014). In the UK, between 1990-2019 there was an increase of 5.9 million international migrants. In London alone more than 300 languages are spoken (Talk London, 2020). It can be assumed that this is also reflected in psychotherapy, as many clients and therapists are bilingual or work across languages/cultures. Costa and Dewaele (2012) reported that, although there is no clear picture of multilingualism[1] among therapists, 18% of the active members registered with the United Kingdom Council for Psychotherapy are able to conduct therapy in more than one language.

Although it is widely believed "that clients can communicate efficiently and directly in a second language" (Kokaliari and Catanzarite, 2011), this has not been fully explored, as it seems to disregard the clinical complexities of therapy, more so when cultures meet and psychotherapists and/or clients are multilingual. Multilingualism in psychotherapy has been under-explored due to an ethnocentric view on the subject, as "much of the traditional linguistic research into bilingualism and multilingualism...had been permeated by monolingual norms" (Burck, 2005, p.32). This was evident when I participated in a review of all the outcome research in Family Therapy that had been published between 2000-2009 in English peer reviewed journals (Silver, Nascimento and Stratton, 2013; Stratton, *et al.,* 2011; Stratton, *et al.,* 2015). One of the variables I chose to include was the authors' report on the participants' ethnicity. Out of 225 studies only 41% reported ethnicity. Our study concluded that some researchers seemed to believe that ethnicity and language were not relevant contextual factors that might influence the outcome of their studies and psychotherapy. Anderson and Goolishian (1988) described therapy as a 'linguistic' activity and problems as 'constructed/organised in language'. Anderson (2007) termed

[1] For the purpose of this research, I use *multilingualism/bilingualism* when referring to people who have acquired a second or third language at a later stage of their lives (e.g. following migration) with differing levels of proficiency and not as native speakers.

language as "the vehicle of the process and search through which we try to understand and create meaning-knowledge about our world and ourselves. Language thus limits and shapes our thoughts and our expressions" (p.9). Burck (2005) emphasised that “if an individual’s other languages are ignored in the relationship altogether, significant aspects of their experience and of themselves might never be brought forth in the relationship” (p.130). Various studies have shown that cultural factors, such as a therapist-client ethnic/language mismatch, impact on all aspects of psychotherapy, including engagement, incomplete or distorted mental state assessment, and drop-out rates (Bauer and Alegria, 2010; Bernal, 2009; Oquendo,1996; Smith *et al.,* 2011a,b).

As a Venezuelan of Portuguese descent, who went to a French school, and has lived in the UK for over 20 years and works as a Systemic Psychotherapist, I have always been interested in therapy across cultures and how different ethnic/cultural groups interact with each other. This study is based on my clinical experience and observations at the Marlborough Family Service, in London, where I offered Multifamily therapy (a therapeutic model for a number of families with similar difficulties working therapeutically together). Multifamily therapy is an efficient, cost-effective therapeutic tool that greatly benefits families at different levels (personally, emotionally, relationally and socially). These groups are often formed of families from different cultural backgrounds, who speak multiple languages.

From my clinical experience, I believe that when group members 'connect' with each other and group cohesion develops, it brings a different quality to the group, as group members listen to each other more, and they become more open, supportive and challenging towards each other. I believe that there needs to be a balance of enough similarities and differences between group members for them to make connections with each other and be productive and generative. Zafra (2021) stated: “La desigualdad son las limitaciones para desarrollarse libremente, pero la diferencia tiene que ver con la diversidad, que es enriquecedora. Somos mejores cuando nos mezclamos” (which I would translate as: “inequalities create limitations for free development, but difference is related to diversity, which is enriching. We are better when we mix”). Similarly, Powell (2018) claimed that being diverse and inclusive gives research groups a competitive edge. Greesonbach (2019) summarised studies which showed the benefits of diversity and inclusion in the corporate world, in terms of profitability, productivity, creativity and innovation.

When I started offering this therapeutic model, I was slightly sceptical about its use with families from different cultures, but I soon became fascinated by how it worked. I noticed not only how some groups seemed more successful than others, but also how some groups connected with each other, despite language barriers and different cultural backgrounds, and others did not.

Whilst a significant number of research studies have demonstrated the efficacy and efficiency of Multifamily therapy, as reviewed by Cook-Darzens, Gelin, and Hendrick (2018) and Gelin, Cook-Darzens, and Hendric (2018), its process and cultural factors have received little attention and there is a lack of qualitative research. As my specific interest is in therapeutic processes, I decided to focus on group cohesion, because a number of studies have shown that group cohesion is one of the most influential factors in the outcome of any group. Burlingame, McClendon and Alonso (2010) conducted a Meta-Analytic Review of 40 Group Psychotherapy studies (3,323 patients in total) and found a moderate correlation (r =.25) between cohesion and the success of therapy, and the overall effect size was statistically significant. They concluded that their findings were independent of the settings (inpatient and outpatient) and diagnostic classifications, "as cohesion levels increase in groups, client outcomes improve and psychological symptoms decrease" (p.11). A major aim of MFT is to 'connect families' and, in this respect, therapists 'act as a catalyst' (Asen and Scholz, 2010). I was particularly interested in exploring what therapists did in dialogue to nurture/hinder group cohesion between monolingual and multilingual families. My study is innovative, both in terms of its topics and process.

As I write, the relevance of these themes in society has become more striking, as issues around multicultural society/discrimination/racism are in the public domain again. In January 2021 the Department of Health and Social Care announced a landmark reform of mental health laws, which included a plan to tackle mental health inequalities for people from black, Asian and minority ethnic (BAME) communities, allowing patients' voices "to be heard better than in the past". The highly criticised Commission on Race and Ethnic disparities report was published in 2021. These themes are mentioned regularly in the news, for instance, in relation to four Congresswoman of colour (US citizens), on 14th July 2019, Donald Trump tweeted: "why don't they go back and help fix the totally broken and crime infested places from which they came". A few days later, on 24th July 2019, Boris Johnson became the UK Prime Minister. His previous racist comments (i.e. referring to Africans as 'picaninnies' with 'watermelon smiles' and to Muslim women wearing burqas as 'bank robbers') were back in the news, but without significant impact on his popularity.

However, the Conservative party was questioned on grounds of Islamophobia and The Singh Independent Investigation into Alleged Discrimination (2021) was also published. Some of the Brexit campaign contained distinctly xenophobic elements (Gabbatiss, 2017; Wilton, 2017). The plight of black young men is back in the media due to an increased number of murders in London, involving them as victims. The #BlackLivesMatter movement has had worldwide impact following the deaths of George Floyd and Breonna Taylor, amongst many others. The impact of longstanding inequalities both in the UK and worldwide (in particular against BAME groups) is sadly evident and has been exacerbated by the Covid-19 global pandemic (as evident in the Public Health England review (2020): *Beyond the data: Understanding the impact of COVID-19 on BAME groups*).

Writing this research invited me to think about my own position in relation to cross-cultural therapy, racism, and my own social GGRRAAACCEEESSS (Burnham, 1992; Roper-Hall, 1998). I am aware that my views and position are influenced by being a white middle-class female bilingual family therapist from a minority group. I state this not to apologise for my unearned white privilege from my 'invisible knapsack' (McIntosh, 1998), nor in response to a 'historic debt with less privileged', nor to clarify my 'cultural situatedness' (Rober, 2012), but to acknowledge how my cultural situatedness and experiences impact on my position and views. For instance, when reading about culture I notice that it is often used in reference to race, and that race is described only in terms of 'white' and 'black', without considering any variation in between these, which, in my view, is discriminatory of other races and aspects of culture, and contrasts with my understanding of race growing up in Venezuela- a multicultural and multiracial society. I am mindful that there are many issues that I am not aware of, as my "own ideas, attitudes and knowledge about the world, about relationships, about bodies, about personhood and subjectivity are socially constructed…[so they] might not be visible or available to be voiced" (Krause, 2012b, p.13). As Flaskas (2012) observed, we can simultaneously know and not-know the social contexts in which we are located. Thus, "how can we overcome ethnocentric ideas and practices?" (Davolo and Fruggeri, 2016, p.111). As a starting point, I consider Dyche and Zayas' (1995) recommendation that cross-cultural psychotherapy should be based on a disciplined attitude of 'cultural naïveté and respectful curiosity' (p.389).

SECTION A-LITERATURE REVIEW

In this section, I will review the literature that is relevant to this research project. It comprises important works in the fields of Multifamily therapy, group relationships, group cohesion, multilingual/cross-cultural therapy and dialogical therapy. The review is divided into four sections. The first chapter covers seminal papers on Multifamily therapy, including evidence, process of change studies and cultural issues. The next chapter provides an overview of group relationships and, more specifically, group cohesion drawing on Multifamily therapy and group therapy literature. The third chapter describes contemporary conceptualisations of therapy across different languages/cultures, considering the therapeutic relationship. The final chapter focuses on dialogical therapy, including its history, an overview, and exploring 'the other' and power issues.

CHAPTER 1-MULTIFAMILY THERAPY

This chapter is divided into four sections. The first part provides a historical review of Multifamily therapy (MFT). The second section focuses on evidence for MFT. The third explores the understanding of the process of change, while the fourth considers cultural issues within MFT.

1.1.-MULTIFAMILY THERAPY HISTORY:

I only provide a brief overview of the history of Multifamily Therapy (MFT) as this has been clearly outlined elsewhere (Asen, 2002; Asen and Scholz, 2010; Edwards, 2001; Sempere and Fuenzalida, 2017). The early history of Systemic Therapy is relevant for the understanding of groups. Bertanlaffy (1969) described General Systems Theory, as "a general science of wholeness", in which there are "complexes of elements standing in interaction" (p.33). The concepts of homeostasis[2] (Cannon, 1929) and context[3] (Bateson, 1979) are also pertinent. Multifamily group therapy was developed by various teams in the United States of America. Laqueur is recognised as the founding father of MFT who, in the 1950s-1960s, started using Multifamily groups in a hospital setting in New York with adults diagnosed with schizophrenia. Laqueur (1976, cited in Edwards, 2001) concluded that MFT was time- and cost-efficient because it promoted change faster than individual family therapy. This approach was then used in North and South America and Europe. In the UK, it was first used in day hospitals in the 1970s, when a number of clinicians from the

[2] "The coordinated physiological reactions which maintain most of the steady states in the body are so complex, and are so peculiar to the living organism… that a specific designation for these states [is] employed-homeostasis" (Cannon, 1929, p.400).

[3] Which explains why "the meaning of a given type of action or sound changes relative to context" (Bateson, 1979, p.115).

Marlborough Family Service, including Cooklin and his colleagues, worked with “multi-problem families”.

It is believed that, in MFT, families benefit from both family and group therapy. The similarities and differences between family therapy and group therapy have been clearly outlined both in the literature and by clinicians, who have "demonstrated how families can be viewed as a group (Becvar, 1982) and how family theory can be utilised as a group resource" (ibid, p.5). However, in “applying these group frameworks to groups of families instead of individuals, they become limited in addressing the complexity of interactions” (Edwards, 2001, p.42). Family therapy does not fully account for group processes and group therapy does not fully account for family processes and interactions. Therefore, it is very important that MFT therapists have knowledge of both theories and are very skilled in implementing this unique modality. Theoretically, MFT provides families with opportunities to address some of their functioning within group processes (Edwards, 2001).

1.2.-EVIDENCE FOR MULTIFAMILY THERAPY:

The multiple benefits of MFT for an array of mental health problems have been evidenced in clinical accounts, reviews and empirical studies[4]. Asen (2002), Asen, Dawson and McHugh (2001), Asen and Scholz (2010), Cook-Darzens, Gelin and Hendrick (2018), Edwards (2001), Gelin, Cook-Darzens and Hendrick (2018), and Sempere and Fuenzalida (2017) described the effectiveness of MFT in different settings and for a variety of presentations, including: working with multi-problem and isolated families; with schools, parents and pupils; in the management of child abuse and neglect, educational failure and exclusion and children with emotional and behavioural disorders; with medically-ill children; with children/young people with attention deficit, eating, or mood disorders; substance misuse problems and first-time juvenile crime offenders. For adults, it has proven effective when they present with severe mental illness (schizophrenia, depression, bi-polar, or obsessive-compulsive, eating, or borderline personality disorders, substance and alcohol misuse); domestic violence; marital disharmony; divorce; bereavement; chronic organic illnesses; chronic pain and for elderly people in long-term care.

[4] Some studies on specific disorders include: Eating Disorders (Colahan *et al.,* 2002; Hollesen *et al.,*2013; Mehl *et al.,* 2013); Mood Disorders in adults (Hellemans *et al.,*2011; Lemmens *et al.,*2009a; Lemmens *et al.,*2009b; Miller *et al.,*2004; Solomon *et al.,*2008), adult Schizophrenia/ Psychosis (Carra *et al.,*2007; Bradley *et al.,*2006; Deane *et al.,*2012.*;* McDonnel *et al.,* 2006; McFarlane (2004, 2016); Petersen *et al.,*2005; Hazel *et al.,*2004; Dyck *et al.,*2000; Yamaguchi *et al.,*2006); Diabetes (Wysocki *et al.,*2006); Youth Offending (Quinn and Van Dyke, 2004), children at risk of exclusion due to emotional/behavioural problems (Morris *et al.,* 2014)and a few uncontrolled outcome studies (Lemmens *et al.,*2005; Scholz and Asen*,*2001).

Depestele, Claes and Lemmens (2015) reported that the empirical evidence shows that MFT increases participants' sense of hope, and is as effective as single-family therapy, but more cost-effective. Edwards (2001) concluded that, although the outcomes of MFT vary depending on the therapeutic goals, overall, they include an improvement in symptoms, and an increase in: marital satisfaction; children's self-confidence; parenting skills; noticing children's and families' strengths', improved family communication and problem-solving skills and emotional expression; family empowerment, participation and diminished isolation. Gelin, Cook-Darzen and Hendrick's (2018) review stated that MFT is superior to single-family therapy for first episodes of schizophrenia and chronic psychosis, as it increases social support, reduces families' anxieties and the relapse rate. Gelin, Cook-Darzen and Hendrick (2018) concluded that further process research was vital to operationalise MFT, as described by therapists, patients and families.

The Association of Family Therapy (2011a) review of NICE guidelines recommended Multifamily Group intervention for BAME families with a member who has schizophrenia, but they questioned whether "family interventions adapted for ethnic groups help with engagement, and reduce distress in families and reduce relapse?" (p.14).

Voriadaki *et al,.* (2015) and Hollesen, *et al.,* (2013) found that MFT produced significant changes in young people with eating disorders, including: healthier weight/exercise, attitudes to eating, self-esteem, self-affirmation, mood and reducing self-blame: while their parents/families may experience an improvement in mood and empathy with the young person, and greater self-efficacy. Shumway *et al.,* (2011) described a growing body of research on substance misuse recovery which "recognises the impact a person's family has on the recovery process" (p.248), as Multifamily psychoeducational groups "improve coping skills, reduce stress, and help individuals manage their addiction better at the individual and family levels" (ibid, p.249). Van Noppen and Steketee (2003) described a model of Multifamily behavioural treatment for families where one adult member had been diagnosed with obsessive-compulsive disorder and had not benefited from standard cognitive behavioural therapy and pharmacological methods.

These studies show that, although the clinical and empirical evidence for MFT is very rich, its process of change is unclear. I will therefore review this in the next section.

1.3.-MULTIFAMILY THERAPY PROCESSES OF CHANGE:

This has been investigated by different studies in the fields of psychosis and eating disorders. Theoretically, there are many explanations for how change is promoted in MFT. I will describe some of them, along with the idea that MFT fosters less dependency on therapists, inviting more alliance with the group. Laqueur (1976) stated that MFT brought the views of the community into therapy via other families. Edwards (2001) claimed that its effectiveness was based on allowing participants to experience their own family dynamics/processes in other families, without feeling overwhelmed, and being "able to listen to other families while not having to prepare their next comments" (p.4). He conducted a Delphi study to understand more about the elements that contributed towards successful Multifamily Group Therapy, by exploring with a panel of experts their understanding of the essential elements and then trying to reach a consensus and create some guidelines for future MFGT programs. Among many elements that he identified, the following are relevant to this research (please see his paper for further details):

- The client: is able to speak and understand the language used and feel valued by the therapist;
- The therapeutic setting: is safe and respectful, rules are established and adhered to;
- The therapist: encourages and respects group members' perspectives, gives attention to group processes and all the members involved, has a good sense of humour, is able to show leadership and, when necessary is directive, whilst also collaborating as a team member with a co-therapist (this is particularly important when working with families) and they communicate their roles clearly;
- Group relationships: the group is not controlled by one person; it should involve no violence and hostility should be minimal.
- MFT groups should be facilitated by at least two therapists.

In terms of therapeutic change, Bateson (1987) explained:

> *The process of psychotherapy is a framed interaction between two persons, in which the rules are implicit but subject to change. Such change can only be proposed by experimental action, but every such experimental action, in which a proposal to change the rules is implicit, is itself a part of the ongoing game. It is this combination of logical*

types within the single meaningful act that gives to therapy the character not of a rigid game like canasta but, instead, that of an evolving system of interaction (pp.197-198).

Sempere and Fuenzalida (2017) described therapists as architects of group dialogues. Gelin, Cook-Darzen and Hendricks (2018) stated that, in psychiatric disorders, change is encouraged through MFT by the therapeutic alliance, group cohesion, experiences of communalities, connections, sharing, learning and observation. Asen and Scholz (2010) emphasised that collaboration between group members is essential. Tantillo (2006) argued that mutual empathy and the empowerment experienced in a therapeutic social network facilitate healing. Springer, *et al.,* (2010) stated that, in the context of a supportive helping system, by focusing on the interactions between members and families in the here-and-now of group experiences, group members learn how they impact on or are perceived by others, get feedback about their behaviour, learn from one another, and practice new skills.

Despetele *et al.,* (2015) asserted that MFT blocks the central role of eating disorders as there are different families present in the group learning indirectly from each other about how others deal with similar problems, "without the need for explicitly expressing thoughts and emotions" (p.26). MFT provides a context where families are able to model, inspire, support, and confront each other, challenge their subjectivity, and which helps them to “broaden their own perspectives and to try out new behaviour. The experience of communality may further reduce feelings of guilt and reduce the burden on these families, leading to the better recovery of the patients (Mehl *et al.,* 2013; Uehare *et al.,* 2001; Whitney *et al.,* 2012)" (ibid, p.26). Voriadaki *et al.,* (2015) conducted a pilot study seeking to understand "how changes in cognitions, emotions or behaviour are related to particular aspects of the treatment and interventions used" (p.7). They focused on the first 4 intensive consecutive days of a 10-day MFT group (over 9 months) involving 6 families of adolescents diagnosed with anorexia nervosa, based on their clinical experience, and concluded that: “this period leads to the greatest amount of change in a short period of time” (p.7). They found sharing similar experiences, role playing, and perceived mutual learning and support facilitated change. One of the parents observed: "I feel the group is bonding and as if we all care about each other. The girls are now really helping each other. It feels very positive that we will succeed" (p.14). There are many factors that contribute to change in MFT, but the impact of cultural issues is unclear, so I will describe this next.

1.4.-FAMILY THERAPY AND MULTIFAMILY THERAPY AND CULTURAL ISSUES:

Reflecting the cultural mix of the place where families live, Multifamily groups are often formed by families from a wide range of cultural backgrounds. McKay *et al.,* (2004) found that many authors emphasised the need for services to provide more "culturally sensitive" interventions such as collaborating with families/parents to increase access to care, and actively working with families/parents to enhance attendance and involvement in care, improve their engagement and reduce drop-out rates. The Werry Centre's (2009) report described the international literature on cultural competence for family therapists as 'sparse' and argued that, the "notion of 'culturally sensitive practice' is both perplexing and intriguing" (p.19), explaining that even though it encourages systemic therapists to be more 'culturally sensitive', it is unclear what this actually means, nor how to achieve it, but seems refer to a "service/intervention delivery philosophy"(ibid). Some literature focuses on 'culturally competent practice', which seems to refers to therapists having certain skills/abilities/attitudes to achieve culturally sensitive practice. Durie (2005) described 'cultural competence' as "recognising other belief systems without needing to defend science as the only legitimate way of looking at the world" (p.6).

Historically, some studies have explored the applicability of family therapy to families from different cultures, and highlighted some clinical issues to consider. The following are just a few: Tamura and Lau's (1992) study in relation to Japanese families; Kung (2001) on working with Chinese American families caring for a mentally-ill relative; Asmal *et al.,* (2011) explored cultural challenges associated with implementing family therapy for schizophrenia in the multicultural South African context. McKay *et al,.* (2004) explored the impact of cultural factors on predicting the premature termination of Mexican and African-American families' engagement with child mental health services in the USA. They found that focusing on parents' attitudes and expectations of services was important. From a Maori perspective, Drury and Munro (2008) recognised that engagement is a critical element in the achievement of success for clients, but that attempting engagement in crisis situations can prove detrimental to both clients and workers. They stressed that engagement was facilitated by careful "respect for other", hospitality and creating an atmosphere in which 'the mana' of all participants is enhanced.

Smith, Domenech-Rodriguez, and Bernal (2011b) conducted a meta-analysis of 65 experimental and quasi-experimental studies, involving 8,620 clients in total. They evaluated the effectiveness

of culturally adapted therapies (including matching language and/or ethnicity/race, cultural content of sessions) vs. traditional (non-adapted) therapies. The results indicated that culturally adapted therapies were moderately more effective (effect size d =0.46) than non-culturally adapted treatments or culture-sensitive treatments. A further two meta-analyses of culturally adapted psychological interventions were conducted, one specific to children and youth (Huey and Polo, 2008) and another with clients of all ages (Griner and Smith, 2006). Both found average effect sizes of moderate magnitude (d=0.44 and d=0.45, respectively), indicating that culturally adapted interventions have a moderately strong benefit. Griner and Smith (2006) completed a meta-analytic review of culturally adapted interventions and found that interventions targeted at a specific cultural group (such as same race participants) were "four times more effective than interventions for groups consisting of a variety of cultural backgrounds… Interventions conducted in clients' native language (if other than English) were twice as effective as interventions conducted in English" (p.531). Other authors, such as Hall (2001), insist that there should be minimal or no adaptations, as disorders and interventions are universal.

Based on Lambert's (1992) review[5] of outcome studies in psychotherapy, which described the main factors accounting for therapeutic change, I believe that although disorders and treatments may be universal (accounting only for 15% of outcome variance), there are significant contextual factors (such as discrimination, migration, racism, poverty, language use and acquisition) that impact on people's lives and therapy. Families should be able to choose the type of therapy they want according to their preferences and experiences, as these are likely to impact on their engagement with therapy (including the therapeutic relationship and their hopes, accounting for 45% of outcome variance).

Regarding the MFT literature, Asen and Scholz (2010) described many activities, games and exercises that can be used with families from different cultures. McFarlanes's MFT programme has been culturally adapted in several ways, internationally, and has shown encouraging outcomes

[5] Cited by Hubble, Duncan and Miller (1999) who concluded that the main factors accounting for therapeutic change are: 1) Client/extra-therapeutic factors (clients' life circumstances including strengths and environmental support): account for 40% outcome variance; 2) Therapeutic relationship factors (empathy, warmth, acceptance, mutual affirmation, encouragement of risk taking and mastery): account for 30% outcome variance; 3) Placebo, hope and expectancy (client's knowledge of being in therapy, following a credible treatment): account for 15% outcome variance; and 4) Models/technique factors (beliefs and specific treatments): account for 15% outcome variance. However, this review did not specify the cultural identity of therapists or clients. By not referring to diversity issues, they assumed that these results apply universally and seemed to dismiss wider contextual factors.

(Gelin, Cook-Darzen and Hendricks, 2018). Springer, *et al.,* (2010) claimed that MFT is effective with a variety of populations (Meezan and O'Keefe, 1998; O'Shea and Phelps, 1985), but they did not elaborate further. Using semi-structured interviews and observations, Bentelspacher *et al.,* (1996) empirically explored the effectiveness of a MFGT program for 30 ethnic Chinese and Malay families in Singapore with a relative with schizophrenia. They concluded that this programme benefited these families by instilling hope, altruism, and guidance, but as it is forbidden to self-disclose within these cultures, this created obstacles to therapy. More recently, Ma, Lai and Wan (2017) described how MFT can be adapted in Chinese societies such as Hong Kong to help families of children diagnosed with attention deficit hyperactivity disorder and clients to assess it. The parents evaluated it positively whereas the children were less positive. They proposed some modifications, including a 30-minute pre-group meeting for the parents and more challenging games and outdoor activities for the children.

Weine, *et al.,* (2008) conducted a research study to evaluate whether a nine-session MFGT group increased access to mental health services for (n=197) refugees from Bosnia-Herzegovina in Chicago with post-traumatic stress disorder (PTSD). Their results indicated that MFGT was "effective in increasing access to mental health services and that depression and family comfort with discussing trauma mediated the intervention effect" (p.146). Prior to this study, Weine, *et al.,* (2005) conducted a mixed methods study of family factors and processes involved in Bosnian refugee families engaged in multiple-family support and education groups. They found that "families that engaged experienced more transitions, more traumas, and more difficulties in adjustment" (p.558), and concluded: "engagement strategies for multiple-family groups should correspond with the underlying family processes by which refugee families manage transitions, traumas, and adjustment difficulties" (ibid, p.558). Kira *et. al.* (2012) described a variety of group therapies used with refugees and torture survivors and how these can be adapted to fit their unique experiences. Within these therapies, they focused on The Bashal group for African and Somali women and the Bhutanese MFGT, which further developed group therapy by adding an ecological dimension to it. They stated that, in these cultures, community healing is particularly important as well as individual treatment. They promoted the development of social clubs and organisations to further develop "the values and culture of the graduates of the therapy group and the continuation of social support" (p.69). Finally, McDonald, *et al.,* (2006) conducted a study to evaluate the implementation of a Randomised Controlled Trial with 180 low-income urban parents

of Latino children, either to participate in an after-school Multifamily Group (FAST: Families and Schools Together) or to receive eight behavioural parenting pamphlets with active follow-up (FAME: Family Education). They concluded that there were statistically significant differences in favour of the FAST treatment modality rather than the FAME modality on academic performance and classroom behaviours, including aggression and social skills.

This section briefly described some existing MFT research in relation to cultural differences. It outlined how some authors have concluded that adaptations/modifications are necessary while others reject this idea.

CHAPTER 2-GROUP RELATIONSHIPS: GROUP COHESION

The developmental formation of small groups was clearly described by Tuckman (1965). He created a model which represents the different phases before a group becomes a team: (1)Forming: when group members orient "relate to the therapist dependently" (p.387) and group structure develops by testing and dependence and more guidance and direction is needed; (2)Storming, as there is intragroup conflict/tension and members might psychologically disengage from the group, but its purpose is clearer; (3)Norming, when group members become "a cohesive unit and developed a sense of being as a group" (p.389) and leaders facilitate; (4)Performing, when "the group is seen as serving a function performing, in which interpersonal structure becomes the tool of task activities" (p.396), achieving more. Even though I believe that group development is more dynamic than this model, as group members might be at different stages at the same time, I have decided to focus on the third stage of group development.

This chapter is divided into four sections. The first focuses on different definitions of group cohesion. In the second part I give my definition of group cohesion. The third provides a brief description of MFT and group cohesion research. The final section covers issues around group cohesion and cross-cultural validation.

2.1.-GROUP COHESION DEFINITIONS:

I commence by considering the etymology of *cohesion,* which means the 'act or state of sticking together'. It originates "from French *cohésion,* from Latin *cohaesiōnem* nominative *cohaesiōn)* 'a sticking together'" (Online Etymology Dictionary).

Brown (2010) defined connection as bidirectional energy that "exists between people when they feel seen, heard, and valued; when they can give and receive without judgement; and when they derive sustenance and strength from the relationship" (p.19). From an evolutionary neuroscientific and psychological perspective, Porges (2015), the founder of the Polyvagal Theory, described connectedness as a 'biological imperative', which constitutes "requisite functions that a living organism must fulfil to survive" (p.116). Some theorists have proposed alternative biological imperatives to Darwin's (1859): 'survival of the fittest', such as "'the fittest may also be the gentlest', because survival often requires mutual help and cooperation (Dobzhansky, 1962)" (ibid). Regarding the process of evolution, Porges emphasised that, for mammals, "functionally, social

connectedness enabled proximity and co-regulation of the physiological state between conspecifics[6], beginning with the mother–infant relationship and extending through the lifespan to other significant partnerships" (ibid). Therefore, evolution, anatomy and biology have developed in such a way that enables social engagement and reciprocal connection. Dana (2020) claimed that connecting invites clients "into exploration of social connections, reciprocity and co-regulation" (p.169).

Due to the contextual differences between groups, there are multiple definitions of 'group cohesion', which creates difficulties when researching this concept. In 1978, Bednar and Kaul, stated that, over time, reviewers have demanded definitional clarity, as "there is little cohesion in the cohesion research" (quoted in Burlingame, *et al*., 2011, p.34). The most popular definition seems to be Carron and Brawley's (2000), who described group cohesion as dynamic (changing over time) and multidimensional (multiple factors impact on its process, including various social perceptions). Burlingame, Fuhriman and Johnson (2001) described the therapeutic processes of group cohesion as: *intra-personal* (including a sense of belongingness, acceptance and individual commitment to the group); and *intra-group* (including attractiveness, compatibility, trust, support, empathy, caring, mutual stimulation and challenge, and collective commitment to group goals). Casey-Campbell and Martens' (2009) defined group cohesion as: "the group members' inclinations to forge social bonds, resulting in the group sticking together and remaining united" (p.223).

To broaden the understanding of group cohesion in different contexts and consequently how it is assessed in diverse domains, I considered Hung and Perez-Gatica's (2010) view from the organisational management perspective, which claims cohesion is a necessary part of collaboration between social or professional teams (including business teams, sports teams, psychotherapeutic groups, military training groups). They developed an observation tool to assess group cohesion levels by measuring interactive nonverbal communication behaviour, based on Braaten's (1991) definition, who "suggested 5 factors that affect group cohesion in group psychotherapy: attraction and bonding, support and caring, listening and empathy, support and caring, self-disclosure and feedback, process performance and goal attainment" (ibid, p.2).

[6] Members of the same species.

Johnson *et al.,* (2005), Burlingame, McClendon, and Alonso (2010) and Krogel *et al.,* (2013) asserted that there are two dominant and orthogonal dimensions of the therapeutic relationship in group psychotherapy: structure and quality. As multiple relationships can be formed in any group therapy treatment, structure refers to the direction of the relationships. Vertical cohesion describes member-leader relationships, and how group members perceive leaders' competence, genuineness and warmth. I noticed that leader-group relationships are not considered in this concept. Horizontal cohesion describes member-member, member-group and leader-leader relationships. Burlingame *et al.'s* (2002, cited in Krogel *et al.,* 2013) review identified that two thirds of the research literature focuses on the member-group relationship, while the member-leader relationship has been neglected. Johnson *et al.*, (2005) noted that only a few studies have explored more than one of these relationships concurrently (Kipnes, Piper, and Joyce, 2002; McCallum, Piper, Ogrodniczuk, and Joyce, 2002). Burlingame, McClendon and Alonso (2010) defined quality "by how members feel with their leader and with other members (positive bonding relationship), by the tasks and goals of the group (positive working relationship), and also the empathic failure with the leader and conflict in the group (negative relationship)" (p.11), on the basis that each member has different experiences of the group atmosphere/climate and group processes.

Johnson *et al.,* (2005) sought to provide a parsimonious description of the therapeutic relationship in group psychotherapy. They used an exploratory factor analysis and confirmatory factor analysis to produce a comprehensive three-factor model of the group relationship. Their sample included 662 group members from 111 clinical and non-clinical groups in the middle stage of group development. They found that the quality of the relationship was more relevant to group members than the structure of the group (e.g. who was involved). In the literature, some constructs (e.g. empathy and alliance) were so highly correlated (greater than r=0.90) that they overlapped. They proposed three factors: the first was the positive bonding relationship: which includes the emotional connection or attachment between members, and between members and leaders (including bonding and empathy) and members and the group as a whole. The second factor constituted the positive working relationship: including member-member and member-leader agreement on the therapeutic goals and tasks and their collaborative engagement in therapeutic work. Finally, the third factor consisted of the negative relationship element in the group which includes conflict, avoidance, distrust within the group and gross empathic failure with the leader,

which may affect members' engagement with the group and the therapeutic work. They found that these factors seemed to cross over with the main group relationships (member-member, member-leader, member-group), but not with leader-leader relationships. They concluded that, even though each factor is different, they are all related, and therefore, "if a group member felt positively about one type of relationship within the group, that member tended to feel positively about all of them" (p.318). Krogel *et al.,* (2013) added that "Positive Bonding has a moderate positive correlation with positive working and a moderate negative correlation with Negative Relationship. Thus, a group that is bonding well together is likely to also be working well and have fewer aspects of Negative Relationship" (p.7). However, this does not mean that Negative Relationship is the opposite of Positive Bonding. Similarly, Bakali (2013) stated that "group members' experience of significant therapeutic work during sessions further increases the level of group cohesion. By way of contrast, problems with subgrouping or member acting-out can have deleterious effects on group cohesion and, in turn, the productivity of sessions" (p.7).

In summary, group cohesion has been inconsistently defined by different authors. Some define it broadly (e.g. sticking-togetherness) while others are more focused (attractiveness). It involves many interconnected factors.

2.2.-MY DEFINITION:

To define group cohesion, I combine the three-factor model of group relationships established following the exploratory and confirmatory factor analysis research by Johnson *et. al.* (2005), the factors considered by Friedlander *et al.,* (2006a,b) when observing the therapeutic alliance using SOFTA, Hung and Perez-Gatica's (2010) study, and Gullo *et al.,*'s (2015, p.10) suggestion that it should be defined: "as the members' sense of belongingness to a group and their belief that the group is important to their outcomes".

I view group cohesion as a multifaceted concept, which can be understood across many dimensions in a variety of contexts, including task and social cohesion, vertical and horizontal cohesion (i.e. between group leaders and group members or between group members), personal and social attraction, and belongingness. I understand group cohesion as comprising the following factors (based on Bordin, 1979, and Johnson *et al.,* 2005), which I describe in detail below:

1. Positive bonding relationship in the group: emotional connection between members and with therapist and the group as a whole. It has also been described as cohesion, engagement, empathy, sense of belongingness, experiences of acceptance, caring, trust, sharing experiences, self-disclosure and feedback, negotiating, sense of security, and commitment to the group by each member. Perceptions of a therapist as someone who has expertise and really cares, is trustworthy, likeable, similar (e.g. on the same wavelength as the client: values, life perspectives), familiar and has friendship potential. In terms of observable behaviours, it entails: physical seating distance, physical contact, amount of eye contact, jokes, self-disclosure about personal life or emotions, similarities between group members and interests in others apart from therapeutic goals.
2. Positive working relationship: attendance, collaborative engagement in therapeutic work between family and other group members and therapist and group as a whole. Family group members view treatment as meaningful and therapy as a place to take risks, be open and flexible. There is cooperation within the group. Progress towards therapeutic goals, which have been agreed between member and therapists. Confidence in group ability to perform a specific task (feelings of collective self-efficacy). Taking the process seriously and believing that change is possible and noticing it. A sense of solidarity in relation to the therapy. In terms of observable behaviours, it involves: therapist explaining how therapy works and asking client(s) what they want to talk about and their goals, physical closeness, praising others, supporting each other towards goals, participating in group tasks or homework, noticing positive changes, drawing in quiet clients, listening, encouraging group members to ask each other about their perspective, emphasising commonalities. Therapist changes topic to something more pleasurable or non-anxiety provoking when there seems to be tension or anxiety.
3. Negative relationship factors: which affect the bond or impede the therapeutic work. These can manifest in empathic failure with the leader, conflict in the group, distrust, members acting up, hostile, sarcastic or critical interactions, avoidance within the group and problems with subgroups, early termination, imposing tasks, failing to intervene when group members argue, verbal abuse, intimidation or threats or someone dominating and overpowering others in the group.

2.3.-MULTIFAMILY THERAPY AND GROUP COHESION RESEARCH:

Overall, MFT process research is limited, in particular regarding group cohesion and qualitative studies. Group psychotherapy research is also lagging behind (Krogel *et al.,* 2013). The way in which the therapeutic relationship has been described in individual therapy has informed how it is understood in group therapy and Systemic Psychotherapy. Bordin (1979) explained that the therapeutic (working) alliance involves establishing bonds and negotiating the goals and tasks of therapeutic treatment. Group cohesion has been used to describe the therapeutic relationship in this context, "with multiple, collaborative and bonding alliances, having intrapersonal, interpersonal and intragroup features" (Burlingame, Fuhriman and Jonhson, 2001, p.374). However, Deane *et al.,* (2012) emphasised that group cohesion is different to the dyadic concept of a “working alliance”.

In individual psychotherapy, there is a consensus that the therapeutic alliance is the best predictor of therapeutic gain (Muran and Safran, 1998; Horvath and Bedi, 2002; Horvath, Del Re, Flückiger and Symonds, 2011; Martin, Garske and Davis, 2000, cited in Bakali, 2013). In group therapy, where there are multiple relationships, some authors believe that the therapeutic relationship is less strong in comparison to individual therapy (Bakali, 2013).

In Systemic Psychotherapy, the therapeutic alliance is more complex, as it not only involves more members, but also each family member has different levels of motivation and engagement, they share a common history/lives outside of therapy, they bring differences and conflict with them and some may be concerned about real-life consequences of what happens in therapy (e.g. separation/divorce, reporting violence) or about “What will the others say? or Who will be blamed?” (Friedlander *et al.,* 2006a,b; Rober, 2015). Rober (2015) stressed that “within such a high-tension context, it is not easy for the therapist to form an effective therapeutic alliance with each of the family members, as well as with the family as a whole” (p.106).

In Friedlander et al.,’s (2006a, 2006b) studies, separate teams across the USA, Canada and Spain developed an observation and a self-report system (System for Observation of Family Therapy Alliance-SOFTA) to evaluate the therapeutic relationship in family therapy both from clients' and therapists' perspectives. They described the therapeutic alliance as composed of four different factors: engagement in the therapeutic process, emotional connection to the therapist, safety

within the therapeutic system, and shared sense of purpose within the family. They stressed that a sufficiently safe context is essential for any therapeutic work, but more so when dealing with families' complex relationships, where therapists have to "maintain balanced therapeutic alliances with multiple clients simultaneously" (Friedlander *et al.,* 2006b, p.215).

Over time, group cohesion "has become synonymous with the therapeutic relationship in group psychotherapy" (Burlingame, McClendon and Alonso, 2011, p.34) between all group members and therapists. There is a strong empirical relationship between group cohesion and the effectiveness of group therapy. Some studies (including meta-analyses) that support this association are: Burlingame, McClendon, and Alonso, 2011; Burlingame, McClendon, and Chongming, 2018; Crowe and Grenyer, 2008; Cruz, Osilla and Paddock, 2020; Kivlighan *et al.,* 2020a,b; Lindgren, Barber and Sandahl, 2008; Vicente *et al.,* 2021. However, other studies have shown mixed results or even challenged this view, e.g. Hornsey, Dwyer and Oei, 2007; Joyce, Piper, and Ogrodniczuk, 2007. Burlingame, McClendon, and Alonso's (2011) meta-analysis concluded that: "cohesion is reliably associated (r=0.25) with group outcome when outcome is defined as reduction in symptom distress or improvement in interpersonal functioning. This association was found for groups across different settings (inpatient and outpatient) and diagnostic classifications" (p.39) and when group leaders focused on interactions between members, independently of their therapeutic orientation (interpersonal, psychodynamic, or cognitive– behavioural therapy) and the duration of the group, but is "strongest when a group lasts more than 12 sessions and is comprised of five to nine members" (ibid). Cohesion requires sufficient member interaction and time to build. They also found that: "younger group members experience the largest outcome changes when cohesion is present within their groups" (ibid). Theoretically, cohesiveness between members is an important component in the effectiveness of group therapy (Yalom, 1995).

Burlingame *et al.'s* (2002, cited in Krogel *et al.,* 2013) review identified the main variables often used to describe the quality of the therapeutic relationship, which are linked to the effectiveness and outcome of therapy, as:

> *Group cohesion (a sense of belongingness to the group), alliance (a fond working relationship between the therapist and the member), group climate*[7] *(a sense of*

[7] Gullo, *et al.,* (2015) described the group climate as an "indicator of the atmosphere in a group, and it was defined as a

> *constructive interpersonal investigation), and empathy (a sense of being understood)* (pp.1).

Various research studies have shown that supportive and challenging group relationships not only contribute towards individuals' improvement in groups, but also to lower drop-out rates (Burlingame, Fuhriman and Johnson, 2001; Castonguay, Pincus, Agras and Hines, 1998; Marziali, Munroe-Blum and McCleary, 1997, cited in Krogel *et al.,* 2013).

The relationship between these concepts has been studied by different authors who found that:

> *The empirical overlap between cohesion and alliance (Budman et al., 1989; Gillaspy, Wright, Campbell, Stokes and Adinoff, 2002; Marziali et al., 1997), cohesion and empathy (Roarck and Sharah, 1989), alliance and empathy (Horvath, 1994), and empathy and group climate (Phipps and Zastowny, 1988) have suggested that they are highly related to one another and theorized to serve most of the same functions within the group* (Johnson *et al.,* 2005, pp.310).

Burlingame, Fuhriman, and Johnson (2001) concluded that they are interrelated even though there are significant empirical clinical differences between them. Overall, group cohesion is the concept that has been studied most, and cohesion and alliance are the most frequently paired concepts (Gillaspy, Wright, Campbell, Stokes and Adinoff, 2002; Joyce, Piper and Ogrodniczuk, 2007; Lorentzen, Sexton and Hoglend, 2004; Marziali *et al*., 1997, cited in Krogel *et al.,* 2013).

Bakali (2013) suggested that alliance and cohesion are relatively different processes as their variability is unequal at different stages. Some authors distinguish alliance as being related to member-leader relationships and cohesion to member-group relationships. Other authors have described cohesion as a member-leader relationship. However, as Bakali observed: "what constitutes bonding to other members and bonding to the group-as-a-whole is not so clear cut" (p.76). This obviously depends on how group cohesion is defined and some more recent definitions of group cohesiveness include both member-member and member-group relationships. Bakali

multidimensional construct that comprises a participant's perception of other members' engagement with the group, avoidance of important or difficult topics, and conflict among group members" (p. 10-11).

used a clinical sample of 145 patients attending 9 short-term (20 sessions) and 9 long-term (80 sessions) psychodynamic psychotherapy groups to explore the processes of alliance, cohesion, and group climate. He concluded that, "later in therapy, the bonding between member and leader was no longer important for the member-group bonding, and the model was then better described as member-leader alliance, member-group cohesion, and negative relationship" (ibid, p.8). Bakali, Baldwin and Lorentzen (2009) found that member-leader bonding provides a "bridging function" between positive working and bonding relationships in group therapeutic processes. They concluded that the member-leader emotional bond is an important factor for developing early group cohesion, but that as therapy progresses, group cohesion progressively develops independently from the leader and that this relationship "operates as a relatively independent process dimension, even early in therapy" (p.340).

Edwards' (2001) delphi study found that most participants concluded that a family-based group provides a natural connection between group members, which fosters cohesiveness, as a context where similarities and differences could be acknowledged is created, diminishing isolation and providing learning opportunities.

Asen and Schuff (2006) described a model of MFT implemented for families with a member experiencing psychosis. They concluded that participants in their programme developed personal, collaborative and cohesive relationships which impacted on their feelings of being "much more connected to the wider service context" (p.69). Dean *et al.,* (2012) described how empirical research has supported group cohesion but that minimal empirical research has been conducted to assesses its role in family group treatments. They carried out research about group cohesion and homework adherence in Multifamily Group Therapy for Schizophrenia, where results showed higher group cohesion in association with "higher rates of spontaneous between-session therapeutic activity" (p.128) and "no significant relationship between cohesion and scheduled homework completion" (ibid). Tantillo (2006) reported that, in relational/cultural theory, it is believed that psychoeducational Multifamily therapy groups heal by experiencing mutual empathy and empowerment as part of diverse social therapeutic networks, because members are encouraged to develop strong connections whilst honouring individual differences and identifying "various disconnections that keep the eating disorder in place and build new relational opportunities in recovery" (p.82).

The research literature on the association between group cohesion and the outcome of groups in different contexts is very rich, including therapeutic groups (but not specifically MFT groups): (Burlingame, McClendon and Alonso, 2011; Burlingame, McClendon and Yang, 2018; Crowe and Grenyer, 2008; Deane *et al*., 2012; Gallagher *et al*., 2014; Marziali, Monrow-Blum and McCleary, 1997; Schnur and Montgomery, 2010); business (Banwo and Onokala, 2015; Casey-Campbell and Martens, 2009; Chiocchio and Essiembre, 2009; Greene, 1989; Tekleab, *et al.,* 2016); the military (Ahronson and Cameron, 2007; Kanesarajah, Waller, Zheng and Dobson, 2016); music (Dobson and Gaunt, 2015; James and Freed, 1989; Matthews and Kitsantas, 2007); and sports (Carron, 1982; Carron, *et al.*, 2002; Eys, Loughead, Bray and Carron, 2009; Eys and Kim, 2017; McLaren *et al.*, 2017; Ha and Ha, 2015).

2.4.-GROUP-COHESION CROSS-CULTURAL VALIDATION:

Group cohesion has been found to be associated with therapy outcomes across cultures. Johnson *et al.,*'s (2005) model has been re-tested cross-culturally, using different populations (inpatient, short- and long-term group analysis) in a study in Germany and Switzerland by Bormann and Strauss (2007) and another study in Norway by Bakali, Baldwin, and Lorentzen (2009), which corroborated Johnson's *et al.,*'s (2005) three-factor group process model in different cultures and considered a member-leader alliance, member-group cohesion, and a negative relationship factor, indicating that the alliance is a factor related to the therapist, which contains both working and bonding processes. The second factor involves members' bonding to the leader and to other members. Borman and Strauss' (2007) study did not replicate Johnson's *et al.,*'s (2005) study.

Gullo, *et al.,* (2015) completed an exploratory study about common factors in group processes and their relationship with attachment involving graduate students attending interpersonal growth groups in Italy, which supported the three-factor quality model.

In a meta-analysis Burlingame *et al.,* (2011) stated that, when considering all these variables, group cohesion is consistently a significant moderator and predictor of therapeutic progress and outcomes across a wide range of therapeutic orientations and client populations.

CHAPTER 3-MULTILINGUAL FAMILIES/ MULTICULTURAL THERAPY

The complexity of multicultural societies and intercultural therapy is beyond the scope of this research. However, given the research participants, its relevance, and my interests, I will provide a summary of some significant issues to consider in intercultural therapy and more specifically when working with bilingual/multilingual and mono-lingual families simultaneously. This chapter is divided into three sections. The first part provides an overview of the most important issues in intercultural Systemic therapy. The second section focuses on therapy across different languages. The third section covers issues specifically around the therapeutic relationship across different languages.

3.1.-CONTEXT OF INTERCULTURAL THERAPY:

Defining culture is complex and has led to disagreement. I will not attempt to define culture precisely, but I include different views which inform my understanding of culture. Bourdieu (1977) stated that "culture" can be regarded as a "map" and described this analogy in terms of "an outsider who has to find his way around in a foreign landscape and who compensates for his lack of practical mastery, the prerogative of the native, by the use of a model of all possible routes" (p.2). He added that there is a gulf between a potentially abstract space, without landmarks "or any privileged centre… and the practical space of journeys actually made" (ibid). He also suggested that anthropologists have "to break with native experience and the native representation of that experience: it has to make a second break and question the presuppositions inherent in the position of an outside observer, who, in his preoccupation with *interpreting* practices, is inclined to introduce into the object the principles of his relation to the object" (ibid), for instance by naming practices. Bourdieu observed that it is difficult to define the cultural identity of a group when we are both outside and inside a group, as from outside we would struggle to perceive the dispositions and understand the meaning of practices, while from inside it would be difficult to describe its own habitus/identity. I find these ideas relevant when considering intercultural therapy, as it is difficult to define both "others' cultural identity" and our own. Although I have experienced migration, and learned about my identity in comparison to others, I am aware that I also have blind-spots in relation to my own cultural identity.

Sue and Sue (2008) described how we are born in a shared "cultural context of existing beliefs, values, rules, and practices" (p.33). I will not attempt to define culture precisely, but I include

different views which inform my understanding of culture. Hardy and Lasloffy's (2002) suggestions that "all human relationships are characterised by both sameness and difference" (p.572) and that no human being would ever share the same cultural identity, as each person brings a subjectivity within "'rich cultural borderland', overlapping zones of difference and similarity within and between cultures" (Rosaldo, 1989, cited in Falicov, 1995, p.376; Falicov, 1998), where inconsistencies, conflict and connections exist, are important. Finally, Davolo and Fruggeri's (2016) definition of culture as "a process generating meanings and constructing realities through the participation of people in joint actions with others and in relation to the available artefacts" (p.122), which is more evident when in contact with 'others', is also influential.

Krause (2009) explained that, in its early stages, Family Therapy focused on behaviours and a mechanistic interpretation of Batesonian cybernetics rather than on Bateson's ideas about culture and meaning. Pocock (2012) suggested that, when "'culture' was considered more directly in Family Therapy it acquired a compensatory idealised gloss, a corrective script (Byng-Hall, 1995)" (p.72), possibly in response to its previous omission. As 'context' is a very significant concept in Family Therapy, it is shocking that even 30 years after Hardy (1989) noted that most therapists were not prepared to work effectively with clients from minoritised groups, and often got stuck, these issues still have not been fully addressed in training courses, nor in practice. At the time, Hardy explained that Family Therapy training encouraged the belief that all families were 'virtually the same', which he called 'the theoretical myth of sameness' (TMOS). It can reasonably be argued that therapeutic training and practice are socially constructed (Flaskas, 2002), and that we are not fully aware of some of our 'invisible knapsacks' of white privilege (McIntosh, 1998) or the cultural assumptions we hold.

From a social constructionist/relational perspective, culture is determined by people's contexts and interactions, as the different ways in which individuals are positioned and position themselves in their cultural milieu depend on their experiences of "racialisation, ethnicity, gender, class and sexual orientation among other factors" (Burck, 2005, p.23). Campbell (2012) described race and culture as 'totalising' terms, which obscure their subtle meanings in different contexts. He clarified that, "to move toward dialogue is to recognise that the position I hold in relation to race and culture is maintained by the existence of other positions" (p.44). For instance, being privileged vs being oppressed.

Krause (2012b) claimed that: "in everyday practice in systemic psychotherapy, differences, and especially those which are conceptualised in terms of race, culture, and ethnicity, evoke primitive states and 'othering' processes in therapists no less than in other persons" (p.22). She considered Bakhtin's notion of the 'dialogical self' (i.e. a person is both subject and object to him/herself), and suggested that, as embodied selves, we intuitively know that we are not objects, but especially when bodies are very different to ourselves, we run the risk of objectifying them. She added that "power, stereotyping, discrimination, and racism[8] are processes of objectification in which one party relates to the other as subject to object and mutuality in perspectives has been lost" (p.23). Reflecting on identity formation and the value of otherness, Jensen (2011) claimed that, "The other is always the other as in inferior, not as in fascinating" (p.65). He defined 'othering' as "discursive processes by which powerful groups, who may or may not make up a numerical majority, define subordinate groups into existence in a reductionist way which ascribe problematic and/or inferior characteristics to these subordinate groups. Such discursive processes affirm the legitimacy and superiority of the powerful and condition identity formation among the subordinate" (ibid). Frosh (2009) warned that "otherness cannot be colonised as 'same', can never, that is, be regulated or fully understood" (p.187): we should respect the other and we cannot colonise their inner space; we can connect with them as a bridge, but not as 'invaders'. He further suggested that 'otherness' "might be something we are compelled to stand in awe of, not to make comprehensible, and that this might constitute its challenge and also its humanising core" (ibid).

Based on Benjamin's (1998, 2000) intersubjective theory, which emphasises mutuality, Frosh (2009) stated that in the intersubjective stance: "The other is related to but is not appropriated… (in knowing the other we come to colonise her/him)" (p.188). Frosh (ibid) described *recognition* as formed from understanding that each participant in any interaction is an autonomous subject, in relation to one another.

Daniel (2012) stated that, "in hierarchical contexts, recognition of others is so often dependent on the 'other' accepting those representations" (p.99), as a result of 'symbolic power' (Bourdieu,

[8] "Racism is an act that denies a person or group humane treatment or a fair opportunity because of racial bias… all expressions of racism are rooted in an ideology of racial superiority/inferiority that assumes some racial groups are superior to others, and therefore deserve preferential treatment" (Laszloffy and Hardy, 2000, p.35).

1977). She added that intersubjectivity (a psychological theory) and dialogism (a philosophical position) highlight interactions as "meeting grounds" where those who are capable influence each other by paying attention to how each other's view of ourselves impacts on what we say and do in the therapeutic relationship, and also create "perturbations" for us to learn from. She highlighted that, in talking about 'othering' and deconstructing it, we perpetuate it, not only because "we are always dependent on the representations of the 'other' to define who we are" (p.98), but also because "'othering' is a form of discrimination when it categorises certain groups as 'other' (for example, highlighting ethnicity only in relation to minorities), when it either excludes them from 'mainstream' thinking or responds to them as stereotypes or representatives of categories" (p.97).

These issues often seem salient only to those in a "minoritised"[9] (Gunaratnam, 2003) group. This is evident to me not only when every time I attend any workshop/training on race and culture, most of the participants are from minoritised groups, but also as the majority of the literature around these themes tends to be written by therapists from minoritised groups. There are many explanations for this, such as ethnocentric/colonising practices and therapists'/studies' blind-spots. Many therapists remain unaware of their 'invisible knapsack' (McIntosh, 1998), without self-reflection, and lacking feedback from 'the oppressed'. It is therefore not surprising that, as Kareem and Littlewood (2000) observed, minoritised groups are significantly hostile towards psychotherapy as they perceive it as a 'Western, middle-class' treatment, and that white therapists often describe psychotherapy as not suitable/effective for minoritised groups.

How can these themes be addressed in Family Therapy? Flaskas (2012) argued that intercultural work is "where we are the most deeply immersed in a living history of oppression" (p.62), while Rober and Seltzer (2010) stressed that therapists unintentionally act as colonisers.

Campbell (2012) stated that, when we talk about cultural differences in therapy, we invite historical legacies such as colonialism, racism, and discrimination into the room. Therefore, it is important that they are challenged and acknowledged in the therapeutic space. He emphasised the need to 'keep the conversation going', especially as:

[9] Gunaratnam (2003) used this term to reflect the dynamic sense of becoming a minority.

> *Race and culture carry such emotionally laden baggage, we can easily fall into the trap of accepting a statement about race as though we know what it means to the speaker, and avoiding the more difficult, perhaps uncomfortable, process of finding out the range of meanings the speaker attaches to the statement* (pp.42).

Päivinen and Holma (2016) stressed that it is vital that, in intercultural couple therapy, therapists remain aware of marginalised and silenced cultural discourses. Meanwhile, Rober (2012) highlighted that although 'dominant societal norms' encourage us to be respectful to each other and embrace/tolerate diversity, racism, colonialism and insensitivity are present in our society. In response to these dominant discourses of tolerance there are marginalised discourses questioning multiculturalism which mask inequality/intolerance and "a patronising attitude" (Brown, 2006, quoted in Rober, 2012, p. xix). Even though intolerance is shallowly buried by society, racism and colonialist views often resurface in different ways. Brown (2006) argued that, "being tolerant to others can be read as 'we accept that you remain connected with your cultural traditions, but we -enlightened as we are- see the relativity of cultural beliefs and practices. So, we are flexible and suspend our own cultural connectedness in order to be tolerant, and respect you in your cultural traditions" (ibid). Even the term 'diversity' has been described as "racism in disguise" (Karp, 2016) because diversity is connected with BAME people, rather than white people, who are often described as a "monolithic" race or a "big lie for white people", who use 'diversity' as a way of talking about race when we can't talk about it (Berrey, 2015).

Bertrando (2007) described that true (less colonising) dialogue happens when the therapist is an opinionated partner, who puts his/her ideas into play with the clients' ideas.

Based on Kakar's 'ethical relativism' Malik and Mandin (2012) argued that "accessing culture is an emotional process which requires a level of reflective practice, emotional engagement and reworking of cultural themes by both the clinicians and the family" (p.202), whereby therapists create a context for the therapist and client to come to 'know' together' rather than trying to sustain an open 'not-knowing' and non-judgemental position. Larner (2009) explained that 'the ethical therapist' is "open to an experience of the *other,* is moved by the uniqueness of therapy encounter. In receiving the other, I become aware she is separate from me; as *other* he overflows the 'I'" (p.208). He added that, "the therapeutic relationship, is asymmetrical: like the mother with

her baby, as a therapist I am there *for* the other. I think and reflect as a therapist on what knowledge is available to help influence stories of suffering and adversity" (p.212). Literature exploring this intersubjective ethical therapeutic stance in multicultural work is scarce (Laszloffy and Hardy, 2000) and more reflections are needed (Rober, 2012), especially about the impact of multiculturalism on the therapeutic relationship.

Daniel (2012) suggested that cross-cultural competence can be learnt through different experiences in our everyday lives and that "we all have a responsibility to develop our own 'polyphony', to embed intercultural thinking into our everyday lives, rather than regarding it as a position we adopt when we see families who are 'different'" (p.105). She stated that the concept of self-reflexivity is limited, and instead advocated the term '*cultural reflexivity*' which she described "as an attention to the process through which we negotiate cultural identities, through which we bring forth cultural meanings and the ways in which we engage with aspects of 'otherness' and difference" (p.92), as difference is inevitable and it requires 'the other' to be respected, as well as "risk taking and extending ourselves beyond our own cultural comfort zone" (p.91). She emphasised that therapists from minoritised cultures read cultural nuances more easily. She wondered what therapists from the majority culture would need to be culturally reflexive about their own positions "without disempowering themselves by becoming so conscious and tentative that opportunities for close engagement are lost" (p.94). Additionally, Daniel suggested creating spaces where feedback about blind-spots and these therapists being exposed to experiences of 'othering' and being 'othered', and feeling disqualified by a lack of understanding of cultural norms or language, could use. Likewise, Rober (2012) warned that if therapists only try to be 'culturally sensitive', being respectful of 'otherness' and trying not to offend, they might risk being too passive/absent, as "the therapist as a person disappears" (p.xx). He claimed that: being 'other' we "find a way in the complexity of cultural differences, of historical debts, and also a sense of shared humanity" (p.xxii). He further suggested that, to address this issue, reflexivity is essential, as a way of focusing on ourselves and attempting to orientate towards others. Krause (2012b) believed that '*comprehensive reflexivity'* is called for*,* which "encompasses recursiveness between different aspects of meaning, interpretation, and experience held or expressed by persons (either clients or therapists) *as well as* the reflexivity of both the therapist and clients *vis-à-vis* their own history, development, and background and the contexts in which they participate" (p.9). In ethical

practice, the reflexivity process involves having your own views and developing the view that the other has of your own perspective "against the background of their own perspective" (ibid, p.20).

Laszloffy and Hardy (2000) suggested that "it is necessary to understand one's self as a racial being" (p.40), not to have a dialogue about differences, but to act and live differently. They emphasised that it is ethically imperative for therapists to change 'oneself' rather than changing 'others', even when they are perceived to be 'different'. One way of doing this is by following and advocating anti-racist practices[10], which have recently been highlighted by many, including Kendi (2019) and DiAngelo (2019). Racism overtly and covertly has a profound effect on people's lives and therefore on the therapeutic processes. Therapists need to validate the significant role that race plays in the client's life, both inside and outside the therapy room to establish a trusting therapeutic relationship (Hardy and Laszloffy, 1994). The concept of 'racial trauma[11]' has been theorised by many, including Carter (2007); Chavez *et al.,* (2019); Comas-Díaz (2016); Comas-Díaz, Hall, and Neville (2019); Williams *et al.,* (2018); and Williams, Lawrence and Davis (2019), which highlights not only the effect of racism on health, but also how "racialised trauma, in a person over time, can look like personality. Racialised trauma in a family over time can look like family traits. Racialised trauma, in people over time can look like culture" (Menakem, 2020a). These issues have been exposed by the current COVID-19 pandemic, as highlighted by the United Nations Human Rights Commission (2020), but also minimised by the Commission on Race and ethnic Disparities Report (2021).

In this section, I have briefly discussed how, despite the global multilingual context, we, white people, are still unaware of our 'invisible knapsacks'' of white privilege (McIntosh's, 1998) and its impact on our lives and therapy. In defining culture, I considered the ideas of 'rich cultural borderlands' (Rosaldo, 1989, cited in Falicov, 1995, p.376), where there are similarities and differences, determined by 'joint actions with others' (Davolo and Fruggeri, 2016) and different

[10] "Anti-racism is the **active process** of identifying and eliminating racism by changing systems, organisational structures, policies and practices and attitudes, so that power is redistributed and shared equitably" (attributed to NAC International Perspectives: Women and Global Solidarity)" by Alberta Civil Liberties Research Centre (2021). Kendi (2019) described an antiracist as: "one who is supporting an antiracist policy through their actions or expressing an antiracist idea" (p.13).

[11] "A form of race-based stress, refers to People of Colour and Indigenous individuals' (POCI) reactions to dangerous events and real or perceived experiences of racial discrimination. Such experiences may include threats of harm and injury, humiliating and shaming events, and witnessing racial discrimination toward other POCI. Although similar to posttraumatic stress disorder, racial trauma is unique in that it involves ongoing individual and collective injuries due to exposure and re-exposure to race-based stress" (Comas-Diaz, Hall and Neville, 2019, p.1).

contexts. I stressed that therapists have a duty to remain ethical, and open to an experience of the other (Campbell, 2012, Larner, 2009), as well as to sustain a position of ethical relativism (Kakar's, 2006), using cultural reflexivity (Daniel, 2012) and 'comprehensive reflexivity' (Krause, 2012b), and being aware of marginalised and silenced cultural discourses (Päivinen and Holma, 2016, Rober, 2012), thus validating the role that racism plays in people's lives (Hardy and Lasloffy, 1994), including 'racialized trauma' (Menakem, 2020a) and advocating anti-racist practices (Kendi, 2019). Taking the aforementioned ideas into consideration, I intend to be careful in my research about not colonising others as 'same' and to consider how intersubjectively we influence each other in the "meeting grounds" (Daniel, 2012) between the therapists' interactions and my interactions with the group. I also maintain an awareness of Rober and Seltzer's (2010) idea of therapists unintentionally acting as colonisers.

Finally, Burck (2005) stressed that culture and language are inextricably connected, as language is "'culture soaked'-cultural concepts are embedded in language and its use, as well as language being signified as carrying cultural identity" (p.23). Through language we construct our racialised identities, ethnicities, and cultural identities, and our positioning within a language, is influenced by racialisation, ethnicity and cultural identity, both in equal and unequal power relationships. Costa (2020) proposed the term 'linguistic agency', which she described as the use of language to think and "communicate our decisions, act and impact on others" (p.12), through which we discover a sense of agency in the world. I am aware that there are writers who would not separate 'language' from 'culture'. I will now specifically consider the impact of language on the therapeutic space.

3.2.-THERAPY ACROSS DIFFERENT LANGUAGES:

Even though London is one of the most linguistically diverse cities in the world, "there is considerable pressure for those who speak other languages to assimilate by speaking English" (Burck, 2005, p.1). Burck stated that throughout the world English is deemed to be a 'strong language' and "its status, built on is colonial past and promulgated through the dominance of the United States [is]… intimately entangled with power relationships and its use disseminated through globalisation" (ibid, p.18). She explained that there are different hierarchical and power relationships between languages, which impact on the use and meanings of languages, such as which languages are used in public, as "individuals are required to use the dominant language

which at the same time constitutes them as assimilated subjects" (ibid, p.19), resulting in them being acculturated and excluded simultaneously. In my view these issues reproduce colonial practices, as people's languages/identities/cultures are unrecognised/dismissed/lost.

Costa and Dewaele (2013) noted that, despite increasing interest in the role of language in therapy, both for multilingual therapists and clients, there has been "relatively little investigation compared with the amount of interest dedicated to the role of culture in therapy" (p.20). Contemporary Family Therapy has developed as 'talking therapy', so 'language' is overdetermined and has become a centralised part of it. It is understood that new meanings emerge in language and that the therapist's role involves co-authoring stories through language. Krause (2019) argued that "too much emphasis on the role of language in social construction tends to prioritise the role of language in general, rather than the differences represented by different languages". She suggested that emphasising language and texts in therapy has been unhelpful as privileging language is in itself a cultural assumption, which excludes 'the self' and 'the subject', and more embodied, emotional, non-verbal interactions and experiential dimensions (2012b). She stressed that these dimensions implicate cultural meanings, expectations, and history, and an emphasis on culture, race, and power, and raised questions about continuity as well as patterns of meaning which may be historically and socially implicit and outside consciousness altogether. For instance, using English as a colonial language, when clinicians from a powerful position, as representative of the majority, and of their institution, normalise their practices, such as, using reductive diagnostic categories, prescribing certain treatments, coercing disclosure, or appropriating language,[12] they position clients in a powerless/marginalised position. The very notion of therapy itself may be colonising and exclusive, as in many societies therapy does not rely exclusively on language, but also on actions and embodiment, for instance, 'Somatic Abolitionism', (Menakem, 2020b, 2021a, 2021b), 'Sensorimotor Psychotherapy' (Ogden, 2015), Art Therapy (Malchiodi, 2012) amongst many others.

[12] Bleyle (2020) described this as dominant cultures stealing "language from the people that they oppress in order to profit off of those oppressed cultures". She further explained that "white authors wanted to write black characters (usually a slave or helper character, almost never a protagonist of any kind) who spoke the way that white people perceived black people to speak, and so they often would include a dialect for their black characters". She described this practise as harmful because it was often inaccurate, offensive and it did not show understanding of the origin of the dialect; rather, "they simply wanted to include the dialect in order to make their characters seem more 'black'. This led to stereotypes, which still persist.

Malik and Mandin (2012) highlighted that, obviously, therapists are not a blank slate, but they need to be aware of their own cultural position and 'hold in suspension' their preconceived ideas in order to get to know someone in their context, which "can be especially challenging when the therapist does not speak the client's language, and requires a level of emotional engagement that is containing but also can withstand the pulls of highly opposing cultural viewpoints within the therapist and therapeutic system" (p.220), and avoid colonial practices. Bowker and Richard (2004) stressed the importance of native-speaker therapists being mindful of power issues in the relationship with bilingual clients. Borštnar *et al.,* (2005) highlighted that, in an intercultural Family Therapy training session in Slovenia, British trainers, as speakers of a dominant language, were positioned as powerful, in contrast with Slovenian trainees. They highlighted that in this position/context the British trainers were particularly aware of their unearned privileges in all contexts.

Kokaliari and Catanzarite (2011) noted that clients struggle to communicate efficiently in a second language, but this is widely unrecognised by psychotherapists, which has clinical implications. Similarly, Costa and Dewaele (2013) stated that some therapists may "not consider this as a potential issue and will not address their patients' choice of language at all. Sometimes it is the patient who is left to ponder on its meaning" (p.20). They further explained that many therapists may share Perez Foster's (1998) early descriptions of therapy in a second language as 'pseudotherapy' (as it was understood as resistance to their 'mother-tongue') or as 'quasitherapy' (as the essentiality of therapy is lost in translation). On the other hand, Perez Foster (1996, quoted in Costa and Dewaele, 2013) proposed that, when speaking in their shared native language: "both members of the therapeutic couple are pulled into a sensorial space...this experience is similar to the child and early caretaker's sharing of affective states and moods" (p.71), which might not only potentially increase empathy and intimacy, but also collusion.

However, even when therapists and clients' language is matched, there may still be miscommunication and a false sense of understanding each other. Bhui and Morgan (2007) highlighted that "communication of internal states of mind is difficult even in a shared language. Across languages and cultures, the task must include slow and paced review of all that is thought to be known and assumed by both the therapist and the patient" (p.191). Tsatsas (2019) described some clinical challenges of working in bilingual's therapists' mother-tongue, which impacted on

therapists' maintaining neutrality. Such as: having different lifepaths, even with same mother-tongue, transference-countertransference experiences, therapeutic boundaries (because sharing a language brings intimacy and identification) or having a different sense of 'homeland'.

Skulic (2007) pointed out that the research around bilingualism in therapy questions its effectiveness in a client's second language and in clinical situations when therapists and clients are linguistically different. The obstacles faced by clients when communicating in a second language were highlighted by Myers (1999). Therefore, DeZulueta (1990) and Fernando (2003, cited in Skulic, 2007) concluded that, ideally both therapist and clients should engage in the therapeutic process in their first language to enable access to services. Because as Sue and Sue (1999, cited in Skulic, 2007) stated: if English is used standardly as the main language, it immediately disadvantages those unable to communicate fluently in English. Studying this in detail, De Maesschalck (2012) conducted research into linguistic and cultural diversity in the consultation room and concluded that clients are given fewer explanations by clinicians when they have less language knowledge. She reported that, in a European study, it was concluded that "health care providers underestimated their language issues and that language barriers resulted in greater feelings of paranoia and aggression during their encounters with health care providers" (p.40). Nevertheless, there is also evidence in the literature that demonstrates the utility of the second language in enabling clients to access emotionally-charged material (Burck, 2004), as this gives them "a wider perspective and willingness to engage across differences generally" (Burck, 2005, p.108). Perez Foster (1998, quoted in Costa, 2010) proposed that the "'the use of a translator in a psychodynamic or psychoanalytically oriented treatment approach would almost be untenable...' for a variety of reasons, which include the complexities of transferential projections" (p.16).

Finally, even though as early as 1989, Javier identified that further research was necessary around these issues, specifically in relation to how the bilingual's choice of language impacts on processes such as the working alliance, empathy and transference, little research has been carried out. Although I agree with Krause (2012a) that emphasising language in therapy is a cultural assumption, I wanted to focus on language in MFT groups, because, being bilingual, I am interested in the details of the impact of language on group cohesion.

3.3.-THERAPEUTIC RELATIONSHIP ACROSS DIFFERENT LANGUAGES:

Despite the primacy of the therapeutic alliance having consistently been found essential to success in mental health therapy, it has frequently been ignored in research, practice policies and in relation to the complexity of conducting therapy in a bilingual context. Lebow (2006, cited in Drury and Munro, 2008) stated that, over the previous 20 years, research funding patterns had been medical model-focused, i.e. the specific ingredients of the treatment are seen as more important than '*who* provides', '*who* receives' [my idea] or '*how* interventions are delivered'. Psychotherapy outcome research considers common factors, such as the level of client trust and the quality of the therapeutic relationship, to be more significant than specific modifications to psychotherapy content or methods (Wampold, 2001), an ethnocentric view.

Smith, Domenech-Rodriguez, and Bernal (2011a) stated that the therapeutic relationship is highly dependent on context, and influenced by factors, "such as the therapy format (e.g. family, individual therapy), clinical setting (e.g. group, home, wilderness retreat), and personal characteristics of the participants (e.g. age, gender, culture) influence the content and process of therapy" (p.166). Language is one of the factors that influences therapeutic processes (Flaskerud and Liu, 1991; Oquendo,1996; Rosenblum, 2011; Smith, Domenech-Rodriguez and Bernal, 2011b; Ziguras, *et al.,* 2003), but the focus on its significance varies. Dylman, Champoux-Larsson, and Zakrisson (2020) asserted that, "given the alleged role of language in the perception of emotions, we cannot study human emotion devoid of language" (p.13). They stressed that, as language is learnt within a cultural/emotional context, to understand any of these three areas, it is necessary to understand their interactions. Burck (2005) emphasised that professionals "can-and often do" silence other language experiences. Therefore, "if we do not consider languages explicitly, significant aspects of self and relationships are missed" (p.190). She suggested that professionals can avoid this by working to include "individuals' languages as significant dimensions of their lives" (p.191), such as experiences of self and perspectives on the world (e.g. understanding illnesses). As Pocock (2012) noted: the "self is constructed from multiple relational-cultural experiences" (p.75).

Emotional recall/expression are complex with bilinguals. Altarriba (2014) found that there may be challenges "translating emotion words, as these words may not always have a precise translation across languages" (p.186), in comparison to translating concrete words like *pencil.* Translation is

not as simple as an issue of semantics or grammar. Harris (2004) used psychophysiological measures of emotional reactivity with Spanish-English bilinguals. She concluded that L1[13] is not inherently more emotional than L2[14], as factors such as age of acquisition, language proficiency, the context in which emotions were first experienced and their intensity moderate physiological reactions to emotional language. Skulic's (2007) literature review highlighted that there are different linguistic selves linked to idiomatic patterns of thought, emotion and perception, and experiences are better recalled in the language they were encoded and stored. Dufour and Kroll (1995) identified "two separate language stores in the brain for first and other languages. This allows for separate processing areas and thus the potential to keep the intensity of feelings in one language separate from the experience of re-telling the events in the other language" (Costa, 2010, p.17). Burck (2005) reported that there are "research studies into adults who speak several languages which discovered that they describe different experiences in different languages" (p.17).

Drawing on Derrida's work, De Haene and Rober (2016) found that, when undertaking therapeutic work with refugees who have experienced pervasive marginalisation in their host societies, the therapeutic relationship becomes a necessary healing space within an unjust wider societal climate. They suggested that violence and the lack of hospitality should not be exclusively identified as a wider social issue, but that we should accept the "complicity of the therapeutic position with this social or institutional context" (p.105). In this context, clinicians need to "find an inner space in which one can bear to be a violent healer and to negotiate a therapeutic space that opens up spaces to address those relational processes of balancing healing and violence" (ibid, p.108). They used Derrida's notion of the aporia of hospitality to invite us to continuously and carefully reflect on our own position as therapists, as we may unwillingly participate in categorisation and exclusion practices. They suggested that actively including interpreters as conversational partners -part of the client's community- constitutes an explicit invitation to multiple social and cultural voices/meanings as an attempt to shift the expert/directive position of the therapist and decentre their role and open up the "often monolithic institutional discourse" (ibid, p.107), which is closer to the client's life. By doing this, their suffering is expressed as a personal and collective story, accounting not only for intimate, social and political meanings, but also forming a story of isolation

[13] L1: first language learned.
[14] L2: second language learned.

and disconnection. This hospitality allows a space to be created within therapy "in which different ways of understanding and performing illness, suffering and healing can circulate, exchanged and negotiated as valid universes of meaning and action (De Haene *et al.,* 2012), or even lead to novel forms of healing and coping" (ibid, p.107). They stressed that in the face of the clients' suffering, therapists are responsible for disrupting their clients experiencing "otherness". A therapeutic space might become healing by creating a 'welcoming place', "a moment of hospitality with the larger social fabric, a space of welcoming and holding divergent stories of suffering in a community divided by a shared history of violent conflict" (p.108), in which healing and violence are simultaneously intertwined in therapy and hope and despair are voiced. They added that "such understanding clearly moves beyond the emphasis on establishing a non-hierarchical, collaborative therapeutic relationship, and it even denies that such a therapeutic relationship would in practice be possible" (ibid, p.108). I assume that this proposition does not rely on language alone.

Kokaliari and Catanzarite (2011) claimed: "the dynamics of therapy are always shaped by language, especially when the encounter is intercultural", and that these are also influenced by the political context. Kokaliari *et al.,* (2013) conducted a qualitative study exploring therapists' experiences of language in psychotherapy with bilingual clients. Even though their small study used a convenience sample and the analysis method was unclear (it appears that they did a literature review and thematic analysis), they reported that, as bilingual clients' narratives in psychotherapy are often 'incomplete' in their second language, it is typical for them to switch back and forth between primary and secondary languages. They concluded that, for therapists, "language was reported to be a factor that influenced the therapeutic alliance, as, encoded in language, were issues of trust, idealization, and hostility toward the psychotherapist" (p.110).

Regarding therapists' experiences, Pugh and Vetere (2009) completed a qualitative study using IPA to understand mental health professionals' experiences of empathy in clinical work with an interpreter. They found that participants "felt that using an interpreter caused the relational dynamics to become more complex and sometimes undermined the sense of intimacy" (p.317) which is required for developing empathic interactions, within the therapeutic relationship. They stressed that in indirect dialogues with clients (through an interpreter), many non-verbal qualities of empathic communication are lost. They recommended that mental health professionals should "remain sensitive to clients' non-verbal communication when working transculturally, as this can

provide further insights into clients inner experiencing" (p.318) and that interpreters should "attempt to mirror the expressiveness and tone with which empathic messages are first conveyed when making translations" (ibid). Anderson (2012) argued that in mental health settings, interpreters can function as "interference or an instrument of therapeutic communication" (p.1), through clarifying at inappropriate times, questioning the therapist's practice, and disrupting therapeutic silences. She exemplified its impact by quoting Dr. Bart Main, a child and adolescent psychiatrist, who, when faced with the challenge of conveying empathy and connection to his client with an interpreter present, stated that "it is like trying to make love through the phone operator—it just doesn't go". He added, "for the interpreter to be empathically connected, both with the therapist and the client, is really, really useful" (p.7). Hamerdinger and Karlin (2003) described using interpreters in mental health clinics as "a necessary evil". They further clarified that "one that has to be addressed in a holistic manner if there is to be a reasonable expectation of successful therapeutic work".

Derrida's (1978, 1985) position on translation was that translators work on the boundaries of the difference between signified and signifier. Therefore, translation is both possible and impossible. I have experienced this both in my personal and professional life, as I struggle to convey the full meaning of words, sayings or jokes. Many translators describe the process as "an 'elaborate act of improvisation' (Lockhart, 1992)" (quoted in Burck, 2005, p.26).

To conclude, it is evident that the literature about the therapeutic relationship across different languages presents conflicting views. As a field, we need to be mindful not to silence other language experiences (Burck, 2004), and we could also try to provide therapy matching the language of the therapist and client, and use interpreters more effectively, as "conversational partners" (De Haene and Rober, 2016), disrupting clients experiencing "otherness" and conveying empathic messages in a richer way. As Krause (2019) observed: "if translation can never be complete then perhaps therapists and clients rely on more than semantic equivalence, such as how something was said, and the general demeanour of both parties and the connection".

CHAPTER 4-DIALOGICAL PRACTICE

I understand psychotherapy as a dialogical, polyphonic activity, a process of actively talking and listening, where words/meanings are found for "those experiences in one's life that have not yet been given words" (Seikkula, Laitila and Rober, 2012, p.668). I will now summarise some seminal papers about Dialogical Therapy. This chapter is divided into six sections. The first part of the chapter will focus on the history of Dialogical Practice. The second section will describe how Dialogue is defined. The third section will provide an overview of Dialogical Practice. The fourth section will cover issues in dialogical practice and 'The Other', including culture. The fifth section will provide a brief overview of power issues in Systemic Therapy, focusing on Dialogical Therapy in particular. The final section will provide a brief critique of Dialogical Therapy.

4.1.-BRIEF HISTORY:

Based on Bakhtin, Vygotsky and Voloshinov's work, over the last 40 years there has been an increasing interest in dialogical practices within Family Therapy. This approach started in 1984 in Finland, where the management of inpatient admissions was revolutionised by introducing a network meeting and focusing on listening, respecting and validating the identified person in distress, their family and their network. It became known as Open Dialogue practice in 1995, and its basic premise is that a few ingredients are necessary for transformative conversations to occur: the planning and decision-making process is transparent, clinicians do not have preconceived ideas, there is "tolerance of uncertainty" and all voices intermingle (dialogue polyphony) and are equally heard and responded to. Whereas in Systemic theory human beings are understood as part of a network of relationships, in Dialogic Theory human beings are understood as living different worlds, who need to communicate, through dialogue (including attitude, tone and word choices). As our consciousness is intersubjective, a 'polyphonic self' is socially constructed in response to others and their responsiveness (Seikkula, 2011). For further information about the history of Dialogical Practice, please refer to Bertrando and Lini (2019).

4.2.-DEFINITION OF DIALOGUE:

Dialogue is another term that has not been described precisely. Before attempting to do so, I will first consider its etymology. *Dialogue* originates from Ancient Greek "*diálogos*, 'conversation, discourse', from *diá*, 'through, inter" +*lógos*, 'speech, oration, discourse', from *dialégomai*, 'to converse', from *diá*+ *légein*, 'to speak'" (Wikipidea, 2019). Marková *et al.,* (2007) described

dialogue as “sense making and sense creating activities in the social-cultural space, which takes place in various kinds of temporal relations” (p.27). Dialogism (Bakhtin, 1986, p.143) starts from the idea that “all words (utterances, speech and literary works) except my own are the other’s words. I live in a world of others’ words. And my entire life is an orientation in this world, a reaction to others’ words (an infinitely diverse reaction), beginning with my assimilation of the wealth of human culture”. Each individual dialogically constructs and re-constructs the social world in a set of multi-voiced realities within culture.

In the Systemic field, Seikkula, Laitila and Rober (2012) defined dialogue as: “the meeting of different points of view, within which each voice expresses something from its perspective, activating another voice speaking from another point of view in a continuous play of agreement/disagreement (content) or identification/differentiation (position), hierarchies” (p. 670).

Seikkula and Trimble (2005) claimed that Bakhtin “understood dialogue as the condition for the emergence of ideas… in the interpersonal space between them” (p.465), where utterances are exchanged and understanding and meanings are jointly generated. Rober (2016) called this the ‘dialogical space’-a “virtual environment of expectations and entitlements about what can be talked about in a certain chronotope” (p.20) or what cannot yet be said. Participants are interested in one another, and welcome and invite each other’s utterances, including those who are often marginalised or known to be ‘sick’. These interchanges of meaning and voices are heterarchical and generate continuous tension. They can happen within one person (inner dialogue) or between people (outer dialogue). According to Bakhtin (1984), dialogue is polyphonic, because multiple voices are used by participants present (horizontal polyphony[15]), absent or even virtual (vertical polyphony[16]). By communicating, participants “convey their thoughts about social realities, and feelings of their past and the present experience, as well as anticipations of the future. They draw upon and transform social knowledge when they talk and think together” (Marková *et al.,* 2007, p.47). Quoting Bakhtin, Rober (2016) described dialogue as “agitated and cacophonous” (p.344), ongoing and unfinishable.

[15] Haarakangas (1997, quoted in Seikkula, 2011) described horizontal polyphony as including “all those present as embodied human beings in the conversation” (p.187)

[16] “The vertical polyphony includes all the voices a single participant has in the horizontal dialogue” (Haarakangas, 1997, cited in Seikkula, 2011).

4.3.-OVERVIEW OF DIALOGICAL PRACTICE:

I will now outline how Dialogical Theory is put into practice. Marková (1994) defined dialogism as an epistemological approach to studying mind and language. Seikkula (2011) described dialogism as a 'way of life'. Anderson (2007) asked "How can you assume a way of being that invites dialogue? How can you invite another person to talk *with* you?". She offered the following thoughts in response, based on her interviews with clients, therapists and students:

> *It involves authentically living what most of us desire for ourselves: to be believed and trusted as a worthwhile human being, no matter what our life circumstances: to be accepted, no matter how nonsensical our words and actions may seem; and to have a safe place and ample opportunity for full expression* (pp.40).

This seems to me more easily applicable to those in a privileged position and not to those who are marginalised/discriminated against (due to language or social GGRRAAACCEEESSS).

Anderson (2007) described therapeutic dialogue as "inherently transforming" (p.35), as each participant brings something to the conversation and is changed by it, including the therapist. She explained that dialogue naturally involves 'not-knowing[17] and uncertainty', as each speaker takes the other speaker's unpredictable possible response into account and engages with the other in a 'mutual or shared inquiry'.

Bertrando (2007) explained that therapy may be defined as 'dialogic', "only if the therapeutic conversation acquires the characteristics of dialogue as delineated by Bakhtin...: that is polyphonic cohabitation of different discourses and different visions from which a new vision-a new language-may possibly emerge, but where the difference of discourses is accepted in any case" (p.89). He described psychotherapy as:

> *Paradoxical because its subject is itself, and at the same time everything that happens outside it. What makes a therapy a therapy is its specificity as a non-everyday dialogue, but the therapeutic dialogue is also an everyday dialogue. If it were not, what is*

[17] Anderson (2012) described 'not-knowing' as a therapist's orientation towards knowledge, which emphasises 'knowing with' or 'relational knowledge'. Rober (2005) suggested that there are two aspects of 'not knowing': first, receptive listening and secondly reflective responding.

achieved within the therapeutic frame would be true only within it and would not be transferable 'outside' into 'real' life. A therapy is, instead, considered successful only when what emerges in it is somewhat reflected in life (pp.127).

Therefore, therapy oscillates between being distinct from and not too distinct from real life/everyday dialogue. Therapy is a "joint action" (Shotter, 1995) and an enriching experience for many, by providing a new individualised understanding of one's positioning in one's context. With reference to Bakhtin, Seikkula and Trimble (2005) stated that "focusing on dialogue as a form of psychotherapy changes the position of the therapists, who act no longer as interventionists but as participants in a mutual process of uttering and responding. Instead of seeing family or individuals as objects, they become part of subject-subject relations" (p.465). Avdi (2016) claimed: "positioning emphasises the location of the person in discourse and within a moral order" (p.75). Positioning has its own limitations, as one's position is influenced by what one can see or not, and it is always relational, because "the act of positioning someone in a discourse inevitably entails positioning the other participants relative to that initial positioning" (Päivinen and Holma 2016, p.91) and there might be a 'counter position'. They explained that the "psychotherapeutic discourse is one of the discourses in which the clients and the therapists are already positioned in their interaction. From his/her institutional position the therapist has the right and the duty to help the clients find out how cultural discourses work in their relationship" (p.101).

In Dialogical Therapy, Olson, Seikkula and Ziedonis (2014) explained that when people attend therapy, it is assumed that, even though their situation is meaningful, the network has not made sense of it and they might be stuck in a situation incapable of dialogue. By untangling confusion and ambiguity, connecting ideas, making "them less threatening to the family" (Haarakangas *et al.,* 2007, p.231) and reinforcing a sense of agency[18] for the person in distress and his/her family and giving orientation to the network, 'not-yet-said meanings' are created (Seikkula, 2002). They elucidated that, not only is it the fact that each person is heard and understood, but also that "it is the unique interaction among the unique group of participants engaging in an inevitably

[18] Jensen (2011) defined it as "the capacity to act within as well as up against social structures" (p.66). Ong, Barnes and Buus (2021) defined agency as "the ability to create action, is made up of a number of elements including controlling (or determining that a behaviour will occur), composing (the selection and execution of a behaviour), and the anticipation of how that behaviour will be responded to" (p.12-13), plus accountability and that those involved explicitly own their value position. Agency and relatedness are fundamental innate human needs and are at times in an ongoing tension, which helps to understand the ruptures which occur in the therapeutic alliance.

idiosyncratic therapeutic conversation that provides the possibilities for positive change" (p.5), as well as the therapist sharing his/her inner dialogue, integrated with the client's/network's inner dialogues.

Olson, Seikkula and Ziedonis (2014) stated that Open Dialogue does not have prescribed phases/sessions, as therapists listen ('with personal warmth, feeling and compassion') and adapt to the language used in a particular context. This encourages a therapeutic connection by avoiding "being too distant or giving clients the sense that they are being scrutinized or objectified" (p.29). Nonetheless, they provided a list of twelve different therapists' conversational actions, which they described as Key Elements of Dialogic Practice[19] to create a context for dialogical flow and to activate the resources of the person in distress and their network. They stressed that the first step in a crisis is for the therapist to engage in a dialogue with the person at the centre of the crisis, even if it means helping to find words. Similarly, Falicov, Nakash and Alegria (2020) described a model committed to centring client's voices in family therapy, that involved recognising and respecting "clients' views and resources in ways that encourage greater participation and less hierarchical, more equitable interactions with the practitioner" (p.3), who is an expert at creating a 'dialogical space'.

Therefore, overall the therapist's stance involves being "present and engaged, attuned to ones' own inner dialogue and sensitive to the outer, shared dialogue, responding utterance by utterance as an exchange unfolds" (Olson, Seikkula and Ziedonis, 2014, p.31) in a shared inquiry about the therapeutic goals. Bertrando (2007) described the process of sharing and combining the systemic hypothesis from the therapist's polyphonic inner dialogue with the client's own ideas and emotions as the most basic therapeutic dialogue. Anderson (2007, 2012) explained that collaborative therapists are "open and make their invisible thoughts visible …by making private thoughts public", which Bakhtin (1981) described as *"responsive understanding"* and Shotter (1999) described as *"relational-responsive* kind of understanding*".* These therapeutic dialogues are not only respectful and courteous, but also minimise the risk of monological inner and outer talk.

[19] Please see appendix 1 for a summary.

Bøe *et al.,* (2013), who studied Levinas' and Bakhtin's ideas about 'dialogical dynamics of becoming' argued that therapeutic change "may be seen as an ongoing ethical event and that the dynamics of change are found in the ways we constantly become in this event" (p.18). Furthermore, "it is in these moments of 'aliveness' in Open Dialogue when a speaker or listener has been touched by something new in the exchange that holds the possibility for transformation" (p.31). These are also known as "striking moments" in therapy. Chetcuti (2016), who defined this in relation to what Shotter and Katz (1999) called a 'language of momentary doings', believed that the main focus should be on being 'present and engaged in the moment', following the therapeutic conversation and avoiding the imposition of theoretical ideas or hypotheses. Therefore, "the therapist's activities remain internally responsive as opposed to externally driven" (Chetcuti, 2016, p.17).

There is a growing interest in embodied experiences of dialogue, known as intersubjectivity, which is based on Trevarthen's (2001) and Bråten's (1991) work on infants' intersubjectivity (following mother-baby communication studies), which showed that pre-linguistic dialogue, and embodied/emotional attunement develops in the first few weeks of life. Andersen (1992) looked at the breathing of the client and therapist. Darwiche *et al.,* (2008) observed that *mutual smiling episodes* in therapist-couple triadic interactions are key in regulating the therapeutic relationship through affective exchanges. Seikkula *et al.,* (2015) explained that dialogical therapists synchronise their linguistic movements to the clients' when they respond to clients' utterances, including these within their own response. Thus, they become attuned to each other in the dialogue.

In summary, the therapist's role is to create and foster a context which invites collaborative relationships and dialogue, "in which participants mutually explore and share expertise or knowledge as they strive to understand each other and achieve desired futures" (Anderson, 2007, p.47). Seikkula and Olson (2016) described it as a position of 'responsive responsibility', in which therapists are part of a 'joint project' to further develop the understanding of the particular situation which preceded a request for help, where therapists take "responsibility for the other and for the situation" (p.48) by actively responding to clients' utterances. Cecchin (1987) claimed that "therapeutic responsibility begins with seeing your own position in the system" (p.409).

4.4.-'THE OTHER' IN DIALOGICAL PRACTICE (CULTURE):

I will now consider the concept of 'The Other' in Dialogical practice, which is embedded in dialogism, as "the very capacity to have consciousness is based on otherness…it is the differential relation between a centre and all that is not that centre" (Holquist, 2002, p.17). 'The Other' position is "put at the centre of any relationship and togetherness" (Shotter, 2008, 2011, quoted in Sundet, 2016, p.94). As 'The other's' perspective widens, so does my own perspective. In Bakhtin's (1935/1981) words: "He [The speaker] enters into dialogical relationship with certain aspects of this system, 'The speaker' breaks through the alien conceptual horizon of the listener, constructs his own utterance on alien territory, against his, the listener's apperceptive background" (p.282). Citing Salgado and Gonçalves, Rober (2015) stated:

> *I can only start to get to know myself through the other's outsideness. Through the continual dialogical process with others, myself– distinct from those others– is in a constant state of becoming: I am different from others and it is exactly by this constant and ever-changing dialogue with otherness that I continuously become the distinct centre of experience that I am* (pp.109).

Shotter (2003) argued that "the meaningfulness of our language does not initially depend on its systematicity, but on our spontaneous, living, bodily responsiveness to the others and otherness around us" (p.359). He described an extraordinary phenomenon that only occurs when "we enter into mutually responsive, dialogically structured, living, embodied relations with the others and otherness around us—when we cease to set ourselves, unresponsively, over against them, and allow ourselves to enter into an inter-involvement with them" (p.365). He further explained that this invisible phenomenon develops in the dialogically embodied "orchestration of the interplay" between our mutual responses to others (or otherness). He used Steiner's term 'real presences' to define it, arguing that its effect is similar to another person communicating and instructing our actions and it is "felt by all involved as participants within it in the same way" (ibid).

'The Other' has been described differently by various authors, for example as: `Ego-Alter' or 'I-Others' by Moscovici (1976) when referring to his theory of interdependence between minority and majority and to his 'genetic model' of social influence. According to Marková *et al*., (2007), "Dialogically, minorities are defined in terms of majorities and a group could be the majority only

with respect to the specific minority… Minorities and majorities exert mutual effect on one another" (p.13). Similarly, Buber viewed the concept of 'I-Thou", quoted in Brown (2015), as inseparable: "I become through my relation to the Thou; as I become I, I say Thou. All real living is meeting" (p.191) and added that "the degree to which inclusion is possible at any given moment depends upon each person's capacity to remain within their own 'felt reality' while experiencing the other's position" (p.196). She described his famous concept as 'the narrow ridge', which creates a context for dialogic relation and "is influenced by the capacity of each person to recognise, acknowledge and remain present to the difference of self and other moment-to-moment, without imposing one's own opinion or giving up one's own ground" (Buber, 1958; Graf-Taylor, 1996, cited in Brown, 2015, p.195). This was also recognised by Seikkula and Trimble (2005), who explained that "Open Dialogue meetings in many ways, invoke Buber's (1923/1976) ''I-Thou'' relationship, a wholehearted encounter in which one engages with the other with all of oneself" (p. 473).

Guregard (2009) conducted research about using Open Dialogue across cultures using Dialogical Sequence Analysis to study the therapeutic relationship with refugee families. She noted that even though Seikkula considers "dominance factors" and tries to avoid excessive dominance over the person in distress and their network by the professionals, power issues are always part of therapy research. She found "dominance" in meetings with refugee families, due to the "hierarchical nature of some refugee families". Therefore, therapists must pay attention not only to power differences within families based on age or gender, but also between therapists and family members, "due to the refugee's exposed position, in addition to her assumed expert knowledge." (p.33). I will consider issues of power and dialogical therapy in the next section.

4.5.-DIALOGUE AND POWER:

Even though power issues inevitably develop both in therapy and research, this is a controversial area within systemic and dialogical therapy theories. Unfortunately, as Afuape (2011) highlighted, "despite the obvious link between power and emotional distress, until recently (the past three decades) power was largely ignored by family/systemic therapists" (p.28), contributing to the oppression of minorities/disadvantaged people. There is a well-known explanation for this, relating to Bateson's book "Steps to an Ecology of Mind", which had an influence on how power was ignored in the therapy field at the time. According to Bateson (1987):

> *They say that power corrupts; but this, I suspect, is non-sense. What is true is that the idea of power corrupts. Power corrupts most rapidly those who believe in it, and it is they who will want it most. Perhaps there is no such thing as unilateral power. After all, the man 'in power' depends on receiving information all the time from outside. He responds to that information just as much as he 'causes' things to happen… But the myth of power is, of course, a very powerful myth and probably most people in this world more or less believe in it. It is a myth which, if everybody believes in it, becomes to that extent self-validating. But it is still epistemological lunacy and leads inevitably to various sorts of disaster* (pp.492).

Referring to this, Dell (1989) stressed that Bateson's epistemologically incorrect, linear, non-relational description of power is inconsistent with the systemic field. Bateson's statement was later strongly criticised by feminists and others who also focused on inequality, abuse and violence. In 1993, Flaskas and Humphreys concluded that family therapy needs "to abandon the restrictions of Bateson's ideas on power, and to tackle the task of developing in its own knowledge a recursive understanding of power" (p.46). I believe that there is still further space for development on this subject.

Collaborative therapy tried to address social and power inequalities by focusing on the idea that clients and therapists are "human beings involved in human interaction" (Anderson, 2007, p.53) and by developing concepts/practices such as 'not-knowing'. Falzon (1998, quoted in Afuape, 2011, p.34) stated: "power is not overcome in dialogue but operates in flexible and turn-taking ways". Bertrando (2007) described power as "not something static, given once and for all, it is a very unstable network of relationships, where a position is never granted. In most dialogues there is some exercise of power too, but the (dialogical) power current is not unidirectional" (p.168). Given the significance of the other in dialogism and power relationships, he highlighted the importance of understanding: "Does dialogue entail power, or does it have to be located outside power relations?" (p.167). He stated that dialogical therapists' answers to this question are often ambivalent. To elucidate this, a few authors (Afuape, 2011; Bertrando, 2007; Dell, 1989; Guilfoyle, 2003, 2005, 2018) have shown interest in the relationship between dialogue and power in Collaborative Systemic/Dialogical Therapy. Amongst these researchers, Guilfoyle (2003) used discourse analysis to understand this relationship in detail by studying one of Anderson's cases

and he criticised the idealistic 'not-knowing' position traditionally adopted in dialogical therapy, arguing that, by following 'not-knowing' practices and uncertainty "power is deferred and denied by the therapist" (p.331), which is detrimental to the therapeutic relationship. As dialogical therapists describe power negatively, they can "superimpose a value hierarchy, negate differences and limit understanding" (Solas, 2000, p.347), so they misleadingly believe that by not using control, domination, authority and hierarchical processes and not using monological discourses, power disappears. However, Guilfoyle (2003) concluded that, "as a multiplicity of forces, power cannot merely be controlled by the therapist-client dyad" (p.340).

Afuape (2011) claimed that the therapeutic relationship is "powerfully modelled by and reproduces culturally dominant ideas about what therapy is" (p.34). Päivinen and Holma (2016) believed that, even when therapists "are not aware of their position and the possible oppressive nature of the cultural discourses that are drawn on, there is a risk that social injustice and oppression will be reproduced in the therapy room" (p.91). Hare-Mustin (1994) pointed out "how the therapy room is a mirrored room that can reflect back only the discourses brought to it by the family and therapist" (p.19), from dominant discourses in the community and culture. She suggested that therapists "need to develop a reflexive awareness if muted discourses are to enter the mirrored room" (ibid). When people come to therapy requesting help and to share their problems, therapists inadvertently display power by interrupting and controlling the conversational process and topic change (semantic and interactional dominance).

However, "therapists could exercise their professional responsibility like other conversationalists by waiting for a turn to speak, in order to invite someone else to speak or to introduce a new topic or to speak themselves" (Stratford, 1998, p.387). Guilfoyle highlighted that as power is unavoidable, it should be addressed differently. Guilfoyle noticed in his analysis that 'discursive uncertainty markers' (such as: 'I don't know', 'to me', 'I would imagine', 'it seems that') invite collaboration and joint creation of meanings (dialogue), but they do not constitute 'not-knowing'. He suggested that power must be included in dialogical therapy rather than excluded. Guilfoyle also concluded that the clients' resistance (e.g. walking out of the session at any time; refusing to speak or to agree with the therapist's suggestions or meanings) is a way of implicitly/explicitly exerting power in that particular therapeutic relationship and it should have a legitimate space in general in therapy, creating dynamic and reversible dialogical process.

More recently, Watson (2017) conducted a study using Conversational Analysis about understanding issues around power between systemic psychotherapists and parents within a social care context. She concluded that it might "be important to think about specifying and making distinctions about different kinds of power arising in different contexts between people" (p.154). She argued that the description of power should be *worked with* as 'power with' rather than 'power over 'and considered further, in particular: "power as a generalised and accepted concept; authority as jointly created (legitimised and useful) power; and *therapists' pursuit of authority as an invitation to clients' agency*, as important concepts bridging abstract generalised ideas of power, and detailed consideration of the impact of language use" (p.154). She emphasised that therapists' biases and prejudices must be accepted. Equally, therapists should do their "'knowing' while closely attending to what clients offer in return and incorporating clients' emergent understandings, descriptions, and preferences into how both parties go forward" (Sutherland 2007, p.206). Sutherland *et al.,* (2013, cited in Watson, 2017, p.40) developed the concept of 'Responsive Persistence', which entails therapists remaining responsive to clients' feedback and adjusting their own responses accordingly (including using their knowledge) to avoid using power abusively. Power develops in complex joint actions between clients and therapists, rather than positioning the therapist as powerful (with its negative connotations) and the client as powerless.

4.6.-DIALOGICAL PRACTICE CRITIQUE:

Pollard, Hepple and Elia (2005) asserted that, as Bakhtin's dialogical model of discourse and consciousness was established from literary criticism and philosophy rather than psychotherapy, it is difficult to critically praise its applicability to psychotherapy. Therefore, they declared that "from an ethical point of view there are problems with Bakhtin's notion of dialogue as it can never be judged (Emerson, 1997)". They questioned the assumption that therapeutic transformation occurs through dialogue, listening and respecting multiple perspectives and warned about the "dangerous slide into post-modern relativism in which truth becomes a matter of 'choice' or even indifference" and the risk that a dialogue might make things worse. They also highlighted that dialogical interactions are asymmetrical "because people do not have equal access to the power of words". I believe that this is more relevant in the case of bilingual speakers. They described an inner dialogue as selfish, because there is no responsibility towards others. They believed that Bakhtin treated inner and outer dialogue equally, but apparently overlooked the "fact that

external dialogues between people are conclusive" and avoided any discussion about the dialogue's content, "as to do so would undermine his thesis of the benevolent nature of the polyphonic consciousness as opposed to the finalising monologic consciousness".

Bakhtin has been criticised for being overoptimistic about dialogism. Solas (2000) claimed: "'helping professionals', have invested considerable time and effort researching, and have placed an inordinate amount of faith in, the healing power of dialogue in therapy" (p.347). In the Systemic Therapy field, Bertrando (2007) stated that, supporters of Open Dialogue, such as Seikkula, have a "very gentle, delicate idea of dialogue" (p.61). He added that Bakhtin sees understanding as an active process, in which the listener assimilates in a "new conceptual system" (ibid) what the speaker says. Dialogue is exposed to misinterpretations and one has to be actively involved in its process.

SECTION B-SUMMARY AND RATIONALE FOR DOING THIS STUDY

As evidenced in the literature review, MFT process research is limited, including about group cohesion. Multilingualism in psychotherapy research has often consisted of interviewing psychotherapists about their impressions without observing and analysing to gain clients' experiences/perspectives. After many years of MFT practice and research, it is still not clear how MFT works, how different factors interact in the therapeutic processes, and what helps or hinders group cohesion in MFT with multicultural/multilingual families. Further research is therefore necessary to improve this. To expand on previous studies, this research will include multiple perspectives: families and therapists and an analysis of in-session processes. I believe that exploring MFT therapeutic processes in detail will provide new and relevant clinical information. My overall aim is to contribute to MFT and individual FT clinical practice with multilingual families.

1.-RESEARCH QUESTION(S):

When setting the research questions, I was guided by my experiences as a bilingual therapist working with multilingual families in a MFT setting:

- *What do Multifamily therapists do in dialogue to create a context for horizontal (between group members) and vertical (between family members and therapist) group cohesion between multilingual and monolingual families?*

- *What do Multifamily therapists do in dialogue that inadvertently hinders the horizontal and vertical group cohesion between monolingual and multilingual families?*

- *What is the intersection between MFT, group cohesion and language, including interpreters' roles?*

SECTION C-MY EPISTEMOLOGICAL POSITION

Prior to describing the study methodology, I consider it vital to reflect on my epistemological position, both in practice and whilst doing research. As Paré (1995) observed:

> *One cannot operate without epistemological assumptions, although it is possible to be unaware of them. Our theories are founded on epistemology- whether theories of psychotherapy, or personal theories of life manifest in the choices we make on a daily basis. When one considers, then, that epistemology informs all of our beliefs about where problems come from, how they are maintained, and what facilitates their resolution* (pp.2).

Reviewing the epistemology literature, it is strikingly evident that (like most Family Therapy models) these have been developed in the Western world. Philosophies such as 'Ubuntu[20]' or Eastern world-views based on religions such as Buddhism and Hinduism or Wai Yung-Lee's work around 'depressed families' in China and 'parental conflict' have not had a significant impact on Western epistemologies/theories and Family Therapy. To my knowledge, even though contextual factors are considered in Family Therapy, only a few models actively involve ethnic minority community members in their practice, staff and theoretical foundation, such as the Just Therapy model developed in New Zealand by Waldegrave and Tamasese.

Reviewing the MFT literature, I could not find specific articles on its epistemological basis. However, given the historical development of this model, involving Laqueur's work with 'schizophrenics' and the creation of 'sheltered workshops' and psychoeducational groups, I assume it was a modernist epistemology. Currently, Multifamily Therapists seek to help participants develop new meanings and stories as part of the group interactions, discussions, observations and activities. As therapists' main role is to be catalysts (Asen, 2002), they are not expected to play a central role in the therapy. In my experience, therapists have more of a central role when a group is forming and less so once it is formed. I believe that MFT therapists are in a constant dance between modernism and post-modernism. I position myself within a postmodern epistemology, but I also move between postmodernism and modernism due to wider contextual

[20] A South African philosophy, "often translated as 'humanity towards others' (Wikipedia, 2020). One of its tenets is that "to be human is to affirm one's humanity by recognising the humanity of others" (Wikipedia, 2020).

demands and cases. I believe that any knowledge is uncertain and constructed in relationships (Social Constructionism) and this informs my research and clinical practice. Social Constructionism has been criticised because, if there is no such thing as 'truth', it cannot be immune from this conclusion itself and is socially constructed, and therefore no more valid than any other paradigm. Its relativism has been criticised by feminists for not challenging the influence of wider social contexts (gender, socialisation, power imbalances) on individuals or what is socially constructed as a 'healthy/functional family', and avoiding ethnocentrism. I agree that Social Constructionism is socially constructed, but, as therapists are social agents, it is our role to stand up against certain social issues and ideas, such as inequality, violence, discrimination and racism. This has also been emphasised by Knudson-Martin, McDowell and Bermudez (2017), McDowell, Knudson-Martin and Bermudez (2019), who given that individuals and families are impacted by their wider socio-political contexts, proposed a socioculturally attuned practice to enable therapist to expand their "abilities to conceptualize and understand the impact of power dynamics and societal systems on what is presented in therapy" (Knudson-Martin, McDowell and Bermudez 2017, p.48). Therefore, promoting third order change[21], systemic change. They explained that therapists need to "expand the metaview of their participation with families to more intentionally include the impact of societal systems and power dynamics as well as collective meaning making and culture" (McDowell, Knudson-Martin and Bermudez, 2019, p10) in 'third-order thinking'. Given this, therapists can "conceptualize sets of alternatives within interconnecting systems and effectively respond" (ibid), which allows the development of framework to effectively integrate sociocultural awareness across practices.

To understand and address the issues involved in the research, develop the research questions and methodology I considered Critical Race Theory (CRT), which can be applied:

> *(a) to explain how previous models have not been culturally responsive but have been ethnocentrically imposed upon minority populations;*
> *(b) to criticise the ways by which this lack of sensitivity has been kept in place; and*
> *(c) to empower researchers and therapists…to learn about and identify a model that is culturally responsive* (Seposnki *et al.,* 2013, pp.33).

CRT is “driven by the study of social structures, freedom and oppression, and power and control" (Lincoln, Lynham, and Guba, 2011, p.103), and seeks to further human emancipation and reduce oppression through empowerment. It uses methods such as Dialogic/dialectical therapy to produce social change. Subjectivity is assumed, as knowledge is socially constructed and lies 'in the eyes of the knower'. Findings are value-mediated (e.g. by gender, ethnicity, culture, class, structural/historical insights). Its *ontology is that* reality can be studied through science and understood as constructed historically and socially (including culture, economy, ethnicity and gender values). Critical Theory had a significant impact on Family Therapy through Feminism which challenged taken-for-granted views of society and therapy. McDowell and Jeris’s (2004) review critiquing trends in the Journal of Marital and Family Therapy in terms of race and racism is one example. CRT has been criticised because although it “aims at fostering human emancipation, it remains incapable of specifying a political action-strategy for social change” (Corradeti, no date).

My epistemological stance is also influenced by Russian philosopher and literary critic Bakhtin, who emphasised its social dimension, presupposing that human beings are naturally dialogical and share social knowledge. Hence, otherness and interactions between individuals are particularly important.

As a researcher and clinician, I remain willing and able to have my knowledge challenged. I understand the research accounts and observations as social constructions. I see this as a vital ethical role of the researcher, including how, just by his/her presence, epistemologies impact on the research process from design through to data collection and analysis. Based on Seponski, Bermudez and Lewis's (2013) study, in the research design I considered methods that were responsive to clients’ needs and non-invasive, such as observations and focus groups; and I organised "data collection around the convenience of the clients, family, community, and therapists" (p.31).

SECTION D-METHODOLOGY

1-INTRODUCTION:

The previous chapters offered a description of the theoretical and clinical context of this research, the rationale for this study and the research questions. In the present chapter I explain the methodology used to explore the research questions and the decisions I made about data collection and analysis. I intend to provide a sufficiently detailed description of my decisions and the processes involved to facilitate an evaluation of the results. I also provide a reflexive account of how the research processes and methodology recursively impacted both on the research process and on myself as a researcher.

This chapter is divided into eight sections. The first section describes the context of the research. The second section covers the overall design of the study, starting with the choice of qualitative methodology. The third section describes the data gathering process. In the fourth section, I describe the methods of analysis used. The fifth section describes the research participants and the recruitment process. The sixth section covers the pilot study I completed before gathering the data. In the seventh section, I explain the procedures used. Finally, in the eighth section, I consider ethical issues in detail.

This study is located within the discourse on dialogical research approaches, which understand therapy as "a relational and conversational context" (Avdi, 2016, p.71), and co-authoring, which involves clients reconstructing meanings. Avdi stressed that, as knowledge about how therapeutic change happens is limited, despite the vast theoretical literature on psychotherapeutic change, qualitative, exploratory research on therapy sessions is needed. She proposed that "studying language-in use (rather than relying on retrospective accounts…) can be a useful focus for process outcome research" (p.72). Considering the aforementioned, and that MFT with multilingual clients and group cohesion in MFT groups are underrepresented topics in psychotherapy process research, and the research questions, I concluded that further exploration was needed.

2.-CONTEXT OF THE RESEARCH:

This study was significantly influenced by my work at the Marlborough Family Service, where I was employed when I started it. This was an innovative inner London CAMHS[22], which had provided

[22] Child and Mental Health Services clinic part of the NHS.

Multifamily therapy groups for families experiencing a significant number of problems for some 35 years. The service ran a number of Multifamily groups with different aims, e.g. supporting children with emotional/behavioural difficulties and their families, school-based problems, parenting difficulties, eating disorders, domestic violence, psychotic presentations.

I now provide a general description of the Multifamily group I recorded. The children were referred by their school and the aim of the Multifamily group was to prevent children from being permanently excluded from school. The children attended the group together with their parents and siblings. Sometimes both parents attended together and sometimes separately (due to other commitments). Even though these families attended voluntarily, they probably experienced some pressure to attend as, otherwise, their child might be excluded.

Before the work started, the therapists, family and school decided on individual targets for each child to improve their behaviour at school and at home. The group ran for 3 hours in the morning. After that the children returned to their mainstream school/classes. This was an open group, so new participants could join/leave the group at any time and sometimes they were referred back. Participants attended either every morning or just particular sessions.

Multifamily therapists use different formal and informal activities in each session. Informal activities include free-time to interact with other group members and with therapists at the beginning and end of the session, and a 15-20-minute break (where members stayed in the clinical room or went to an outside area). Formal activities include therapists using some group exercises not only to encourage interaction and to work on the individual/group goals, but also to get group participants to 'reflect' about their experiences, beliefs, behaviours and interactions. 'Reflections' are regularly used in MFT sessions. I now provide a description of the formal activities observed in the sessions I recorded:

- 'Speed dating': This activity was used in session 1 and session 2. In general, the aim of this exercise is to be an ice breaker and to encourage participants to quickly reflect on a specific issue. Group members are divided into two groups, which sit in two concentric circles. They then form a larger group to provide feedback and 'reflect' about their experience and discussions. In this group, the children sat in the inner circle and the parents sat in the outer circle. Parents were asked to

interview the children to review their targets (individual goals). After a minute or two, each child moved to the next chair, so that they each had a chance to review their goals with all the adults in the group. In the second session, they did this again but additionally focused on one particular child's target. Afterwards this, they all got together to provide feedback and 'reflect' about what they had discussed. Therapists asked most of the questions during this time.

- 'Masked ball': In this activity paper masks are provided to group participants and they are asked to decorate them in a way that shows something about their personality or to play someone else or themselves as they would look in a few years. The day before session 1, participants had been asked to decorate some masks. However, as this was an open group, not all the group members who had completed the task the previous day were present at the session that I recorded and some of those present had not done it. The participants that had made masks the previous day, put them on, and the other participants asked them questions about them, encouraging not only interactions around relevant group/individual targets, but also curiosity between group members.

3.-OVERALL DESIGN OF THE STUDY:

A small scale qualitative exploratory research design was chosen, as qualitative research is often concerned with meaning, and is "interested in how people make sense of the world and how they experience events" (Willig, 2001, p.9). Rober and Borcsa (2016) stressed that it "comes much closer to the unpredictable and ambiguous process of therapy that clinicians experience in their day-to-day practice" than RCTs (p.2), because it allows researchers to "observe and analyse rigorously and systematically what happens in the therapy session, in order to notice what would have remained unnoticed if the researcher had not looked so systemically" (ibid p.3).

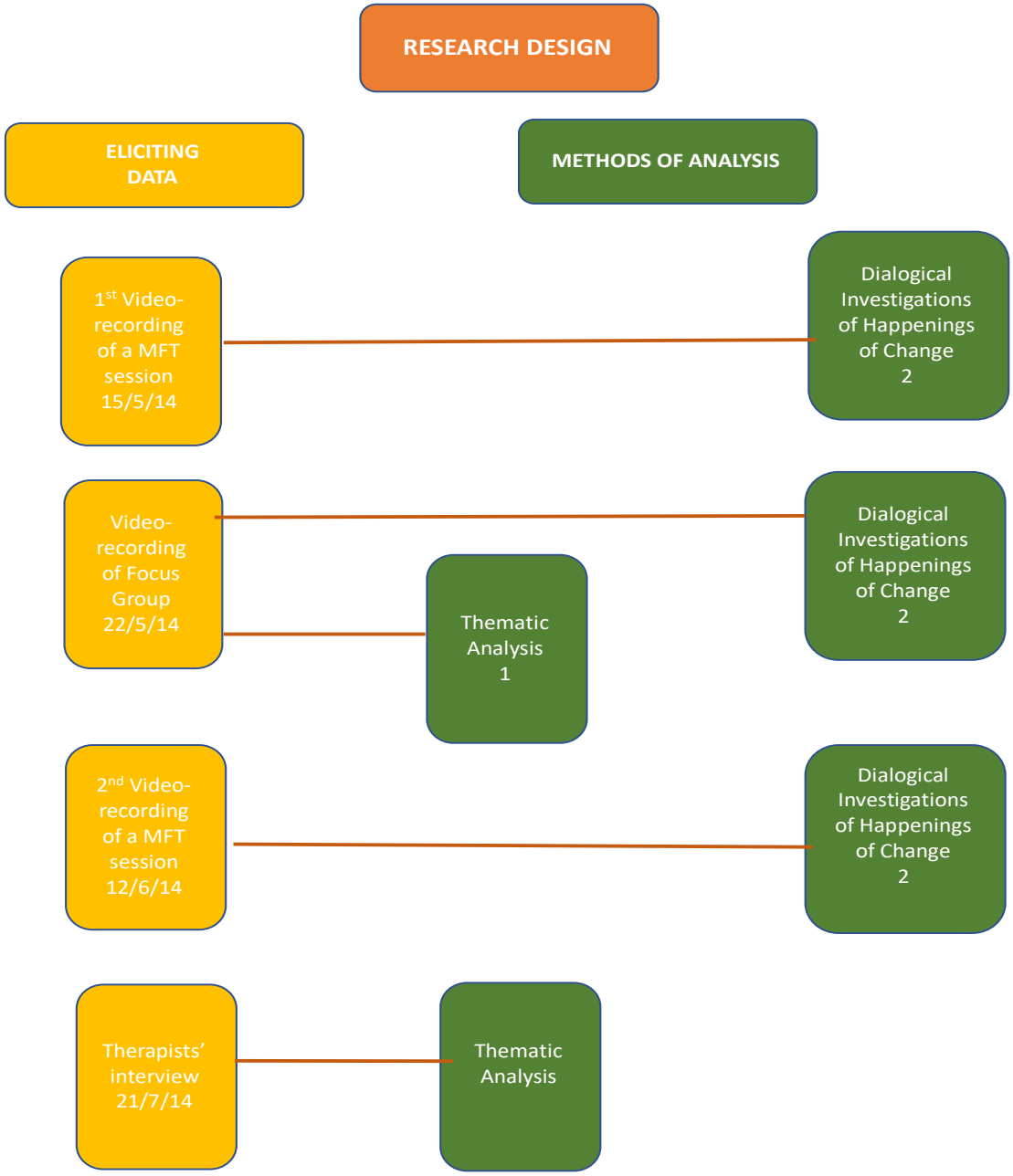
However, this has its challenges, as Nagata, Suzuki and Kohn-Wood (2012) noted: qualitative methods "have always focused on understanding the lives of 'others' in context" (p.9). Researchers' interpretations are based on their 'western perspectives', which involves 'colonizing others' experiences, even when that is not one's intention (Borštnar *et al.,* 2005). To prevent 'othering' multicultural populations, social constructionism, and critical theory form the epistemological basis of this research.

The complex social aspect of the multi-actor setting of this research "calls for tools to look at and listen to these multiple participants as living persons in the situation, not just as voices" (Laitila, 2016, p.35). Engaging them in the research process and increasing the impact of their voices in the services they receive prevents othering these populations (Nagata, Suzuki and Kohn-Wood, 2012), which also demands new and complex methods, and conceptual frames, i.e. "what McLeod, (2001) called 'bricolage', Tseliou described as (2013) 'mixed types of analysis', and Flick (2009) as 'triangulation'" (cited in Rober and Borcsa, 2016, p.5), namely considering different processes and methods/approaches.

Tseliou *et al.,*'s (2021 a,b) research study about process research in Systemic Psychotherapy classified two types of process research. This research study will include an analysis of both types of processes: *post-hoc narrative of systemic psychotherapy process* (the analysis of the focus group interview with Multifamily therapy group participants and the interview with the Multifamily therapists running the group); and *in-session discourse of systemic psychotherapy process* (the analysis of the Multifamily therapy session dialogues).

To facilitate understanding of the research process, I provide a pictorial representation of the research design and analysis (below).

Picture 1- Research design



I now provide a brief outline of the process I followed to *gather the data*: I recorded two Multifamily group sessions; I conducted a focus group with the group participants and an interview with therapists about their views regarding group cohesion in multilingual groups. I analysed the transcripts of the Multifamily focus group interview and the therapists' interview using Thematic

Analysis (Braun and Clarke, 2006) and I used Dialogical Investigations of Happenings of Change (DIHC) (Seikkula, Laitila and Rober, 2012) to analyse the transcripts of the Multifamily sessions and the focus group. This process will be explained fully in the next section.

4.-DATA-GATHERING:

As I am interested in multiple perspectives, I sought to gather all the Multifamily therapy group participants' voices. I chose to use video-recording because the clinic where the group was run had fixed cameras, which were used routinely with the group. I also had a hand-held camera, as a back-up. While I conducted the focus group interview one of the students attending the group helped with the hand-held camera.

There were four steps in the data gathering process: 1.-video-recording one Multifamily group session; 2.-A week later, I video-recorded a focus group interviewing participants (therapists were present) about their views regarding group cohesion; 3.- A month after the first Multifamily therapy session recording, I video-recorded a second MFT session. 4.- A month later, and after the group had ended, I audio-recorded an interview with therapists about their understanding of group cohesion. The MFT sessions, the focus group interview and the interview with the therapists were transcribed verbatim by myself. I included some non-verbal communication that seemed relevant to the research. I used the video-recording from the fixed camera for the transcription.

Description of sessions: The therapists told me what time to arrive/leave. The first session I recorded lasted 135 minutes and the second one lasted 66 minutes. Families arrived at different times (I am not sure if they had made previous arrangements with the therapists). It was clear that therapists knew when group members had to leave early. At the beginning of both sessions, there was an informal time to allow all the group members to arrive and join. Session 1 then started with a speed dating activity. Participants then all fed back to the leaders focusing on all the children's targets. In the second MFT session, during the informal time, they started by discussing in small groups each child's targets within their own family and with the therapists, taking turns. One family moved around and spoke with each family about their child's targets. Next, they did a speed dating activity. In the feedback/reflections section they all focused only on one child's targets (the one whose family had individually spoken with everyone in the room). Following this they had a break and then they did another activity.

Focus groups: are a research method based on "open-ended group discussions that examine a particular set of socially relevant issues" (Marková et. al., 2007, p.32), "to study communication in interaction" (ibid, p.47), as group participants co-create their dialogue about the topic under investigation. They bring together 4-12 people to explore a subject chosen and moderated by a researcher 'in focus' in an "as 'natural' as possible" environment, and listen to each participant's individual perspective. As Palmer (2014) summarised, focus group discussions: are "a qualitative research method that uniquely combines interviewing, group interaction and participant observation producing rich and complex data… with high levels of validity because of the credibility of comments from participants" (p.48). Unlike more traditional focus groups, in this group participants already knew each other, which may have meant that not only would their group dynamics continue in the focus group, but also that their relationships would be evident to the therapists, and myself as a researcher, and a stranger.

The format of the focus group discussion involved all families (adults and children), their interpreter and leaders of the group sitting in a circle to, first, share their ideas about the subject and then show them some video clips from the Multifamily session I had recorded the previous week. Additionally, I had some unstructured questions to help me guide the focus group conversation[23]. The short clips I chose were based on my observations and understanding of group cohesion at the time (I showed them some clips about physical contact, praising each other, asking for help, sharing enjoyable experiences, and group members being on their mobile phones during the break). During this discussion, although I had explained that I was interested in hearing from families, interpreters and therapists, it was mainly the families who actively participated in the discussion. Therapists adopted an observer/leader position by asking some questions themselves. At the end, the therapists said that they were curious to hear what others had to say and did not feel that they wanted to share their views. The interpreter also explained that she felt her role was limited to interpreting for the families, and not giving her own opinions.

Finally, I interviewed the group therapists separately, once the group had finished. To conduct this unstructured interview, I considered the questions used in the focus group to guide the conversation. Additionally, I showed them some randomly selected video clips from the group session I had recorded the previous week.

[23] Please see appendix 2.

5.-METHOD OF ANALYSIS:

There were several parts to the analysis. ***First***, I analysed the transcripts from the pilot interview[24] using Thematic Analysis. This informed the thematic analysis of the focus group interview and therapists' interview. My aim was to integrate their understanding of group cohesion into my own definition of group cohesion. I chose *Thematic Analysis* because, as a method, it identifies, analyses, and reports patterns (themes) within data: "It minimally organises and describes your data set in (rich) detail" (Braun and Clarke, 2006, p.82); and because it allows the data to be coded and categorised into themes.

Furthermore, its flexibility is a major strength, as it allows comparisons of different datasets (e.g. from each participant group), and it can be used in inductive and deductive methodologies (allowing themes to be linked to data and theory). As Alhojailan (2012) stated: "by using, thematic analysis there is the possibility to link the various concepts and opinions of the learners and compare these with the data that has been gathered in different situations at different times during the project" (p.40). Thematic Analysis has been criticised for being poorly demarcated, as "there is no clear agreement about what thematic analysis is and how you go about doing it" (Braun and Clarke 2006, p.79) and because it may overlook some of the more nuanced data. It is often used across different methods. I next provide a brief description of this method, starting by considering what counts as a theme. A theme "captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun and Clarke, 2006, p.82). Prevalence is important but relevance is more so.

Thematic Analysis involves six phases:

[24] I interviewed someone who had attended one of the MFT groups I had run previously. I was interested in gaining his opinion about the guide questions and the documents I would share with families (information sheet, consent forms) and about the relevance of my study.

Table 1.

1. Familiarising with the data:	Transcribing data, reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire dataset, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking how the themes work in relation to the coded extracts (Level 1) and the entire dataset (Level 2). Generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story; generating clear definitions and names for each theme.
6. Producing the report:	Including a selection of vivid, compelling extract examples, final analysis of selected extracts, relating back the analysis to the research questions and literature.

In my analysis, I followed the phases described above. I read the transcripts several times, identifying the themes mentioned by the families regarding what they thought made a group cohesive. In the initial stages of the analysis, I completed line-by-line coding to maintain close reference to the data. Subsequently, emerging themes were developed and added to the text. I made some notes of my observations about what they described as cohesive, or moments when I felt the group participants had shown cohesion in this session. Subsequently, I made a list of all the phrases they used to describe group cohesion[25]. I identified the frequency with which these themes were mentioned. I then grouped the topics into: "building relationships", "genuinely caring for each other", "similarities", "good communication", "working together", "sitting together",

[25] Please see the raw data in table 6-appendix 3.

"lots of time together", "having to participate", "doing something enjoyable together", "like a family experience". After careful consideration, I regrouped these topics into the following larger/wider themes: "communication", "working together" and "building relationships"[26]. When participants mentioned these, they also described how they were all connected to each other[27]. I used the themes from the focus group and therapists' interview to inform the definition of group cohesion developed in this research and my analysis of patterns in MFT sessions.

I then completed a Thematic Analysis of the interview with the therapists about their understanding of group cohesion and their thoughts about what helped groups to be cohesive, focusing particularly on language/culture issues and group cohesion[28]. I followed the same stages of Thematic Analysis described above. Subsequently, I made a list of all the phrases they used to describe group cohesion[29] and what fostered it. After careful consideration, I regrouped these into the following larger/wider themes: "planning", "MFT creating a context of working together" and "relationships"[30] The main themes and sub-themes are described in the flowchart and excerpts or words from the raw data are quoted for illustrative purposes.

After completing the thematic analysis, the process of deciding what other methodology to use to analyse the Multifamily sessions and the focus group data took longer than anticipated, not only as I had to suspend my studies twice due to the birth of my two daughters, but also because I struggled to find a method of analysis suitable for my research questions, and my interest in focusing on the participants' voices.

Second, I decided to use a discursive analytic method developed by Seikkula, Laitila and Rober (2012) called *Dialogical Investigations of Happenings of Change (DIHC)* to analyse the two Multifamily sessions and focus group interview, because it "allows for a general categorization of the qualities of responsive dialogues in a single session, and also for a detailed focus on particular sequences through microanalysis of specific topical episodes" (Seikkula, Laitila and Rober, 2012, p.667) in multi-actor therapeutic dialogues.

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[26] Please see the main themes in picture 1-appendix 4.

[27] Please refer to picture 2 in the flowchart showing this process and the main themes and sub-themes in appendix 5, where the main themes are described and excerpts or words from the raw data are quoted for illustrative purposes.

[28] Please refer to picture 3 in the flowchart of this process and the main themes in appendix 6.

[29] Please see appendix 7.

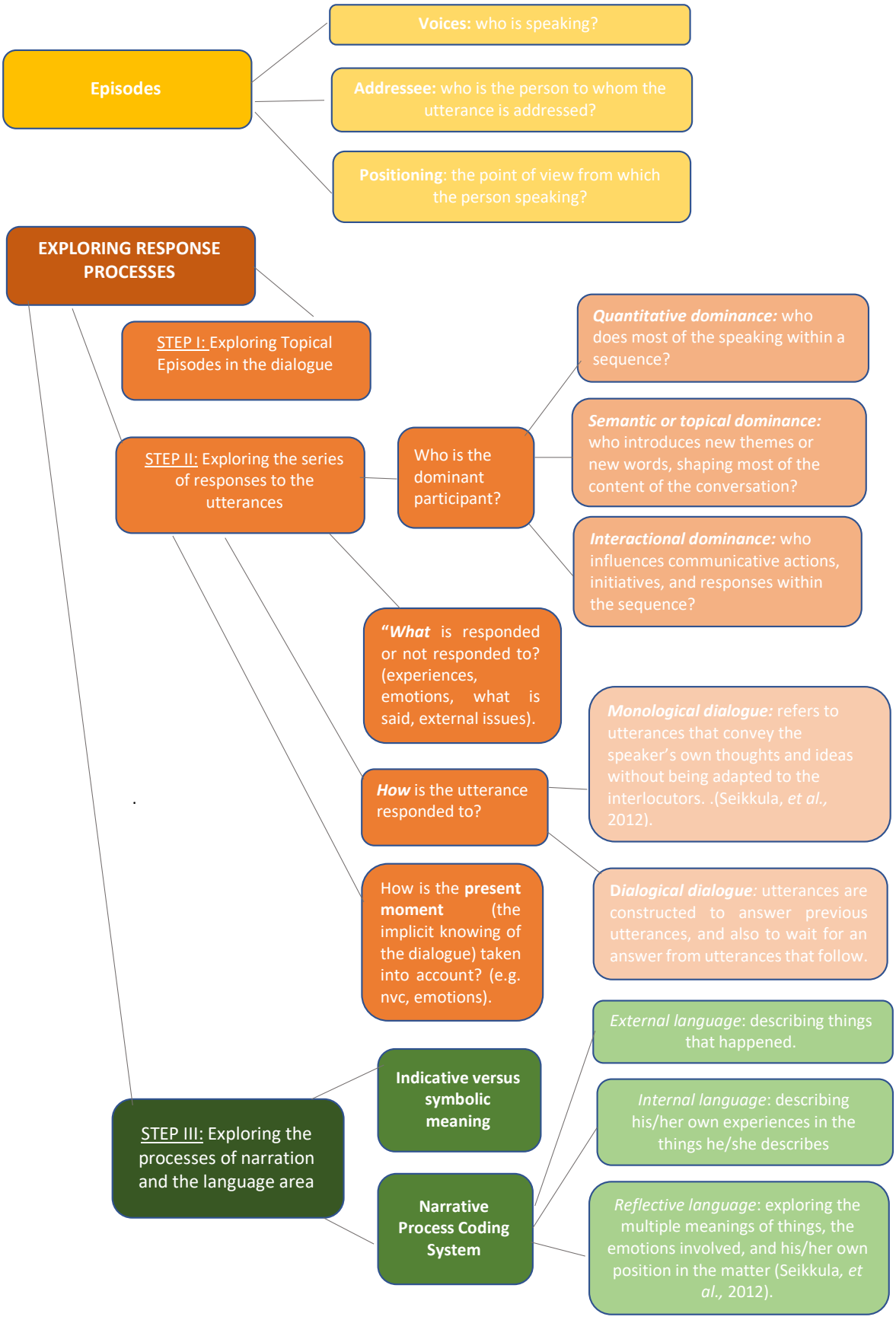
[30] Please see picture in appendix 8.

DIHC helps elucidate the process of change in multi-actor dialogues. Its main focus is not on "*what* is told but rather on *how* things are told and responded to in the dialogical process" (p.668). It focuses on the observation of aspects of the therapeutic process that would have otherwise remained overlooked, such as "transformative sequences" (Seikkula and Olson, 2016, p.67). DIHC allows one to see the "flow of dialogue and how this flow of dialogue is related to the conduct of the therapist" (ibid). Specifically, Seikkula, Latila and Rober explained that "the responses of the therapist(s) in the exchange with the family are key ingredients in the creation of a new and common language for the person's distress that otherwise remains embodied and expressed in symptoms… [creating] new possibilities of meaning and action" (p.47). In each utterance of a topical episode, the voices present, the positioning of each speaker, and the addressees (present or absent) are analysed.

I thought this methodology would help me to understand features of dialogue which showed group cohesiveness in the process of multi-actor dialogues within MFT. As the focus of the research and the design is different compared to the earlier use of this method, I slightly adapted it to my research, applying most elements, and focusing on aspects of group cohesion.

As this is a new methodology, I decided to explain the steps involved in detail. First, I will provide a graphical description of the original steps of the methodology:

Picture 2-Graphical description of DIHC



I will now describe the steps suggested by Seikkula, Laitila and Rober (2012) and how I applied them in this research.

1. Identifying episodes: I identified different MFT activities (instructions, activities, reflections and informal activities) and, within each activity, changes of topical subjects.

   1.1. Each episode was analysed to identify 'cohesive moments' using my definition of group cohesion.

2. To analyse what happens in the dialogue of each of these 'cohesive moments' I looked for:

   2.1. Voices: Seikkula, Laitila and Rober (2012) stated that it is difficult to define voices precisely. Seikkula and Olson (2016) explained that "our embodied experiences formulated into words in a dialogical context become the voice of our lives" (p.48). Quoting Bakhtin, they stated that "every utterance has an author whose position it expresses" (p.49). Words uttered might be my own or others', speaking in different voices, taking different positions in relation to these voices, and creating polyphonic dialogues. Succinctly, this step focuses on *who is speaking?*, including the inner and outer dialogues of clients and therapists, bringing in other people's voices not present in the current dialogue, which could be someone real or fictional, or even an abstract concept/ideal. It is important to note whether utterances invite further responses in the dialogue and how utterances are responded to.

   2.2. Positioning: Positioning complements voices in dialogical processes, as each speaker uses different voices in his/her utterance according to the different positions taken. Positioning involves how an interlocutor puts his/her discourse on stage. It "implies a spatial metaphor, linking a voice with a point of view from which one takes part in the dialogue. Each point of view gives the person a perspective that allows that person to see, hear and experience. Such a point of view has inherent limitations: from each point of view, some things can be seen, while others remain out of focus, in the shadows, or out of sight" (Seikkula, Laitila and Rober, 2012, p.670). Briefly, the main focus is on '*from where is the person speaking?*', which involves considering different perspectives from different points of view. In any conversation, there is always a process of identification and differentiation

between positions. Seikkula, Laitila and Rober also stated that positioning happens "unreflectively, in the process of continuous responses to what is uttered" (ibid).

The process of systemic family therapy often develops as a "continuous dance of changing positions in the session", using positioning questions as invitations to change to a more 'active agent' or from "an unreflective to a reflective and reflexive stance" (Seikkula and Olson, 2016, p.50). Therapists are also part of the family's systemic dance, creating positions from which to start dialogues. In optimal multi-actor dialogue, there would be flexibility in terms of taking initiative, instead of the therapist always doing so" (ibid). In MFT, I would expect the initiative to be more equally shared between its participants, as therapists tend to have a less central role. Power was included because I consider it a very relevant area in any therapeutic relationship or group. For instance, who has the right to say something? How are power and collaboration played out? One of the aims of MFT therapists is to create a space for mutual support, but how does that happen?

2.3. Addressee: "Every utterance has both an author and the person to whom it is addressed, as every utterance is a response to what has previously been said" (Bakhtin, 1986, cited in Seikkula and Olson 2016, p.51), who is present, or it might also be shaped by what response the speaker anticipates from the other audience. Bakhtin also identified the super-addressee, which is when words address some ideology related to our life. This is based on the idea that, in any dialogue, even between just two people, a third party is always present, as "they are addressing their words to those who participated in discussion of the same issue in the past" (Seikkula, Laitila and Rober, 2012, p.670). This is even more relevant when people speak about emotional issues, which may be influenced by the words of those closest to them emotionally. The main focus is on *the person to whom the utterance is addressed*, in response to what was said before in the presence of others. It can be identified in non-verbal communication, for example, by tone of voice or gestures.

In Multifamily therapy, it is significant that participants address their families, other group participants and therapists in the presence of their own families, and they might also address those who are absent. This is a context in which there are multiple layers interplaying within the dialogue, more than for instance in traditional group therapy (where

participants do not know each other and do not bring their "emotional family baggage" with them) or single-family therapy.

3.- Exploring response processes: Responsive dialogical processes had been explored in individual psychotherapy, but not in Family Therapy. To address this, Seikkula, Laitila and Rober (2012) used a method developed by Leiman (2004), called *Dialogical Sequence Analysis (DSA).* This is a "micro-analytic method to examine the dialogical organization of client and therapist utterances" (p.267). As this method does not include therapists' responses in the session, they developed it further to analyse dialogical qualities of conversations in multi-actor therapy sessions. They emphasised that, for a successful exploration, one has to be able to read the text simultaneously with a video or audio recording of the session. I will now outline the steps involved:

3.1.- Step I: Exploring topical episodes in dialogue: The main units of analysis are "defined topical episodes" (Linell, 1998, cited in Seikkula, Laitila and Rober, 2012). This is a retrospective process, which happens after dividing the entire dialogue of one session into sequences and then certain variables are considered in the analysis (described below). Each time the topic of the dialogue changes, a new episode is developed. In terms of analysis, researchers can select which topical episodes are relevant for their research.

3.2. Step II: Exploring the series of responses to the utterances: By following a three-step process, each sequence in a dialogue and its responses are explored. This step starts with any utterance considered by the researcher as the initiating utterance (IU), where, "within each topical episode the responses to each utterance are registered, in order to gain a picture of how each interlocutor participates in the creation of the joint experience in the conversation… The meaning of the response becomes visible in the next utterance to the answering words" (Seikkula, Laitila and Rober, 2012, p.671). The following categories are considered in the analysis:

1) Who is the dominant participant who initiates these aspects: the main focus of our research is to understand the shifting patterns of these three kinds of dominance:

- *Quantitative dominance:* who speaks the most within a sequence?
- *Semantic or topical dominance:* who, by presenting new themes/words "at a certain moment in the conversation… shapes most of the content of the discourse"? (ibid).
- *Interactional dominance:* This relates to the participant who is dominant in the process of the conversation, shaping interactions, for example, when therapists invite a new speaker to respond to the previous utterance. However, "someone who is very silent also can have interactional dominance, by evoking solicitous responses from others" (ibid, p.676).

2) RESPONSIVENESS: what is the interlocutor's response to an utterance?

"*What* is responded to? The speakers may respond to:
- their experience or emotion while speaking of the thing at this very moment (implicit knowing)
- what is said at this very moment
- some previously mentioned topics in the session
- what or how it was spoken
- external things, outside this session
- other issues. (If so, what?)" (ibid).

These categories are not mutually-exclusive, since in a single utterance many aspects can be presented. Its focus is on how answers create a dialogical space in the response to that answer.

3) What is *not* responded to?

What voices in the utterance are not included in the response of the next speaker?

4) *How* is the utterance responded to?

Monological dialogue "refers to utterances that convey the speaker's own thoughts and ideas without being adapted to the interlocutors. One utterance rejects another one. Questions are presented in a form that

presupposes a choice of one alternative. The next speaker answers the question, and in this sense his/her utterance can be regarded as forming a dialogue, but it is a closed dialogue" (ibid).

In *dialogical dialogue* the interlocutor responds to an utterance by including in the next utterance some aspects of the previous utterances, and also by waiting for an answer from their utterance or by using an open-ended utterance which invites others to respond. Not only do they show that there is reciprocity and responsiveness, by listening to each other's utterances, but also a new understanding is constructed between the interlocutors. "This means that in his/her utterance the speaker includes what was previously said, and ends up with an open form of utterance, making it possible for the next speaker to join in what was said" (ibid).

5) How the present moment, the implicit knowing of the dialogue, is taken-into account: This step focuses on emotional responses to emotional issues observed through non-verbal communication, such as body gestures, gazes, intonation, physical contact, closeness.

3.3. STEP III: Exploring the processes of narration and the language area: as this step can be conducted in two alternative ways, I considered both in my analysis:

1) Indicative versus symbolic meaning: Seikklula, Laitila and Rober (2012) explained that this step implies differentiating each utterance in a dialogue by considering whether the words used refer to an object, something factual, which exists (*indicative language*), or whether they are used *symbolically* (i.e. referring to other words) rather than to an existing thing or matter. Avdi, Lerou and Seikkula (2015) explained that metaphoric and symbolic language coexist in dialogue and are considered central for emotional expression and meaning-making. Van Parys and Rober (2013) found in their study that therapists can use metaphorical language to "open dialogical space in the session to talk about things that are hard to talk about" (p.106). Zittoun (2011) described therapy as a laboratory for change, a playful zone,

where various experiences might be explored freely and playfully, with new possible meanings, perspectives and boundaries: “creating new semiotic forms—is the first step for making them actual” (p.333).

2) Narrative Process Coding System: this coding system was developed for individual psychotherapy, where three types of narrative processes are differentiated. Subsequently, Laitila *et al.,* (2001) further developed it for family therapy. This step categorises whether the speaker uses: “(a) *external language*, giving a description of things that happened; (b) *internal language*, describing his/her own experiences in the things he/she describes; or (c) *reflective language*, exploring the multiple meanings of things, the emotions involved, and his/her own position in the matter” (Seikkula, Laitila and Rober, 2012, p.677).

Finally, a conclusion is reached after following all the steps described above to analyse the responses in the topical episodes. This conclusion allows one to consider how the chosen topic is managed in this particular therapeutic conversation.

3.4.- Step IV- Microanalysis of specified topical issues: This entails choosing a specific topical episode as the subject for microanalysis. Seikkula and Olson (2016) explained that it involves considering “what happens within the topical episodes in general, and, in comparison to other topical episodes and thus to see the points, in which the change has started to happen” (p.55). They also suggested looking at what happened in the events of change in close detail.

I used the steps described above to analyse the two Multifamily therapy sessions and the focus group in their entirety. I then selected three different cohesive and three ‘non-cohesive’ moments (when group members seemed to be cohesive or not during informal interactions, formal activities and ‘reflections’). I did a microanalysis of these. I included in the analysis what happened before and after these episodes/moments. Additionally, when analysing the Multifamily therapy sessions, I realised that some themes were repeated across the data and I highlighted them. I then noted in a table when they happened, classifying them into groups/patterns/themes. These patterns are part of the analysis.

6.-PARTICIPANTS AND RECRUITMENT:

I discussed the research informally with clinicians running Multifamily groups in CAMHS clinics. I sent an invitation email[31] to explain the research further to the therapists first and to invite their Multifamily group members to participate in the research study. After obtaining ethical approval for the research, the process of recruiting participants and gaining their consent took a few weeks.

Once they verbally agreed, I met them in person to explain the research and the information sheet[32], describing in detail the research, its aims, the process, video-recording the sessions, confidentiality and consent issues, and giving them the choice of whether to participate in the research, in plain/simple language. This was also an opportunity for them to ask questions about the research, confidentiality and consent. Consent was carefully explained again in person (adults and children) and obtained on the days of the video-recordings[33], when they signed the consent forms[34]. The participants had a few weeks to decide whether to participate in the research before giving consent.

<u>Participants</u>

To maintain confidentiality and anonymity, participants were given pseudonyms and identifying features were changed.

There were three groups of participants:

1- *Family members (adults and children*) attending a Multifamily group for children who were at risk of being permanently excluded from school (nearly all boys, apart from one girl; their ages ranged from 6 to 14). They were all from different cultural backgrounds. For some English was their first language, and for others English was their second language and some needed an interpreter[35]. The majority had experienced migration or were second generation migrants. Additionally, there was an Arabic-speaking woman, who had participated in the group previously and had volunteered as 'an ambassador' to help the group. She often interacted with the other Arabic speaking families. The parents gave consent for themselves and their children to participate in the study. I explained the research to the children using the information sheet and consent

31 Please see appendix 9.
32 Please refer to appendix 10. This letter was verbally translated for the families who did not speak English.
33 This group was accustomed to video-recording for clinical purposes.
34 Please see Consent forms in appendix 11.
35 Please see table 1 below.

forms and they were able to ask any questions. Children gave assent when they agreed to participate.

The number of group participants changed for each session, ranging from 9-17 people (between 4- 9 children). Sometimes the children attended with their mother and sometimes with their father. Apart from the participants described in table 1, there were other group members present in the MFT sessions that I recorded, who were not part of this research, as they did not give consent to participate in the research.

2- *Interpreters* working with the aforementioned families (overall, and whenever possible, the same interpreter was involved throughout the duration of the group). There was at least one interpreter who had been part of the group for five years, translating for different families. There were three formal female interpreters for Arabic, North African and an Eastern European language. A relative also translated informally for one family.

3- *The professional therapeutic team* included three Multifamily Therapists running the Multifamily group, all of White British origin, for whom English was their first language. There were two female clinicians and one male clinician. Two were the main therapists and the third therapist worked with the families or family members who were not involved in the main activities. For this reason, the voice/positioning of this third clinician is not included in the analysis, as she was not part of the main activities. In terms of power, this positioned her differently in front of the families. They had run Multifamily groups together in this setting for several years. Two female students were also observing and helping in the sessions, both of whom spoke English as their first language. Their ethnicities were White British and Black British.

The following table shows a description of the participants[36] (families, therapists and interpreters) who were present in each of the sessions:

[36] Using pseudonyms.

TABLE 2- PARTICIPANTS' CHARACTERISTICS AND NAMES (PSEUDONYMS)

Parent	Child	1st MFT session	Focus Group	2nd MFT session	Native Language	Ethnicity	Interpreter
Salma(pf)	Yasar(cm) 7 years-old	x	x	x	Arabic	Arab	Yes
Cathy(pf)	Kamal(cm) 11 years-old	x	x	-	English	Black British	N/A
	6 years-old sister	x					
Trudy(pf)	Rosan(cf) 13 years-old	x	x	x	English	Black British	N/A
Ibrahim(pm) Samira(pf)	Ismail(cm) 10 years-old	x	-	-	Arabic	Arab	No
Asir(pm)	Jamil(cm) 12 years-old	x	x	x (with Mo)	Arabic	Arab	N/A (fa)
							Aunt
Alisha(pf)	Eric(cm) 6 years-old	x	-	-	English	White British	N/A
Harriet(pf)	Jonathan (cm) 14 years-old	x	-	x	English	Black British	N/A
Kazima(pf)	Abdo(cm) 9 years-old	-	-	x	Arabic	Arab	Yes North African
Atifa(pf)	Ashar(cm) 9 years-old	-	-	x	Arabic	Arab	No
Nusrat(pf)		x	x	x	Arabic	Arab	No
Emira(pf)	Arlind(cm) 10 years-old		x	x	Eastern European	White Other-Eastern European	Yes
Total		**8p 9c**	**5p 4c**	**7p 6c**			
Judith Female		x	x	x	English	White British	N/A
Paul Male		x	x	x	English	White British	N/A
Deborah Female		x	x	x	English	White British	N/A
Katie Female student		x	x	x	English	White British	N/A
Laura Female student				x	English	Black British	N/A
Total		4	4	5			
TOTAL		21+ 1 Interp	13+1 Interp	18+ 3 Interp			3

7.-PILOT STUDY:

I conducted a pilot study to discuss the aims of the study and the research questions with a previous group participant from one of the groups I had run with colleagues years ago (which I felt had been a cohesive group). I had not been his therapist and I approached him informally. He is

of White British origin. To maintain confidentiality, I will call him Ben. When I approached Ben, he was very keen to discuss the research[37]. I showed him the questions and he thought that they seemed relevant.

This interview gave me confidence in terms of my area of study (group cohesion), as when we talked about his experiences in the group, what he found helpful or unhelpful, without being prompted he independently highlighted some issues concerning group cohesion which were significant in his experience. It was striking how difficult this father had found it to ask questions about the process of Multifamily therapy before it started, which may have been due to feeling powerless in a Court-mandated assessment context.

Therefore, I made sure that I explained the research process in detail in a number of ways and times to allow the group participants to ask any questions. First, the clinicians explained it, then I presented the research to all of them as a group and then, on the day of the recording, I went through the information sheet and consent form with each of them individually, giving them space to ask any questions. Each of these occasions allowed group members to decide (without pressure), whether they wanted to participate in the research or not. In fact, not all group members consented.

I did a thematic analysis of this interview to inform the thematic analysis of the focus group and therapists' interview. The main themes of this interview were: what helped him (his answers were relational and connected to group cohesion); and what was difficult (not understanding the process, asking questions). What helped him in the group was: "checking-in" each morning, "sticking with it", "asking questions", "getting help from therapists…they really, really helped". He was "pushed a bit himself, in a good way" and to help others. He added: "I just got to enjoy it. We worked in the group and got to know each other and it was great to be able to work with people... we sort of reassured each other, helped each other, little tips I was given". He explained that it was very helpful to get people's views.

[37] Please see appendix 12 for a transcript of my interview with him and my analysis of it.

8.-PROCEDURE:

Research steps:

Step 1- Observation: I had been running MFG for four years, with multilingual families and observed that some groups seemed to get on better together than others. I was interested in finding out about how we, as therapists, could create a context for connections to develop. We regularly recorded MFT sessions with the families' consent for clinical purposes. I watched some tapes of groups that I thought had been cohesive and some that had not, to help me consider and develop the research questions.

Step 2: Ethical approval: Ethical approval was sought and granted following an application to NHS Research Authority, National Research Ethics Committee (REC) Centre and, additionally, I also obtained approval from NHS/Central North West London Research and Development/Camden Provider Services office prior to the start of the process. I will explain this process in detail in the Ethical approval section (9-below).

Step 3: Recruiting participants: I informally asked other MFT therapists whether they would be interested in the research and whether they could ask the group participants in their groups. When some therapists agreed, I sent them some information about the research. They verbally shared this informally with their group participants and asked them whether they would like to participate. They shared information about consent in detail, once the majority had verbally agreed. I then introduced myself and I explained the research comprehensively and issues around consent. I gave them the information sheet and consent form, which the interpreters translated. I encouraged them to ask me any questions. On the day of the recording I explained the research again, answered their questions and asked them to sign the consent forms.

Step 4: Collecting data:

The whole process of gathering data took approximately two months. I first video-recorded a Multifamily therapy session using a fixed camera, and I also used a hand-held camera. A week later, I held the focus group and I showed them some video clips from the previous sessions. Three weeks later, I video-recorded another Multifamily therapy session. Approximately a month later I interviewed the therapists informally using the interview schedule and we reviewed the focus

group together, selecting random places to talk about their understanding of group cohesion. I audio-recorded this interview.

Step 5: Transcription*:* Two Multifamily sessions and a focus group were video-recorded. The interview with the therapist was audio-recorded. I transcribed these verbatim[38]. I included some non-verbal communication that seemed relevant to the research. I anonymised the details of the participants and used pseudonyms to protect their identity and privacy.

Like many other qualitative researchers, I believe that transcribing is a significant part of the analysis process, because "having to listen carefully to hear each word, rhythm, and emphasis, pauses, interruptions, overlaps, repetitions, breath intakes/exhales, watching the video for visual cues and relevant movement, and repeating this many, many times immerses you in the talk-in-interaction" (Gale 2010, p.17). Even though transcribing was a lengthy process, given the large group and noisy environment, it allowed me to become familiar with the material.

Step 5: Analysis of the data and identifying 'cohesive moments' for the micro-analysis:
I used thematic analysis to explore participants' understanding of group cohesion in the focus group and therapists' interview. I selected episodes/moments when the group seemed to be cohesive, or not, for these episodes/moments to be analysed. I then clustered these moments, which helped me to finalise my definition of group cohesion.

The MFT sessions and focus group interview were analysed using DIHC. I first completed a pilot analysis of the Multifamily therapy session transcripts, identifying an excerpt featuring a cohesive moment and a non-cohesive moment. I covered all the features of DIHC as described in this chapter. From this data and keeping my group cohesion definition in mind, I clustered some dialogical patterns and developed some categories around patterns of interaction related to group cohesion: positive bonding relationship, positive working relationship, and negative relationship factors/'non-cohesive moments'.

I completed the analysis of the first MFT session- reading line by line, identifying aspects of my definition of group cohesion and dialogical patterns. Based on these, I created a table to cluster

[38] For transcript notation, please see appendix 13.

the information. I micro-analysed cohesive and 'non-cohesive moments' identified in three different parts of the session (instructions, activity and 'reflections'). I completed six micro-analyses using DIHC for each MFT session. Next, I followed the same steps to analyse the second MFT session, which was shorter and limited because it focused mainly on one of the families that had not agreed to be part of the research analysis.

I actively sought feedback on my research and analysis: I regularly met with my supervisor, who reviewed my analysis. I also discussed extracts of my analysis with the research community at the Tavistock, in different contexts: the Data Analysis workshop, presenting at conferences and at the Symposium.

Step 6- Reflexivity on the methodology and initial research processes:

The initial research process was rather stressful. A year after starting the Doctorate, I fell pregnant and the team which had agreed to participate in the research came under threat of budget cuts. I felt that I had to race against these significant events to be able to complete the research within the timeframe that I had set myself. During the early stages of the research I had to use my perseverance and determination to the maximum to ensure that I could at least gather the data from the group who were accessible at the time.

During the video-recordings of the sessions, I particularly struggled when considering differences between the groups I had run and the group which was part of my research. I was learning to be in the researcher position, which was different to the clinical position. Even though I tried to be mindful of not judging others, at the same time noticing differences between groups helped me to highlight some moments in the focus group when I believed the group did not seem cohesive. Interestingly, this became a very highly-charged moment in the focus group, because even when my intention was not to judge, group members felt under scrutiny.

Soon after I interviewed the therapists I went on maternity leave and suspended my studies. This had a significant impact on me as a researcher, not only as my time was more limited after having my first child, but also because, when I returned to my studies, my developing identity as a researcher (prior to the suspension) was challenged by my other developing identity as a mother.

In hindsight, I think this was noticeable when considering the length of time it took me to decide on my second method of analysis and complete the analysis.

9.-ETHICAL ISSUES:

Ethical approval was sought and granted following an application to the National Research Ethics Committee (REC) Centre East Midlands in Leicester and my local Research and Development Department (from North Central London Research Consortium-Central and North West London NHS Research and Development/Camden Provider Services) prior to starting the data gathering process.

I had originally planned to video-record only one Multifamily session. I first received provisional opinion on 10th February 2014[39], which included some recommendations for the invitation email and the Adult Information Sheet. I followed these recommendations and resubmitted the documents they requested as advised. I then received favourable ethical opinion from the Committee on 3rd March 2014[40]. I then made some substantial amendments (including the video-recording of another Multifamily therapy session, as advised by my Director of Studies, colleagues and others), which meant I had to seek ethical approval again. The amendments were reviewed by the same committee and they gave me the final favourable ethical opinion on 23rd April 2014[41].

Issues of Consent:

This research was conducted in line with guidelines set out by the Association of Family Therapy Code of Ethics and Practice (2011b) and the British Psychological Society's (BPS) Code of Ethics and Conduct (2009), which view confidentiality as paramount. To achieve this, I use pseudonyms instead of participants' real names to anonymise their identities. Personal information is restricted to the minimum necessary in the research report (i.e. broad languages spoken, ages, ethnicity).

Additionally, the BPS Code of Ethics and Conduct (2009), highlights the importance of eliminating any "potential risk to psychological wellbeing and physical health, personal values or dignity" (p.19). Under the principle of responsibility, two standards for research are set out: protection, and debriefing, of participants. Although I did not anticipate any harm arising from the study, I

[39] Please see appendix 14.
[40] Please see appendix 15.
[41] Please see appendix 16.

communicated to them that, if participants became distressed, they could address this with their clinician or supervisor. I agreed that I would stop any discussion about the research topics immediately if they showed/expressed any distress. I planned to signpost interpreters (if necessary) and told them that they could contact me within 3 months of participation should distress or concerns arise, despite the precautions taken.

Given that their children's school had made the referral to the group, under the threat of their child being excluded from school and that families would experience power differences with therapists and me as a researcher, I was conscious of the fact that they might experience some pressure to comply. Therefore, I was very careful when discussing the research with prospective group participants. I provided an information letter, explaining the study in detail and stating the aims of the research; differentiating it from therapy; and explaining participants' right to participate, decline to participate and withdraw without penalty; anonymity and mutual respect; their consent to video-record MFT sessions; data storage; use of the data they provided for research purposes and complaint procedures. To avoid putting group pressure on their decision, once the majority of the group had individually agreed to take part in the research, I met with all of them (including the children) to explain the project and to give them the opportunity to decide as a group whether to participate or not. This was also an opportunity for them to ask questions before giving informed consent. Each participant signed a consent form prior to any video-recording. Parental consent was sought for any child participant under the age of 16. Children over the age of 11 also gave written consent and children under the age of 10 gave assent. There were two families that did not want to participate in the research. However, they gave me consent to conduct the research, including video-recording, but did not want to be part of the analysis.

<u>Protection of confidentiality:</u>

At the end of the study, video-recordings (which were securely locked away during the study and only accessed by myself and supervisors) will be destroyed. Participants were fully informed of the content and purpose of the study before agreeing to take part, and were reassured that they were not obliged to answer all or any of the interview questions if they did not feel comfortable doing so. They were also aware that they could withdraw at any time from the study.

SECTION E-ANALYSIS

INTRODUCTION

I became interested in group cohesion when I found research explaining that it enables change. I wondered what Multifamily therapists could do to support group cohesion, specifically with multilingual families. The analysis was completed in different phases and covering a variety of data.

There were two different types of analysis: "in-session interactions"/dialogues and post-hoc reflections/narratives analysis, a distinction drawn by Tseliou, *et al.,*'s (2021a) Systematic Meta-synthesis review. I started with the 'post-hoc reflections analysis' of the focus group and the therapists' interview using thematic analysis. Additionally, I used DIHC to analyse the focus group and to consider the main elements of group cohesion: 'building relationships', 'working together' and 'negative relationship factors'. Finally, I examined issues around the intersection between language and group cohesion in MFT. I then described the 'in-session' analysis of the two MFT sessions recorded using DIHC. The first session lasted 2 hours (there were 18 group members, including an interpreter and an informal interpreter) and the second session lasted just over an hour (there were 15 group members with 3 interpreters and an informal interpreter). I divided this analysis into the following sections: Aspects of the therapists' interactional/dialogical positioning. I included contextual/external and dialogical factors which positioned therapists as powerful. I then provided a detailed analysis of the therapists' positioning/voices, considering their impact on group cohesion. Next, I considered aspects of therapists' positioning/voices which encouraged vertical/horizontal group cohesion by 'building relationships' within a safe context and where group members felt that they belonged despite differences, and by inviting group members to 'work together' and remain focused on therapeutic tasks. I then considered aspects of the therapists' interactions/context that hindered group cohesion. Finally, I examined the intersection between Multifamily therapy, group cohesion and language.

The next section describes the analysis of the 'post-hoc reflections'

CHAPTER 1.-REFLECTIONS ANALYSIS ("POST-HOC NARRATIVE OF SYSTEMIC PSYCHOTHERAPY PROCESS") (Tseliou *et al.,* 2021a,b*)*:

1.1.-INTRODUCTION:

To include reflections and group members' voices in my research, I interviewed the therapists about their experiences and understanding of group cohesion. I also convened a focus group with its members to explore their understanding of cohesion. I analysed its content using thematic analysis and I also analysed the dialogical interactions within the group (including myself as the researcher) using DIHC. The thematic analyses helped me develop my own understanding and definition of group cohesion before doing any other analysis.

1.2.- THEMATIC ANALYSIS:

Overall, group participants described how they were all connected to each other (group cohesion). The themes from the focus group were: 'building relationships', 'genuinely caring for each other', 'similarities', 'good communication', 'working together', 'sitting together', 'lots of time together', 'having to participate', 'doing something enjoyable together' and 'like a family experience'. I regrouped these into the following larger themes: 'communication', 'working together' and 'building relationships'. From the thematic analysis of the therapists' interview, the main themes raised were: the 'therapists' roles', 'MFT as a leverage to support, engage and think about each other's behaviours', 'the group's roles' and 'cultural perceptions'. I regrouped these themes into 'planning', 'relationships' and 'MFT creating a context for working together'. Both groups raised similar themes: 'working together' and 'building relationships', but the therapists included wider themes, such as planning, roles and cultural perceptions. Factors that hindered group cohesion were not raised by either group.

1.3.-DIALOGICAL INVESTIGATIONS OF HAPPENINGS OF CHANGE ANALYSIS OF THE FOCUS GROUP:

First, I identified the following **episodes:**

- **SITTING DOWN** (lines 1-19)
- **STARTING** (line 20-92)
- **SIMILAR CHARACTERISTICS** (lines 93-144)
- **DURATION OF THE GROUP** (lines 145-212)
- **LIKE A FOOTBALL TEAM** (lines 213-347)

- **REFOCUSING ON GROUP EXPERIENCES** (lines 348-701)
- **SHOWING THEM VIDEO CLIPS** (lines 702-1285)
- **FINISHING** (lines 1285-1371)
- **LANGUAGE** (lines 1372-1452)
- **DIFFERENT CULTURES** (lines 1453-1488)

1.3.1.-DIALOGICAL ANALYSIS OF MY OWN POSITION- SELF-REFLECTION:

I will start by analysing some of my interactions with the group. Unintentionally, I positioned therapists as powerful, through my non-verbal communication: I made eye contact with the therapists at particular times, such as when participants wanted to leave the focus group or when I was going to start/finish the discussion. Group members responded to these actions, based on their previous experiences of the therapists, by respecting the 'powerful position' (e.g. Yasar(cm) asked Judith(T[42]) if he could leave). Given that I was leading the focus group, I positioned myself, by the task (focus group), and was positioned by others, as holding power, even when I used a collaborative voice to engage them in the research. This is evident when they looked at me for direction. I also had more quantitative, interactional and semantic dominance in this session. Regarding quantitative dominance, in total, I had 155 utterances, followed by Trudy(pf) with 82 utterances, and Asir(pm) with 61 utterances. Even though Judith(T) and Paul(T) left the group at times and Cathy(pf) left early, Paul(T) had 44 utterances, while Judith(T) and Cathy(pf) had 35 utterances each. Out of the children, Yasar(cm) had 23 utterances and Rosan(cf) 15. I showed semantic dominance when I asked questions, such as: *"if sharing similarities (such as language, race, migration) made a difference to how they worked together*". Finally, I showed interactional dominance by "setting the scene" and asking: "*how groups work TOGETHER well, specifically when there are different languages?"* and *"how do you feel connected to a group?"* and by asking most questions, introducing new topics, deciding when to show them video excerpts and choosing which ones. Paul(T) and Judith(T), from the leaders' position, also showed interactional dominance (e.g. by widening the topic when Paul(T) talked about how football players come from different cultures and have a common interest, e.g. to "win the premier league", but they "blend together", "work well as a group", and "connect". Additionally, when Judith(T) said: "we got about 5 more minutes don't we?" she set a time boundary for the focus group. I responded to this by agreeing in response to her position of power and my own feelings of indebtedness, as they were helping

[42] Denotes: 'therapist'.

me (I was 6 months pregnant at the time and the group was ending soon). Finally, group members also showed interactional dominance, for instance, Trudy(pf) readdressed a previous point after the topic had changed.

I also used a collaborative voice, from a powerful position, to invite group members to start the focus group, by saying: *"Shall we start?"*. I explicitly conveyed that I was curious (positive bonding relationship) to hear not only about their understanding of group experiences, including cohesion, but also how this worked across languages. Group members seemed engaged (positive working relationship) in the dialogue, and this was observed both from the ideas they shared and their behaviour during the focus group (e.g. listening to each or completing each other's sentences).

In general, I addressed all the group participants, inviting them to talk by asking them open and individual questions, making eye contact with some of them, including using their names in some cases. Overall, they responded to my invitations. I noticed that I did this with both the most and least vocal group participants. For instance, I had noticed that, as in the first MFT session, Salma(pf) was not participating, so, I explicitly asked about her own experiences/views on the topics. I also explicitly addressed the children and invited them to participate in the dialogue by saying: "*What about the kids? You are all VERY quiet!!... what activities bring you together?* Yasar(cm) responded immediately and said playing football and sitting together (pointing at circle). Trudy(pf) agreed with him. Others mentioned different activities.

I **positioned myself** as another Multifamily therapist (not a researcher), when I replied to what Salma(pf) had said about break time, using her positive comment as an intervention.

I had expected that the therapists would join the focus group. In hindsight, it was difficult for them to join the discussion as full participants, because they still needed to oversee the group and those who had not consented to the research, even though they were with the third therapist. Paul(T) switched between powerful and curious positions. When he talked about football, he was like another participant in the group, but he also occupied a powerful expert position, given his knowledge of the group's interests. He was also a curious therapist when the use of mobile phones was discussed, and he said: *"this is really interesting"*. I will now consider my research questions:

WHAT DO MULTIFAMILY THERAPISTS DO IN DIALOGUE TO CREATE A CONTEXT FOR HORIZONTAL (BETWEEN GROUP MEMBERS) AND VERTICAL (BETWEEN FAMILY MEMBERS AND THERAPIST) GROUP COHESION BETWEEN MULTILINGUAL AND MONOLINGUAL FAMILIES?

1.3.2.-DIALOGICAL ANALYSIS OF GROUP MEMBERS' INTERACTIONS:

Regarding group members' interactions, overall, utterances were mainly responded to in a dialogical dialogue manner from the outset. The most frequent type of language used in this session was external language. There were a few examples of internal language too. For instance, when Cathy(pf) described in detail how, when only the adults were together, she disclosed some difficulties which impacted on how "communicative" she felt during the day and how this in turn helped others to understand her better. Asir(pm) talked about sharing food making the relationship more formal, which was particularly significant for him at the time because he had some domestic issues. Regarding reflective language, there were many examples, as participants reflected on what they had found helpful in the group, (e.g. sitting and talking together, doing adult only activities, outings, playing football). Finally, Judith(T) reflected on her own experience of running the group and what previous group members had said in the past.

The dialogue in which most group members participated took place after I showed them the video-recordings of them on their mobiles during breaktime in the previous MFT session. Trudy(pf) explained that during the group *"she is so like into group and stuff"* and "during the break, she thinks *"right what else I have to do outside of here"*. Asir(pm) agreed with her and added, *"specially at the morning. You are really 100% inside the room, not connected to the outside world".* Then they made eye contact and laughed together, supporting each other. Even Salma(pf) participated in this dialogue spontaneously for the first time using the interpreter, who said: "actually, Salma(pf) wants to say something*: 'we have a rule as a family to enjoy each other and spend time with each other. For example, first, people asked why my son came here, so I can talk with them, discuss this kind of stuff, a good opportunity for us to interact and work well together. Better than anywhere else'"*. This comment showed that Salma(pf) had been listening and that even though she did not often participate in the group, she found it really helpful. Yasar(cm) asked: *"what does 'interacting' mean?",* which showed he was also listening. It is difficult to know whether he was listening to everyone or whether it was because his mother had spoken.

In terms of group **members' voices**, Trudy(pf) was able to use her voice as an open complaint: she said a couple of times that she would like the children to do more schoolwork, especially because they spend all morning in this group. Rosan(cf) mainly used her voice in this session after her mother had spoken to 'defend her' and also to help Yasar(cm). Salma(pf) was able to spontaneously use her voice through the interpreter, as an engaged group participant, when we talked about the use of mobile phones in the group and she expressed how much she valued this group.

When Yasar(cm) asked whether he could leave the group Judith(T) responded: *"Well, I think that is up to your mum... but... they aren't playing, they are practicing their skills. So, you'll have to be away from them and be very sensible".* Salma(pf) was again positioned by therapists as a silenced/powerless/non-agentic[43] mother.

Briefly, I first analysed my own position and interactions in the group from a dialogical perspective. I then analysed group members' interactions. In comparison to the MFT sessions, as this was a group discussion, there were many dialogues taking place. Most group members participated in the focus group dialogue and the longest and most interactive dialogue was when we talked about their use of mobile phones.

1.4.-MAIN ELEMENTS OF GROUP COHESION:

Considering my first question, group participants described group cohesion in the following terms:

1.4.1.-'BUILDING RELATIONSHIPS'- POSITIVE BONDING RELATIONSHIPS:

When asked what significant formal/informal activities/moments might help them to connect with each other, Trudy(pf) responded: *"I think if people would have like, the fact that people we all got same, similar problems"*. She started by qualifying her comment as her own opinion, but then made it more certain by claiming that this is a fact- that it is important to have similar problems. She also personalised it by saying *"we all got".* Asir(pm) agreed with her and used symbolic language to express this: it is *"like being in the same boat"*. Trudy(pf) seemed to have felt listened to, as she replied: *"Yes!!! Basically, yeah"*. This is more relevant when people come from a context

[43] Non-agentic positions have been defined "as not having a place in conversations where meanings pertinent to one's life are produced (Drewery, 2005), not having access to a self-authored autobiography (Bamberg, 2009), nor to have the option to take a reflexive, critical or evaluative standpoint in respect to the self and its actions (Avdi, 2012)" (Wahlström and Seilonen, 2016, p.5).

of misunderstanding, and are judged and accepted by others who are similar in MFT. I paraphrased this by using symbolic language in a dialogical way: *"sharing a journey together?"*, to which Asir(pm) responded positively, *"yeah, yeah!"*. He seemed to have also felt listened to. Trudy(pf)and Asir(pm) seemed to support each other in this dialogue. When I specifically asked the children what activities brought them together, Yasar(cm) responded immediately and said that they always played football together. Additionally, Asir(pm) mentioned that they went to a farm. Many of them described this activity as *"enjoyable*", including Paul(T).

1.4.1.1-Signs of genuinely caring for each other: When I showed them a videoclip of Yasar(cm) telling Eric(cm)*: "come and sit next to me. Have you been a very good boy?"*, Trudy(pf) seemed to be emotionally touched, as she said: *"OH!! Oh!!!... That's sweet!!!".* Many other group members vocalised a similar emotion and smiled. Even when Eric(cm) and Alisha(pf) were not present, Trudy(pf) showed that she was aware of Eric's(cm) goals, as she mentioned that his mother hoped that he could behave better and talk nicely to others. Cathy(pf) expressed that, when she disclosed some health difficulties, others could understand her and empathise with her better.

1.4.2.-'WORKING TOGETHER': **POSITIVE WORKING RELATIONSHIPS**:

There were a couple of examples of group members helping each other. For instance, Cathy(pf) said that by doing activities together parents and children helped each other and that this facilitated group connections (such as doing something visual together, looking at the butterflies). Rosan(cf) adopted a supportive position towards Yasar(cm) and she helped him to understand when he had misunderstood something: he talked about doing puzzles and she told him: *"But she is asking what activities have you done?"*

WHAT DO MULTIFAMILY THERAPISTS DO IN DIALOGUE THAT INADVERTENTLY HINDERS THE HORIZONTAL AND VERTICAL GROUP COHESION BETWEEN MONOLINGUAL AND MULTILINGUAL FAMILIES?

1.4.3.-NEGATIVE RELATIONSHIP FACTORS/ 'NON-COHESIVE MOMENTS':

Considering my second question, I observed:

Leaving early/not being part of the research: Kamal(cm) and Cathy(pf) left before we finished the group discussion. Soon after, Judith(T) informed us of this, Yasar(cm) expressed a desire to join the other children who had not joined the focus group (because their parents had not consented to the research). This might indicate either that: Yasar(cm) had disengaged from the discussion; the impact of either some participants leaving early; or that not all the group members had joined the focus group, which also happened in the MFT sessions.

Briefly, these descriptions and experiences indicated that there was group cohesion in this group.

WHAT IS THE INTERSECTION BETWEEN MFT, GROUP COHESION AND LANGUAGE, INCLUDING INTERPRETERS' ROLES?

1.5.-REFLECTIONS ANALYSIS: INTERSECTION BETWEEN MULTIFAMILY THERAPY, GROUP COHESION AND LANGUAGE:

1.5.1.-ENGLISH AS A SECOND LANGUAGE:

It seemed that, as English is Asir's(pm) second language, even though he was able to communicate, he was still not able to communicate fully, so Cathy(pf) and Trudy(pf) positioned themselves as his informal interpreters. When he struggled to convey the meaning of something, they often gently corrected what he had said. He responded to this positively and recursively, which possibly reinforced Trudy(pf) and Cathy's(pf) positioning and his feelings of being listened to. For instance, when Asir(pm) said that sharing food also helped them by making the relationship more formal, Cathy(pf) added, like a *"family experience",* possibly clarifying what he might have meant or sharing her own perspective. He seems to have felt listened to and he responded positively by saying immediately: *"EXACTLY!"*. Likewise, Trudy(pf) paraphrased in a collaborative manner what Asir(pm) had said about breaks (*Break time, sometimes yes, for, erm, like to share experiences...erm, especially when we come as adults together, away from children, we talk maybe more freely other than you know). "I suppose he is saying that even though you know. It is NOT, it's break, give me my phone bla, bla, it is not like, like that, because sometimes I don't use my phone at all. Sometimes I have no messages or whatever. So, sometimes I make some tea and we gather around the kettle"*. These examples show how differences in language fluency created closer connections.

1.5.2.-WORKING WITH INTERPRETERS:

I invited group members to have a dialogue about the group's views about having different languages/interpreters in the room. Trudy(pf) added that, through non-verbal communication, she could understand what others were trying to say. She thought that it did not make any difference having an interpreter in the group, apart from waiting for the interpreter to translate. I asked Trudy(pf) if she felt she could interact with Salma(pf) during the break without the interpreter. She replied that as Salma(pf) has basic English, they can have basic greeting conversations, for example: *"how are you/your son?".* Salma(pf) said that having an interpreter worked well for her, but Trudy(pf) felt that it might be too noisy when there are several interpreters.

1.5.2.1.-Interpreters as co-therapists: There was an example of this, when Asir(pm) described himself and his family as *"regular customers?"*, adding that he was not sure how long they had been part of the programme this second time. So, he checked with Paul(T), who then checked with the regular interpreter, showing that she was also part of the team.

Briefly, even though I directly asked group members about their experiences of working with interpreters and they generally expressed positive views and said that the only downsides might be waiting for the interpreter to interpret, or noise levels, I am not sure how honest they were able to be in this context (all together).

1.6.-REFLECTIONS ANALYSIS CONCLUSION:

To conclude, even though group members and therapists raised similar themes in the focus group and interview, such as 'working together' and 'building relationships', therapists raised wider themes, such as planning, roles and cultural perceptions. It is interesting that none of them raised factors that might hinder group cohesion.

During the focus group I unintentionally positioned therapists as powerful. Likewise, as the person leading the focus group, I positioned myself, by the task, and was positioned by others, as holding power, even when I used a collaborative voice. I had more quantitative, semantic and interactional dominance, but some group members also had interactional dominance. In terms of 'working together', group members seemed engaged, listened to and supported each other. Regarding 'building relationships', they showed that they 'genuinely cared about each other', enjoyed

experiences/activities, and offered mutual support (including with language). It seems that this focus group allowed group cohesion to develop, as they focused on their positive experiences and interactions as a group, including 'significant cohesive moments' within the group, such as: 'Cathy's(pf) self-disclosure', 'Asir(pm) talking about sharing food', and 'Salma(pf) talking about how she feels the group helped her'. I assume that their sense of self-value, group-value and belonging probably developed even further.

Group participants felt that they could communicate at a basic level without an interpreter in informal interactions. However, I did not observe many informal interactions between people who spoke different languages. None questioned how it might appear from Salma(pf)'s position, who was mainly silent and hardly communicated during formal and informal activities.

CHAPTER 2.-MFT "IN-SESSION DISCOURSE OF SYSTEMIC PSYCHOTHERAPY PROCESS" (Tseliou, 2021a,b) INTERACTIONS/DIALOGUES ANALYSIS:

2.1.-INTRODUCTION

The first Multifamily session I video-recorded included a series of formal activities (e.g. 'speed-dating', reviewing targets, and a review of the 'masked ball' activity from the previous day) and informal activities (pre/in/post-session informal conversations, setting up; break; looking at butterfly project). I identified the following episodes[44]:

INFORMAL INTERACTIONS (lines1-75)
SETTING UP THE EXERCISE (lines 77-190)
'SPEED-DATING' TO REVIEW INDIVIDUAL TARGETS (lines 192-324)
REFLECTIONS/FEEDBACK on speed-dating exercise: (lines 326-1333)
BREAK (lines 1335-1700)
MASKS (lines 1701-2626)
BUTTERFLY PROJECT AND INFORMAL POST-SESSION INTERACTIONS (lines 2628-2816)

Each episode was analysed using the DIHC methodology to understand features of dialogue which showed or contributed towards group cohesion in the process of multi-actor dialogues in MFT.

[44] Please refer to appendix 17 for a full list of episodes.

First, I identified 'cohesive moments' using my definition of group cohesion and I categorised them into patterns, such as: requesting/receiving help, praise, being (or not being) listened to, touch, empathy, refocusing on task, shared enjoyment, power, and belonging, amongst others. I also identified features from DIHC such as interactional/semantic dominance, and reflective/symbolic/dialogical/monological language. Finally, I identified when there were issues around language.

The second Multifamily session I video-recorded included a series of formal activities (e.g. reviewing targets individually, group 'speed-dating' exercise to review targets) and informal activities (pre-session informal conversations and setting up). The analysis is limited by the fact that one parent did not give me permission for his/her family to be part of the research, but agreed to be part of the recordings and he/she was obviously aware of my presence in the room. Unfortunately, he/she was the main focus of the 'speed-dating' activity and 'reflections'.
I identified the following episodes:

TARGET REVIEW with each family (lines 1-172)

INFORMAL INTERACTIONS: pre-speed-dating exercise (lines 173-195)

SPEED-DATING EXERCISE TO REVIEW INDIVIDUAL TARGETS (lines 196-724)

REFLECTIONS (lines 726-1192)

2.2.-I now consider my first research question: ***WHAT DO MULTIFAMILY THERAPISTS DO IN DIALOGUE TO CREATE A CONTEXT FOR HORIZONTAL AND VERTICAL GROUP COHESION BETWEEN MONOLINGUAL AND MULTILINGUAL FAMILIES?***

Analysing the Multifamily sessions, I noticed a repetitive feature in the dialogue: therapists switched positioning between a powerful and a collaborative position, which seemed to impact on group cohesion. This was influenced by multiple factors.

2.2.1.-THERAPISTS' INTERACTIONAL/DIALOGICAL POSITIONING: SWITCHING BETWEEN POWERFUL AND COLLABORATIVE (from a position of power with a collaborative voice):

Given the complex interactional and dialogical processes in MFT, whereby therapists organise and structure the session, they have the power and professional responsibility to lead activities and

create space for dialogue. They had an inherently powerful position in relation to families, influenced by the task, context, and implicit/explicit external factors. The context of being in a group for families whose children presented behavioural difficulties, referred by the child's school (as the last chance before their child was permanently excluded), where the 'experts' were white-middle-class British therapists, and families were from a working-class background (many from a marginalised group, in relation to: race, language, culture, or being a single parent), created an inherent power imbalance between them. Additionally, it is important to consider how migrant families might potentially feel disempowered, according to their perception of the school's referral to a group run by NHS clinicians (part of the medical system), how they might be unaware of local practices and look up to therapists as powerful, and their cultural beliefs. Even though therapists actively tried to remain collaborative, this powerful position was clearly understood by all group members, even by young children (see extract 1 below).

2.2.1.1.-Contextual factors which positioned therapists as powerful:

Apart from the contextual factors briefly described above, I identified the following contextual/external factors and dialogical features which inherently positioned therapists as powerful.

Multifamily therapists created the **therapeutic context** which provided the structure of the group by:

- Deciding on the type of group: open rather than closed group.
- Choosing group participants with similar difficulties.
- Deciding when and how often each family attended.
- Focusing on the practical/physical aspects of the environment, including venue, room setting, length of time, breaks, use of props (e.g. bells, masks) and managing noise level.
- Keeping the environment physically and psychologically safe, including for young children.
- Creating a playful environment.
- Providing a space for informal and formal interactions.
- Informing group members about group or individual plans for the day.

- Deciding on what activities were used each day **(ID[45])**.
- Deciding on how to divide the group into smaller groups for particular activities **(ID)**.
- Deciding when a small group presented **(ID)**:
    - Judith(T): "*OK THIS group, you are all going to try to get the attention from the rest of your class".*
- Deciding whose turn it was to speak **(ID)**:
    - Paul(T): *"You got one more thing to say before we move on"*, *"I'm going to talk about..."*.
- Taking the initiative, both regarding the content and process of sessions **(ISD[46]).**
- Deciding on what topic to focus on: (e.g. X-box, impact of Yasar's(cm) change on his mother, Jamil's(cm) self-control) **(ISD)**.
- Deciding when a conversation would stop **(ISD)**: For instance:
    - Paul(T) said: "*guys just, can I sorry, just before we go on. I'm... Jonathan(cm) I'm not sure what/how much what you are talking about is really sort of relevant to this*".

      Jonathan(cm): "*it is, they are talking about her mask*".

      Paul(T): */"You are talking about Batman and things like that"/*

      Jonathan(cm): */"her mask has got 2 faces!!"/*.

      Paul(T): */"Just hold on for one second Jonathan(cm)"!* (puts his arm/hand out).
    - Paul(T) said: *"We have to move on now. I'll come back to you again!".*

      Ali: *"2 seconds, 1 second".*

      Paul(T): *"I'll come back to you again!* (unintelligible) *Later on I'll come back to you...just hang on...just!".*
- Managing enactments and giving meaning to children's behaviour (e.g. "*he wants your attention"*) **(ID)**.
- Embedding isolated/vulnerable group members into the group (e.g. Eric(cm) ringing the bell) **(ID)**.

[45] Interactional dominance

[46] Interactional and semantic dominance

In brief, I assume that the creation of the structure described above contributed to vertical and horizontal group cohesion as it allowed group members to feel safe and trust therapists. All group members interacted with each other in a therapeutic process.

2.2.1.2.-Dialogical factors which positioned therapists as powerful:

Dialogically, the therapists' powerful positioning was evident because they had quantitative, semantic, and interactional dominance in most of their turns in both sessions. In brief, this seemed to be a recursive relationship, in which their powerful position made them feel entitled to be dominant in the dialogue and this interactional dominance was a performance of power, whereas participants were in a non-agentic/powerless position. Next, I provide some examples:

> **In session 1:** Judith(T) and Paul(T) had quantitative dominance with 114 and 116 utterances respectively. Although there were 18 group members (apart from the therapists), only three adults (Cathy(pf)-90 utterances, Trudy(pf)-63 utterances and Asir(pm)-50 utterances) and three children (Rosan(cf)-40, Jonathan(cm)-35 and Yasar(cm)-78) had some quantitative dominance in the session.
>
> Likewise, Judith(T) and Paul(T) had most semantic dominance, whilst group members were not able to shape the content of the dialogue. For instance:
>
> -Paul(T): *"Can I just ask, can I just ask before we all move on quickly; What do you think the IMPACT is on Yasar's(cm) mum when Yasar(cm) is LISTENING MORE?".*
>
> -Judith(T): *"I'm wondering about the EFFECT of, we know the effect of the fly, flying around is disruptive, but I wonder about the effect of, if Ismail(cm) gets up and down, now Yasar's(cm) got up and down....what's the effect of that? what's the effect of that on everyone?".*
>
> Paul(T) and Judith(T) also showed interactional dominance in most of their turns, as they managed the group structure and activities, which managed their behaviours and interactions and provided a safe setting. For instance:
>
> -Paul(T): *"one more minute"* (structure).
>
> -Paul(T): *"we are gonna start with this group"* (structure).
>
> - Judith(T): *"your first job is getting everyone's attention"* (guiding).

In session 2: Paul(T) and Judith(T) also showed quantitative dominance. They had 73 and 71 utterances respectively. Paul(T) took a lead role when discussing who belonged to which tribe and even though Judith(T) took a lead role in the reflecting part of the speed-dating, Paul(T) also asked questions. In terms of group participants, Jonathan(cm) had 16 utterances. Kazima(pf) was the adult who participated the most with 9 utterances.

Paul(T) also showed semantic dominance. He always presented the activities to the group. For example:

> -Paul(T): "*Morning, we are going to have a look at our targets from yesterday, erm, we are gonna do it in that classic sort of speed targeted… you should also now all belong to a Chio (tribe)*".
> -Paul(T): *"OK! So, when we go around and have a look at everybody's targets. This would be good… Any questions?"*.

Paul(T) and Judith(T) also had interactional dominance in this session; they gave instructions and decided who spoke and when. Judith(T) asked each 'tribe' for feedback and determined when they had a break. They decided when an activity started: (e.g. "*Ready? You are all ready*?") or when a conversation stopped: (Paul(T): *"You got one more thing to say about this before we move on in the next few minutes").*

They influenced group participants' behaviours. When Judith(T) was about to start an activity and drew the group's attention saying: "*OK!!!*", Salma(pf) responded by asking her son to be quiet. Soon after, even though Salma(pf) also wanted to stand up, Paul(T) encouraged her non-verbally to sit down and she immediately responded.

2.2.1.3.-Conclusion: In summary, all the contextual/external factors and dialogical features described above positioned therapists as inherently powerful in their relationships with group members. These factors, together with the therapists' performance of power, had a positive impact on vertical/horizontal group cohesion, specifically, and on positive bonding relationships in the group (including experiencing trust, a sense of security, perceptions of therapists as someone with expertise, trustworthy and who managed difficulties). Given therapists' choice of group

members who shared some similarities (i.e. problems, goals, children's age, race, languages), these also had an impact on horizontal group cohesion.

Analysing dialogical features, I noticed a recursive relationship, in which, by having quantitative, semantic and interactional dominance in their interactions with the group, therapists performed and adopted a powerful position, which in turn positioned group members as less powerful than therapists and in a non-agentic position. Even though, simultaneously, therapists used a collaborative voice, attempting to share power, participants still remained powerless.

2.2.1.4.-Detailed analysis of the impact of therapists' powerful positioning with collaborative voices on group cohesion:

To further understand the phenomenon described above, I analysed dialogues in detail. I identified therapists switching between powerful positions and collaboration, considering what impact this had on group participants and cohesion. I will now provide some exemplars of this[47]:

2.2.1.4.1.-Extract 1: (lines 1714-1810)

A detailed description of my analysis can be found in Table 3 in appendix 19.

Context of extract 1: Session 1- some group members (6/18, 3 families) had decorated a mask the previous day, to represent something about their personality. Eric(cm) and Alisha(pf) had to leave the group early. Before leaving, Eric(cm) realised that they were going to work with the masks again.

Judith(T): Alisha(pf), Eric(cm) is here with his mask. We KNOW...that you need to leave.

Alisha(pf): Um hum.

Judith(T): What would you like him to do and how can we help you to do that?

Paul(T): Yasar(cm)! (signalling him to stop something).

[47] Please refer to appendix 18 for more examples.

Alisha(pf): Come on Er(…), Er, Eric(cm) (background conversations stop-silence)...Come on! Eric(cm)(...)

Judith(T): I guess what we can also say is that people that have not made masks they will be making them and there will be another time to show the masks to everybody. You can join. So there will be/

Alisha(pf): /Eric(cm)...Eric(cm).

Eric(cm) (with his mask on): I want to be in the meeting!! and I want to ring the bell. I wanna ring the bell I don't want to go! (unintelligible).
Alisha(pf): You are going to be late for lunch!

Eric(cm): MEETING!!!! BELL!!!!

Judith(T): how can we help? It's a lot of us/

Yasar(cm): /tomorrow, I let you come with this. You play football with me and...bring the book or not… if you go home.

Judith(T): (to Alisha(pf)) *Carry on! he wants attention!*

Eric(cm): I don't wanna go home!

Yasar(cm): If you ring the bell once and then you go?

Eric(cm): (nods) *I agree!*

Yasar(cm)(cm): Ah?

Eric(cm): I agree!

Yasar(cm): OK, cool.

Judith(T): Alisha(pf) is mum.

(Yasar(cm) says something to the interpreter).

Interpreter: she just wants her son to tell...

(Judith(T) nods)

Yasar(cm): I already did!

Alisha(pf): Er!... We'll come back here on Monday! Do you wanna be able to play outside?

Yasar(cm): Yeah! On Monday you can come back...and play outside!

Eric(cm): Ah?

Alisha(pf): Yeah! Come back and play outside in the break time. Remember?

Eric(cm): I wanna ring the bell!

Yasar(cm): Can we just you just ring the bell once?

Eric(cm): I agreed, I wanna ring the bell!

Alisha(pf): will you come Eric(cm)? PLEASE!

Eric(cm): I wanna ring the bell! (stands up).

Alisha(pf): You need to ask

Yasar(cm): ask Judith(T)!

Judith(T): (talks quietly to Alisha(pf) -unintelligible): *once*

(Eric(cm) walks towards his mother. Yasar(cm) follows him. Eric(cm) goes to his mother. Yasar(cm) returns without being prompted)

Judith(T): OK!!!...

Judith(T): So, now is the chance for... people that made their masks to... present them and for people who are watching to... let's find out what's behind the mask... which family would like to go first?

(Bell rings).

In this extract, Eric(cm) did not want to leave, he wanted to stay and be part of an activity he had started the previous day. First, Judith(T) asked whether Alisha(pf) needed help. Alisha(pf) did not respond. Later on, she suggested that there were many people that could help (including herself implicitly). Yasar(cm) responded and took on a collaborative peer position. Alisha(pf) seemed silenced and non-agentic, as a group member, but also from the position of being a (single) mother, whose child misbehaved and did not listen to her, and possibly felt ashamed. It is unclear whether this positioning was in response to the context, her son's behaviour, was her regular stance, or a response to the therapist's intervention: *'how can we help?',* which, although it is a collaborative/supportive intervention, positioned her as someone who needed help to manage her son (this might just be a fact).

Judith(T) and Yasar(cm) had quantitative, semantic/topical and interactional dominance. Regarding interactional dominance, Judith(T) decided and suggested what to do next in most of her turns and influenced others, such as telling Alisha(pf) that Eric(cm) wanted her attention. From a peer position, Yasar(cm) had interactional dominance; he influenced Eric(cm) and invited him to collaborate. When Yasar(cm) said: "*tomorrow, I let you come with this. You play football with me and...bring the book or not… if you go home",* he took a negotiator/bridge position between the

adults and Eric(cm) (who were managing pushing/pulling, coming and going). Yasar(cm) voluntarily adopted a powerful position: *"I let you come with this".* Addressing Eric(cm), Yasar(cm) used the voice of a collaborative peer, who had found a solution, and was able to voice it (however, it is difficult to know whether this was spontaneous or whether it was by proxy, encouraged by his mother). Eric(cm) was responsive to this voice. He accepted it more than the adults' voices. However, the adults (including therapists) did not respond immediately, which might be due to power differentials with a child. When Judith(T) responded, she then tried to momentarily reposition Alisha(pf) in a powerful position (in front of Eric(cm), Yasar(cm) and others) by telling Eric(cm) that he needed to ask his mother: "*Alisha(pf) is mum*", but then as powerless. Yasar(cm) and Alisha(pf) worked together in collaboration (i.e. "*Alisha(pf): Es!.. We'll come back here on Monday";* Yasar(cm): responded to this by saying: "*Yeah on Monday you can come back...and play outside".* Overall, Yasar's(cm) collaboration with the therapist, Eric(cm) and Alisha(pf) seemed like a sign of vertical and horizontal group cohesion and contributed towards the development of horizontal group cohesion. Eric's(cm) responsiveness also indicated horizontal group cohesion in dialogical interaction. Yasar(cm) seemed to have more power than Alisha. He was listened to, whereas she was not. She had a non-agentic position.

Alisha(pf) only addressed Eric(cm) throughout the episode. She was addressed by Judith(T). Alisha's(pf) and Eric's(cm) utterances were mainly monosyllabic. There were many monological dialogues and fewer dialogical dialogues. Alisha(pf) never responded verbally even when she was spoken to directly (e.g. therapist asked/told her: *"can we help you?*", "*he wants your attention", "you need to leave"*). She only said *"um hum"*, but it is clear that she had listened.

As Eric(cm) did not respond to Alisha's requests, she was often in the position of a 'powerless mother'. This was clear when Alisha(pf) said: *"will you come Eric(cm)? PLEASE!!"* (pleading with him). Eric(cm) did not respond to her plea, but said: *"I wanna ring the bell"* and then stood up. Alisha(pf) replied from a non-agentic position: "*You need to ask"*. The powerful position of the therapists was understood by Yasar(cm), who responded by saying: *"ask Judith(T)".* Judith(T): seemed to collaborate with Alisha(pf) by not explicitly responding herself and talking to her, but she still made the decision about what happened next. She said: *"once"*.

In this excerpt, most utterances used indicative language. Only 4 people spoke. The main type of dialogue was monological, like silos of monologue, as each participant seemed to have his/her own script, but the children seemed to be the connecting pieces. When Judith(T) asked what help Alisha(pf) needed from the group, she did not respond to this, but Yasar(cm) (or his mother by proxy) did. Judith(T) then said that others would do the mask later on, but no one responded: Eric(cm) replied: "*I want to ring the bell*", and his mother told him that he would be late for lunch. He did not respond to that and reiterated that he wanted to ring the bell. Eric(cm) responded to Yasar's(cm) ideas. Alisha(pf) calling Eric(cm) to go was not responded to.

In terms of the present moment in this excerpt, I was interested in the effect of silence (around 5 seconds). I experienced this as a tense moment, possibly an uncomfortable moment for those involved- negative relationship factor. Judith(T)'s response to the long silence was: "*I guess what we can also say is that people that have not made masks they will be making them and there will be another time to show the masks to everybody. You can join…"*. This diverted the attention from the family in focus to the wider group, *refocusing them on the task*, possibly allowing Alisha(pf) to refocus and feel less pressure and for Eric(cm) to hear that he would present his mask another day.

Considering *group cohesion*, as I did not interview my participants after the data collection, it is unclear whether Alisha(pf) felt she did not belong to the group (as a new member), whether she and Eric(cm) were accepted by others or even whether she perceived the therapists as supportive/'genuinely caring'. It is also not clear why Alisha(pf) was quiet in this excerpt, whether she felt ashamed/vulnerable due to her child misbehaving and this being witnessed by many others (including 'professionals'), or whether this was part of her personality. Eric(cm) seemed to feel that he belonged to the group.

From a powerful position, therapists decided to focus on a group member in a vulnerable position during an enactment observed by others. This embedded them in the group and created a space for support, learning and empathy towards the mother to develop. It seemed that either Salma(pf) collaborated with Alisha(pf) by proxy, by telling Yasar(cm) to encourage Eric(cm) to leave or Yasar(cm) collaborated spontaneously. Regardless, I imagine that this empathic interaction between them connected them emotionally, thereby 'building relationships'. Alisha(pf) probably

felt supported and not alone. Salma(pf) might have felt valued if some of the ideas she suggested were listened to and resolved the difficulty. Other parents observing a child not listening to his/her parent might have given them perspective and/or provided a learning experience. The boys supported each other. All these factors contributed towards horizontal group cohesion and might have developed due to horizontal/vertical group cohesions, in a recursive manner.

The therapist often spoke from a position of the helper/helped. In dialogue, Judith(T) shifted constantly between positions of power (e.g. by managing the structure of the group; making decisions and having knowledge; informing others about group or individual plans; opening the floor for others to participate in the dialogue; or instructing/guiding participants how to manage their children's behaviour: *"carry on… he wants your attention";* deciding on the meaning of behaviour "attention"; positioning others as 'vulnerable'; having semantic and interactional dominance. She positioned a mother who needed help to manage her child as non-agentic). Using a collaborative voice (e.g. "*What would you like him to do and how can we help you to do that?"*, "*how can we help? It's a lot of us"*), she invited dialogue and for participants to be curious about and to support each other. In this way she tried to share power and connect group members (horizontal group cohesion/'building relationships').

More specifically, in this extract, I identified three instances when a collaborative voice/message was immediately followed by another message which undermined the collaborative utterance from a powerful position and positioned Alisha(pf) as powerless/non-agentic. 1)The therapist's powerful position was evident when communicating that Alisha(pf) had to manage Eric(cm) (possibly a therapeutic goal) and the collaborative voice was evident when suggesting that the group could support her with managing the child's behaviour: "*What would you like him to do and how can we help you to do that?"*. Considering this in detail: "*What would you like him to do"* positions this mother as the authority and *"how can we help you do that"* positions her as powerless (non-agentic/needing help), while asking her to determine how that help could be given, positions her as more powerful, by giving her authority/agency. 2)Judith's(T) utterance seemed to be intended to praise and support Alisha(pf) in a collaborative voice: *"Carry on",* conveying the message, "you are doing ok", but then this seemed to be undermined by the powerful position when Judith(T) gave meaning to the behaviour "*he wants your attention*", thus positioning Alisha(pf) as powerless again. Finally, 3)When Yasar(cm) unintentionally seemed to

have taken power away from Alisha(pf), Judith(T) supported her by saying: *"Alisha(pf) is mum",* but then Judith(T) made the decision that Eric(cm) could only ring the bell *"once".* These examples support the idea that the powerful position and collaborative voice are intertwined. I wondered if these had a negative impact on group cohesion as it probably had an impact on group members' sense of being valued by the therapists and group, and also put them in a powerless/non-agentic position.

In the following extract, therapists switched between powerful positioning and collaborative voices. I consider their impact on group cohesion.

2.2.1.4.2.-Extract 2: (lines 67-107)

A detailed description of my analysis can be found in Table 4-Appendix 20.

Context of extract 2: Session 1- Whilst families started to arrive, Judith(T) had an informal conversation with Ibrahim(pm) and Ismail(cm). The following happened just before the speed-dating activity started:

> Judith(T)*: Erm Ibrahim(pm), shall I just?... do you want to just explain to everyone? If everyone can just listen to Ibrahim(pm) for a second… Erm, do you just wanna, just, just explain to everyone?*
>
> Ibrahim(pm): *Yeah. I asked Ismail(cm) yesterday, how was your school this morning? and then he said it was very bad. I said: 'why?' He said: 'I wasn't happy'. So, I don't know why he wasn't happy... because of the target yesterday.*
>
> Judith(T): *So, he is going to have to be Ismail(cm)'s memory.*
>
> Ibrahim(pm): *Yeah!!*
>
> Judith(T): *But you would like parents to… help… him with his targets from yesterday, don't you?*
>
> Ibrahim(pm): *Yeah!!*

Judith(T): *Is that OK with people?*

Alisha(pf): (nods- making eye contact with Judith(T)).

Asir(pm): *So, this is not the target/homework from yesterday?*

Ibrahim(pm): *Yeah.*

Asir(pm): *Oh yes, it is!*

Ibrahim(pm): *I just want to tell you the homework from yesterday.*

Judith(T): *And I guess it has/*

Cathy(pf): *What about Monday? Did he have a good day on Monday?*

Ibrahim(pm): *Yes.*

Ismail(cm): *Yeah!*

Cathy(pf): *Well done!*

Ismail(cm): (nodded).

In this extract, Judith(T)'s main role was setting up the next task. She showed quantitative, semantic and interactional dominance. Judith(T)'s positioning switched between a powerful and collaborative position. For instance, when requesting help from the group for Ibrahim(pm), she started from a position of power with a collaborative voice: *"Shall I just?",* thus positioning Ibrahim(pm) as voiceless/powerless/non-agentic, but immediately afterwards, she used a collaborative voice*,* which repositioned him as having a voice/agency/authority, when she asked him: "*do you want to just explain to everyone? If everyone can just listen to Ibrahim(pm) for a second"*. So, from a powerful position, she invited the group members to listen and collaborate in

the task (which encouraged horizontal group cohesion). From this position, she asked Ibrahim(pm) again: "*do you just wanna, just, just explain to everyone?*". Then Ibrahim(pm) explained the context of the problem and Judith(T) defined Ibrahim's(pm) goal in the task: "*So, he is going to have to be Ismail's(cm) memory".* She also requested help from the group: "*But you would like parents to…help…him with his targets from yesterday, don't you?"*. She positioned Ibrahim(pm) as powerless/voiceless/non-agentic and Ismail(cm) as vulnerable, involuntarily becoming the centre of attention. I am unsure whether she had asked Ismail's(cm) opinion about his father's request for help or whether Judith(T) had only spoken to Ibrahim(pm).

It is unclear why Judith(T) completed Ibrahim's(pm) sentences; perhaps because Ibrahim(pm) had not explained what was needed from the group. From a position of power, overseeing the group, Judith(T) clarified what he had not said; it might have been because the idea to request help had been suggested by her and Ibrahim(pm) did not own it (he just followed the suggestion without questioning it); or Ibrahim(pm) needed some help due to his level of English. Whatever the reason, it seems clear that he felt listened to, as he responded enthusiastically to therapists' utterances saying*: "Yeah!!".* Even though Judith's(T) voice throughout this extract was collaborative, her utterances were expressed from a position of power. For instance, she asked the group: "*Is that OK with people?"* (interactional dominance)*.* In this way she opened the floor to others, inviting them to respond (encouraging horizontal group cohesion) and stopping a group member from digressing (<u>refocusing</u> on the task).

Specifically considering <u>*group cohesion*</u>, if the idea of requesting help had been suggested by the therapists and not spontaneously suggested by Ibrahim(pm), this would probably have had a negative impact on vertical group cohesion, by putting group members in a powerless/non-agentic/vulnerable/ashamed position, which they might not be able to reject due to power differentials. If Ibrahim(pm) had asked for help himself, he would have felt listened to and supported, which would have had a positive impact on vertical group cohesion. Regardless, this intervention also encouraged Ismail(cm) and his dad to become <u>embedded</u> in the group, by presenting themselves as being in a vulnerable position (needing help) and encouraging the group to <u>support</u> them by empathising and reflecting together about the presenting problem*.* The group responded to this by asking more questions and being <u>curious.</u> It is likely that these interactions helped with everyone's sense of belongingness, as they might have encouraged Ibrahim(pm) to

feel embedded, valued, listened to and could have helped others to see their own problems in perspective.

In summary, group members flexibly moved between being positioned as helped and helper. As in the previous extract, in this extract I identified three instances when a collaborative voice/message was immediately followed by another message which undermined the collaborative utterance from a powerful position and positioned Ibrahim(pm) as powerless/non-agentic. As stated previously, this would have had an impact on horizontal and vertical group cohesion. I will now analyse this in detail: 1)*"Shall I just?, do you want to just explain to everyone? If everyone can just listen to Ibrahim(pm) for a second?"*; from a position of power with a collaborative voice, Ibrahim(pm) was positioned first as voiceless, powerless and non-agentic, but immediately afterwards he was repositioned as having a voice and more power; 2)From a powerful position with a collaborative voice, Judith asked Ibrahim(pm) again: "*do you just wanna, just, just explain to everyone?*". She let him explain, but after he had explained, she defined his task as *"having to be Ismail(cm)'s memory";* 3)Finally, from a powerful position with a collaborative voice she requested help from the group: "*But you would like parents to…help…him with his targets from yesterday, don't you?"*, positioning Ibrahim(pm) as powerless/voiceless/non-agentic and Ismail(cm) as vulnerable/non-agentic.

2.2.1.4.3.-Conclusion of the detailed analysis of therapists' powerful positioning with collaborative voices:

The therapists' position was powerful not only because they showed semantic, quantitative and interactional dominance in the above extracts[48], but also, given the contextual and external factors described in section 2.2.1.1, because power is relational- a process. The exemplars showed how it changed in dialogue. At times, therapists used a collaborative voice to try to share power with a 'vulnerable' group member, by giving them authority/agency, but this voice was often followed by utterances from a powerful position which undermined the previous collaborative voice. This was possibly unintentional, but it still positioned group members as powerless/non-agentic. In both extracts I identified six instances (in total) of this happening. These examples support the idea that the powerful position and collaborative voice are intertwined.

[48] See appendix 18 for other examples.

From a powerful position and by using a collaborative voice, therapists invited others to participate in a dialogue. They motivated group members to participate in what seemed to be voluntarily supportive interactions, by participating in/presenting to the group. They also encouraged positive working and bonding relationships between everyone by being curious, taking an observer's position, and inviting them to reflect and be empathic towards each other, which helped group members to feel listened to and part of a supportive 'community of help'. They also invited participants in dialogue to support each other, by listening and sharing ideas (fostering group cohesion). For instance, therapists focused on enactments or group members in a vulnerable position, thereby 'pulling in' quiet clients.

It is unclear whether positive bonding relationships facilitated dialogues in the group or whether, as therapists created a context for dialogues, this impacted on the positive bonding relationship between group members. Dialogue may be a way of 'performing' positive bonding relationships and experiencing positive relationships, which may in turn make it more possible to have a dialogue. I am aware that there might be other possibilities that I have not considered.

2.2.2.-DETAILED IMPACT OF DIALOGICAL/CONTEXTUAL FACTORS ON DIFFFERENT ASPECTS OF GROUP COHESION:

2.2.2.1.-INTRODUCTION:

I will now describe in more detail how therapists' positioning created a space, which contributed towards vertical and horizontal group cohesion developing; a space where participants felt safe, had a sense of belongingness to the group and remained focused on the therapeutic tasks. They achieved these, both by taking powerful and collaborative positions/voices. I will give examples from both therapeutic sessions to describe these aspects:

2.2.2.2.-'BUILDING RELATIONSHIPS':

2.2.2.2.1.-Creating a safe context:

2.2.2.2.1.1-Which encouraged vertical group cohesion by:

(From a powerful position)

- Creating the group structure made them feel safe, as group members knew what to expect and who managed the group.

(From a powerful position with a collaborative voice)

- Managing tension or criticism by using distraction/curiosity. This allowed group members to feel protected and not completely vulnerable (e.g. Harriet(pf) quietly challenged Jamil's(cm) passive behaviour: *"/It's not important to him, so he just sits there",* Paul(T) was curious and focused on Jamil's(cm) behavioural change: "*So, what choices are you making in that moment there?"*).
- Managing enactments until they were resolved. By doing this, therapists embedded members who were in a vulnerable position, and struggling because their children's behaviours interrupted the group. The parents involved might have felt supported and/or ashamed/vulnerable.
- Listening: group members felt valued and respected by therapists (e.g. sometimes therapists paraphrased or gave a summary of what a group member had said). For instance, when talking about how each family member managed the X-box, Asir(pm) said: *"It is good when you can use it like negotiating with your child".* Paul(T) responded: *"So you use it sort of as a powerful thing to help you with your parenting to negotiate.... as a reward";* When talking about how children could gain more confidence, Jonathan(cm) suggested: *"Talk to themselves in the mirror".* Judith(T) paraphrased: *"OK. So basically, self-talk can help"*.
- Eliciting confidence/self-agency through empathy: (e.g. when Paul(T) said: "*what do you think that that is like for him* (Asir(pm)) *to see that actually, amongst all the distractions… that actually he sorts of sit"*.

(From a collaborative stance)

- One of the therapists made a self-disclosure (the children knew s/he was a parent). This probably made group members feel connected/better understood by this therapist.
- Therapists used touch as a way of connecting warmly with group participants: Paul(T) touched Trudy(pf)'s shoulder and patted Jonathan(cm) on his back. Male group participants sometimes initiated handshakes with the male therapist.
- Therapists adopted a playful stance, which fitted with the children's developmental stage and probably made them more approachable. They used activities such as masks and speed-dating, talked about football and used humour.

Briefly, all the aforementioned factors contributed to vertical group cohesion, as when therapists offered a group structure, managed enactments, tension/criticism, and when they listened to group participants, they were likely to be perceived by group members as a therapist with expertise, 'who cared'. Additionally, when they used touch and showed empathy, they were likely to be perceived as someone warm who cared. Self-disclosures invited therapists to be perceived as similar (e.g. on the same wavelength regarding life perspectives/experiences/values). Finally, using a playful stance made sessions less formal and therapists easier to relate to, especially for children.

2.2.2.2.1.2.-Which encouraged horizontal group cohesion by:

(From a powerful position)

- Creating a community with similar problems, as group members had been referred for similar reasons. So, they might see themselves reflected in others, and might have felt better understood and less likely to be judged.

(From a powerful position with a collaborative voice)

- Creating a 'community of help', where group members were able to share concerns from a vulnerable position and they could request and receive help from others, connecting them at a basic human level. However, these seemed to be initiated by therapists, which would have implications.

- Creating a space where signs of 'genuinely caring for each other' could be expressed by helping with each other's parenting (i.e. sharing ideas about managing the X-box, managing someone else's children in cross-parenting interactions).
- They also celebrated children's successes together. I assume that this encouraged children to achieve their targets.

  When Rosan(cf) and Yasar(cm) fed back their groups' discussion and talked about Jamil(cm) developing self-control, Asir(pm) said: *"Well done!"* (he started clapping and then everyone clapped). Ibrahim(pm) said: *"I think Jamil(cm), he's decided to change... so to improve that he is been working hard on this".* Then Ismail(cm) clapped spontaneously a few times. When he looked at Jonathan's(cm) targets and his progress, Asir(pm) said: *"WOW!"*

- Use of touch was observed to occur spontaneously both intra- and inter-families. In general, the response to touch was positive. They used it when greeting each other, praising, getting someone else's attention, and as a way of connecting with each other, warmly showing care. Overall, touch was mainly observed with children (apart from handshakes between the male therapist and male group members). It is unclear how touch developed in the group, whether it was due to individual preference/personalities/cultural practices, or whether it was because families were touched by therapists or because they observed touch between group members. The following are examples:
  - When greeting each other: Eric(cm) hugged Yasar(cm) when he arrived, Salma(pf) stroked Yasar(cm) and then he stroked Eric(cm). Asir(pm) shook hands with Jonathan(cm).

    In the second session, during the speed-dating Emira(pf) touched Jonathan(cm) and Yasar(cm) and shook hands with Ismail(cm) (he smiled) and Jamil(cm).
  - When praising others: Therapists praised group members and group members also praised one another.

    Harriet(pf) gave a Hi5 to Eric(cm) after he had rung the bell. They both smiled. The bell rang again and then she clapped

before Eric(cm) left. Harriet(pf) also gave a Hi5 to Yasar(cm) three times.

In the second session, during the speed-dating exercise, Emira(pf) praised Jamil(cm), saying: "well done". She briefly touched his hand and leg.

- To <u>show care:</u> e.g. Harriet(pf) touched Jamil's(cm) thumb when he complained about some pain.
- <u>Playfully connecting with others:</u>

  <u>INTERFAMILIES touch:</u>

  <u>Children:</u> Rosan(cf) called Eric(cm) by grabbing his hand and then hugged him. Later, she pulled his cheeks and said*: "oh, I love those cheeks".*

  Eric(cm) often connected with Yasar(cm) by touch, e.g. hugging him to greet him. Yasar(cm) patted him in response. During break time Yasar(cm) hugged Eric(cm) spontaneously. Ismail(cm) touched Jonathan's(cm) shoulder and carried a younger child.

- <u>Listening</u>, this helped group members to feel valued and respected by the group, and showed that they cared about each other.
- <u>Empathy</u> seemed to develop in pairs. For instance, Rosan(cf) and Yasar(cm) seemed to connect. They developed an 'older-younger sort of sibling relationship'. Rosan(cf) looked after him and Yasar(cm) accepted this. When they were about to present to the group, she told him in a 'sweet tone of voice': "*you got to explain it, you don't have to read it like that, you can just tell them".* Trudy(pf) also connected with him and, after he presented, she told him: *"well done Yasar(cm)!"*. Cathy(pf) often encouraged others: "*they are trying their best"*.
- Creating a context which encouraged <u>dialogue and reflections</u> between group participants by inviting members to participate in dialogical dialogues, by being <u>empathic and</u> <u>curious</u> about each other. Paul(T) asked rhetorical questions and invited others to be curious. I also identified a few examples

when therapists had been curious and the group members were curious in response:

- Paul(T): *"Can I just ask, can I just ask before we all move on quickly, What do you think the IMPACT is on Yasar's(cm) mum when Yasar(cm) is LISTENING MORE?".* This seemed to encourage empathy by inviting them to be curious and reflect about someone else's life/mind/emotions. Cathy(pf) responded immediately, saying that it had a positive effect;

  Paul(T): *"What choices is he making there?",* referring to Ismail(cm)'s self-control.

  These encouraged empathy, curiosity, reflection about someone else's life/mind/emotions and focused them on individual strengths/changes.

- Paul(T): *"Can I,* can I just, can I just quickly*, because ...I'm kind of quite intrigued that you sort of mentioned your Xbox and you are addicted to your PHONE. How do other parents manage Xboxes and phones... in your house?".* Paul(T) invited others to share similar/different experiences which initiated a lengthy conversation. Children voluntarily participated most in this dialogue in both sessions. 4/6 spoke and most adults spoke dialogically because they were curious about other families' ideas.

Briefly, when the therapists invited group members to be curious about each other, they were also invited to: connect emotionally through empathy, and reflect about someone else's life/mind/experiences; they were able to share similar experiences, which made them feel that they were not alone; they took on vulnerable positions, as they were encouraged to request and receive help from others, but also to try more confident parental positions when cross-parenting in the group or being supported whilst parenting their own child in a Multifamily context. In this way they learned from each other, felt supported by others and they shared enjoyment when therapeutic goals were achieved. Finally, this was experienced as group members 'genuinely caring about each other', as they were listened to, felt empathy for/from each other, cared about each

other's children and spontaneously used touch in their interactions. Touch could either be a sign of horizontal group cohesion or that group cohesion had developed through participants using touch to physically connect with one another. All of the above contributed to horizontal group cohesion.

2.2.2.2.2.-Creating a space where members felt belongingness:

2.2.2.2.2.1-In relation to vertical group cohesion:

In their interactions, as the leaders of the group, they created a space where group participants felt a sense of belongingness to the group, despite differences, by developing significant relationships within the group by:

- Using group members' personal names, which conveyed that members were valued by therapists.

  Paul(T) used each of the children's names when he asked them what tribe they were in. Sometimes, Judith(T) also used the parents' names: *"…Another tribe? Kazima(pf)'s tribe?"*.
- When therapists showed that they were listening to participants, they felt valued.
- Using metaphoric language, which embedded group members according to their interests. This sometimes worked across cultures. For instance, in session 2, the targets were reviewed by grouping each family into "tribes" ("Chio"). This was inspired by the interest of a child in "Legochima". Additionally, Paul(T) often used metaphoric language in relation to football: Asir(pm): *"What do you think that is like for, I was going to say Jose Mourinho (Asir's(pm) nickname), but actually Jamil's(cm) dad?".* This was also followed by group members: *"Asir(pm): Go on Jose Mourinho show us"* (looking at Kamal(cm)).
- Involving group members who were not directly involved in the task. Overall, there did not seem to be explicit reluctance from any participant to engage in the activities. They were all sitting, but not always necessarily fully participating. Therapists engaged group members not directly involved by:

- Giving them different roles (e.g. to 'observe' or 'reflect'), which invited them to participate and conveyed the message that they were valued members of the group:
  Judith(T): *"So, now is the chance for... people that made their masks to... present them and for people who are watching to... let's find out what's behind the mask...".*
- Asking open questions to all the participants:
  Judith(T): *"what about talking to the person behind the mask? finding out more about them? interview them!".*
  Judith(T): "Anyone can ask questions".
- By making participants feel that they were important by supporting a child's target. Joining parents together in their parenting tasks so that they had mutual investment in each other's development (supporter or supported).
- Paul(T)*: "OK! So, when we go around and have a look at everybody's targets".*
- Providing therapeutic props, such as masks (which attracted group participants).

- Asking for help: From a position of power, therapists asked group members to help/collaborate with practical things. Jonathan(cm) and Ashar(cm) helped with the chairs, but it is unclear if they volunteered or were asked to do so.

To summarise, in their interactions with group members, therapists created a space where participants could feel belongingness to the group, despite their individual differences and this contributed to vertical group cohesion. They achieved this by using their personal names or focusing on their area of interest, thus making them feel listened to and valued, in order to engage them and embed them into the group. Finally, they actively involved group members who were not the focus of or directly involved in the tasks, in different ways.

2.2.2.2.2.2-In relation to horizontal group cohesion:

Multifamily therapists created a space where participants developed relationships between themselves, which facilitated their feelings of belongingness to the group and connection with each other by:

- Providing opportunities for informal interactions. For instance, Cathy(pf), Trudy(pf) and Harriet(pf) laughed together during the break. It is interesting that Cathy(pf) left after the break. It is unclear whether it was due to timing or if she stayed for the break because she enjoyed the informal interactions.
- Sharing similar difficulties, so they could identify with others and feel that they were not experiencing these alone.
- They were all invited and expected to participate in the activities.
- Engaging group members in the activities, even when not directly involved This communicated that they were all there together and were valued.
- Sharing and reviewing targets together. For example, during speed-dating.
- Group members were able to share concerns, from a vulnerable position, whereby they requested and could receive help from other group members. This seemed to be mainly initiated by therapists and, if that was the case, it would probably have an impact on group cohesion, as members might have felt pressure and/or vulnerable/ashamed.
- Creating a 'community of help', where group members showed that they 'genuinely cared about each other'. They also did this by cross-fostering and giving opportunities, being 'outsider witnesses' and praising each other.
- Inviting group members to reflect about someone else (using curiosity, empathy, feeling listened to): "*what's behind the mask?".*

Briefly, Multifamily therapists created a space where group participants developed relationships between themselves, which helped them feel a sense of belongingness to the group. Parents also joined in their parenting tasks ('cross-fostering'), encouraged by therapists. As part of the group structure, they provided different opportunities for informal interactions throughout each session. As they shared similar difficulties, participants possibly felt 'not alone', understood by others and not judged. Their individual targets were shared and they created a 'community of help', where they supported and encouraged each other to achieve their individual/family goals and

spontaneously celebrated their achievements. All group members were invited and expected to participate in dialogue (reflecting, listening to each other) and they actively engaged group members in the activities, even when they were not directly involved. This communicated that they were all valued and respected in the group and that change was a shared task, nurturing horizontal group cohesion.

2.2.2.3.-'WORKING TOGETHER'- from a powerful position:

- Therapists provided formal/informal activities that connected group members and helped them to review their targets, during speed-dating, and discussing emotions, parenting/boundaries (use of X-box).
- They stopped group members digressing: Pre-speed-dating, Judith(T) said: "*that could be your goal when you talk to him".* Paul(T) told Jonathan(cm): *"you are talking batman".* Paul(T) asked Yasar(cm) to *"hold on for a second".* Judith(T) also tried to bring back a child who had left the group: *"where is Ismail(cm) gone?".*
- They reminded group members of the task at hand: Paul(T) refocused the group members on the task by repeating the instructions several times: *Headlines! Headlines!"*. They reviewed activities: Paul(T) asked: "*where did we get to?"*, as the group had been distracted by a toddler by an open door.
- Focusing on children's positive changes and encouraging these by allowing time to expand these stories.
- Including group members not directly involved in the task by giving them a role, e.g. an observer, which made them feel valued and stay focused on the task (as an outsider witness).

In brief, therapists actively invited group members to remain focused on the therapeutic task by organising activities and using different techniques, such as encouraging them to focus on the activity, the present moment, and what was relevant, including children's positive changes; and by giving them a role (e.g. observer) when not directly involved.

2.2.2.4.-Conclusion of detailed impact of dialogical/contextual factors on aspects of group cohesion:

I have described in detail and given many examples of all the aspects of the therapists' positioning that contributed to vertical group cohesion by creating a safe context, including: offering a group structure, listening to group participants, managing enactments and tension/criticism (these helped therapists to be perceived by group members as experts), using touch and showing empathy (which helped therapists to be perceived as someone warm who really cared), adopting a playful stance and making self-disclosures, which made sessions feel less formal and therapists more approachable (being perceived as similar). Therapists also created a safe context which contributed to group members developing horizontal group cohesion by inviting them to be curious about each other, connect emotionally and empathically, share similar experiences, request and receive help, as part of a 'community of help', where therapeutic achievements were celebrated spontaneously (genuinely caring about each other and using touch).

In terms of belonging, from a position of power with a collaborative voice, therapists created a space where, despite individual differences, group members felt belongingness to the group, by using their names, and focusing on their personal interests (e.g. LegoChima, football or sense of humour). Significantly, they actively involved group members who were not directly involved in a particular task. This supported vertical group cohesion. Additionally, therapists created a space where group participants developed informal and formal relationships between themselves. They seemed to feel valued and respected in the group and children's individual targets were shared, which created a 'community of help' as group members encouraged each other to achieve their individual/family goals. This helped them feel that they belonged to the group and encouraged horizontal group cohesion.

Finally, therapists also actively invited group members to remain focused on the task by organising formal and informal activities and using different techniques, such as stopping digressions by reminding them of the tasks and giving group members a role to engage them in a task.

2.3.-I will now consider my second research question: ***WHAT DO MULTIFAMILY THERAPISTS DO IN DIALOGUE THAT INADVERTENTLY HINDERS THE HORIZONTAL AND VERTICAL GROUP COHESION BETWEEN MONOLINGUAL AND MULTILINGUAL FAMILIES?***

2.3.1.-INTRODUCTION: I identified four factors related to the therapists' interactions that seemed to negatively impact on how therapists encouraged 'building relationships' and 'working together' as a group.

2.3.2.-Group members disengaged when not directly involved in an activity: Even though therapists actively tried to involve all group members, at times they disengaged when not directly involved in an activity and this seemed to have a negative impact. I observed some participants seemingly feeling unsettled as they arrived late and did not know what was happening. There were different reasons for them not being involved in the activity:

Due to attendance arrangements:

Different days: As this was an open group, group members attended on different days of the week. If an activity which started one day was not completed, then it could be followed up another day with a completely different group of participants. This seemed to have a negative impact on the group members. For example, in session 1 Eric(cm) did not want to leave because he had made a mask and they were going to focus on these. As the group focused on two families (Rosan's(cf) and Yasar's(cm)) Ismail(cm) disengaged. He seemed to feel like an outsider: *"he was a little bit worried about the fact that he hasn't done the mask today"*. He struggled to get/remain involved in the activity. He left the small circle a couple of times and returned. Ismail(cm) talked to Jonathan(cm). He asked his dad *"can we go now?"*. In session 2, when one child's target was being discussed for a while, Jonathan(cm) asked his mother: *"can we go now?"*.

Leaving early or arriving late: due to external commitments, which seemed to have been arranged with the therapists beforehand. However, therapists did not seem to inform latecomers what was happening when they arrived. They were not slotted into the activity, and were then effectively excluded and they might have felt that they did not belong/were not valued. For example:

In session 2, four families arrived late and the therapists did not explain to them what was going on in the group. This might have been because the activities at the time were activities that they often did (individually reviewing the targets with therapists), so, they

might have known what was expected of them. For instance, when Jonathan(cm) and Harriet(pf) arrived late, they were not greeted by anyone and they did not greet others. Therapists did not explain to them what the group was doing. Jonathan(cm) seemed disorientated for a couple of minutes (he wandered around aimlessly), possibly feeling that he did not belong/was not valued. No-one noticed this.

In session 2, Judith(T) pre-empted that Rosan(cf) and Trudy(pf) would arrive late, but when they arrived (around 45 minutes after the group had started) they just sat on the outside of the speed-dating exercise, watching. They did not greet anyone. Therapists did not explain to them what the group was doing. They were only acknowledged almost at the end, when Rosan(cf) spontaneously commented on her observations of the group's decisions/discussion.

Therapists focusing on one/few children:

There were a few examples in both sessions when therapists focused on only one or a few children at a time.

In session 2, during the speed-dating, each parent talked to each child, but they only reflected and fed back as a group about **one child's targets** and the other children's targets were not reviewed.

At the beginning of session 2 therapists reviewed the children's targets individually, spending **different lengths of time with each family**. Some families spoke to two therapists, and some to only one for 30 seconds: Paul(T) spoke to Jonathan(cm) for under 1 minute; Paul(T) also spoke to Ashar's(cm) family for approximately the same time. Paul(T) and Judith(T) spoke to Jamil's(cm) family for 8 minutes in 3 episodes; Paul(T) and Judith(T)spoke to Yasar(cm) for 90 seconds in 3 episodes; Paul(T) and Judith(T) spoke to Arlind's(cm) family for around 9 minutes; the student spoke to Ashar's(cm) family. I am unsure if this was an ongoing pattern or whether it shifted over time.

I wondered what impact this had on group cohesion and their sense of belongingness, valuing the group and feeling valued by them. Disengagement could be observed when group members left the room at different points. In session 1, Trudy(pf), Cathy(pf), Yasar(cm), the interpreter and

Abdo(cm) stood up when others were speaking. In session 2, Arlind(cm) and Abdo(cm) stood up again when others were speaking. In terms of safety, it would have had an impact on group members if they disclosed some information to some people at a certain time/day and then someone else joined the discussion later. Regarding the group members' sense of belongingness (group cohesion), the issues discussed above would also have an impact on this, as they might not have felt valued by the therapists, who did not seem to be aware of the impact of this on them.

2.3.3.-Difficult interactions between group members and therapists:

I will now focus on a few examples of negative interactions between therapists and group members.

At times, children put therapists in a non-expert position by not listening to them. For example, Paul(T) asked Arlind(cm) to organise the chairs. His response was: *"I hate that!".* Paul(T) jokingly said "*you love it".* Arlind(cm) still refused, repeating: *"I hate that!"* and did not do what he had been asked to do. As these interactions were observed by others in the group, parents might have thought that "even the 'experts' cannot get their children to listen/or/we are all in this together trying to work out how to get children to listen", and these understandings probably would have had an impact on vertical group cohesion.

- Extract 3[49] (lines 2297- 2322)

Whilst the group was talking about Yasar(cm) and his dad's mask, Yasar(cm) put on his mask.

Yasar(cm): *And this is my mask!*

(Silence -8 secs)

(Ismail(cm) whispered something to his father).

Yasar(cm): *What?*

Jonathan(cm): *It's kind of freaky.*

[49] A detailed description of my analysis can be found in Table 5, appendix 21.

Trudy(pf): *It looks like... erm... you know, what's that one of those Indian chiefs... with feathers and erm...plus take it off, it's got his name inside there.*

(Yasar(cm) took off his mask and showed it to everyone)-(interpreter translated).
Salma(pf): *Um, um.*

Trudy(pf): *Yeah!*
Rosan(cf): (talking quietly) *Oh, oh, OH! what is it called? What's the word?*

Trudy(pf): *It's good isn't it?*

Jonathan(cm): *Native Americans?*

Rosan(cf): *Yeah, what's… what's wrong with me?... It has a specific name.*

Harriet(pf): (unintelligible) or something?

Rosan(cf): No!

Yasar(cm): *WHAT? what are you talking?*

Judith(T): *Is that a surprise to you? What did you think?* (addressing Salma(pf)).

(Paul(T) laughed quietly. He looked at Asir(pm). Asir(pm) said something and they both laughed quietly for about 20 seconds. Jonathan(cm) and his mother looked at them).

Arabic interpreter talked to Judith(T): (unintelligible).

Yasar(cm): *I don't know how to draw stars or hearts.*

Rosan(cf): *It's easy to do it!*

Judith(T): *Why is that making you laugh?*

Yasar(cm): *Yeah, that's what we did.*

Paul(T): *I think it is just really colourful and I really like it.*

Harriet(pf): (smiled).

(eye contact between Ibrahim(pm) and Ismail(cm)- unintelligible)

Trudy(pf): *Did you have fun doing it?*

Yasar(cm): *Yeah!*

Trudy(pf): *Why did you do it like that?*

Yasar(cm): *Because, erm I wanted to write my name on it... I like my name on it.... I was gonna do... I was gonna do 'Yasarboss' (smiling).*

Trudy(pf): *Oh, boss?* (laughs).

Yasar(cm): *Yeah!* (laughs together).

Paul(T): *Can, can I just check in with Salma(pf) actually? Salma(pf) you were not here yesterday, but your husband was, who did that mask... Yasar(cm) can you just hold it up?*

Group members, including a therapist, seemed to be subtly negative towards/critical of Yasar's(cm) mask. Yasar(cm) did not follow the conversation, maybe because he was the youngest member of the group, but he felt tension in the interactions. Trudy(pf) seemed to be working very hard in this extract, perhaps because she was trying to counter the tension felt in the group. At this point, Judith(T) addressed Salma(pf), changing the subject by saying: *"Is that a surprise to you? What did you think?"*. It is unclear whether this was as a response to the tension in the group

(present moment). After that, Paul(T) laughed. At this point, he seemed to be positioned more like another group member, rather than a therapist. He connected with a father by sharing a private joke, but not necessarily with the whole group or Yasar(cm). Following this, Judith's(T) intervention was: "*Why is that making you laugh?"*. His response did not seem genuine and other group members noticed this (smiles and eye contact). I wondered about its impact on vertical cohesion (feeling valued, trusting the therapist), both for Yasar(cm) and the others who witnessed these interactions. After this intervention, Paul(T) reconnected with his therapist' position, as moments after praising the mask, he then invited dialogue through semantic dominance saying: "*Can, can I just check in with (Yasar(cm)'s mother) actually? Salma you were not here yesterday, but your husband was, who did that mask... Yasar(cm) can you just hold it up?".*

2.3.4.-Not using participants' names:

Sometimes group members or therapists forgot to/did not use participants' names, which is likely to have had an impact on their sense of belongingness and safety. I noticed this more often when the names were from a different language. It is unclear why this happened; whether they could not remember or could not pronounce them. It is also unclear if these were one-off incidents or ongoing patterns over time.

The following are examples: *"Cathy(pf): Kamal(cm) and erm, erm, Jamil(cm)*". Paul(T): "*Some families need to leave like Kamal(cm) and…., erm"*. Judith(T) completed this, saying*: Cathy(pf)*. Judith(T) did not use Salma's(pf) or Emira's(pf) names. Instead she pointed at them when asking them about their tribes.

Sometimes therapists used participants' role rather than their names when they talked about them: *"He's been good dad"* (to Asir(pm)), *"Impact on Yasar's(cm) mum"*. Paul(T) also used a playful/football related nickname when referring to group participants: *"What do you think that is like? I was going to say Jose Mourinho, but actually Jamil's(cm)'s dad"*. This example shows some of the complexity of group cohesion as it seemed that there was a warm/playful connection between Paul(T) and Asir(pm), but also, as his name was not used, this might impact on vertical group cohesion as it seemed that his identity could not be fully valued/recognised.

2.3.5.-Not listened to/addressed/responded to: There were a few examples of group members frequently not being listened to, which probably impacted on their sense of safety and belongingness:

In both sessions I noticed that Jonathan(cm) was interrupted and not listened to by the therapists on various occasions. I wondered if he felt **misunderstood, not valued or mistrusted** by them. However, he still participated. For instance, when Paul(T) asked Abdo(cm) directly what his tribe was, he gave the wrong answer (line 409). Jonathan(cm) corrected him and gave the right answer, *"mammoth"*, a few times (lines 421, 460, 464, 468). After his fourth attempt, Paul(T) listened and repeated his answer (line 478). Similarly, after Paul(T) recapped the aim of the speed-dating exercise and told the adults about their role, he asked the group if they had any questions. Jonathan(cm) raised his hand, but Paul(T) did not seem to believe that what Jonathan(cm) was going to ask would be relevant to the activity: he asked Jonathan(cm) *"about LEGOchima?*". His answer was unintelligible, but then Paul(T) asked again: "*Any questions ABOUT the LEGOchima?"*. Similarly, when some of the children started talking between themselves, Paul(T) told them: *"guys, just, can I sorry, just before we go on… I'm not sure what/how much what you are talking is relevant"*. However, Jonathan(cm) seemed to have been listening and he felt misunderstood, as he replied: *"IT IS!, we are talking about masks!"*. Paul(T) replied: *"you are talking about batman and things like that"*. He did not seem to believe Jonathan's(cm) explanation. Paul(T) responded from a powerful position whilst trying to refocus him, but this rupture might have shut Jonathan's(cm) curiosity down as he seemed less involved afterwards. This example shows how adults' preconceived ideas about a child shape their interactions with him rather than being open to discovering something new/changing/changed about him.

Similarly, **the voices of the mothers with interpreters** seemed silenced. They were not addressed directly and they hardly participated in any dialogue. I assume that this had an impact on vertical and horizontal group cohesion, as it would affect their sense of being valued/recognised/belongingness and the group's sense of them belonging to the group (vertical/horizontal group cohesion). This is a very significant finding, as therapists seemed unaware that they were not enabling them to engage with others, and neglecting to engage some members who are already marginalised in the wider context due to language differences.

Likewise, Alisha(pf) only **spoke when directly spoken to**.

2.3.6.-Gender issues of power: Even though both therapists had interactional/semantic dominance, overall Paul(T) shaped most of the dialogue's content. I assume that they had decided on the activities together, but Paul(T) always presented the activities to the group. He asked rhetorical questions and invited others to be curious.

2.3.7.-Conclusion: In brief, in this section, I described a couple of difficult interactions with therapists, which were observed by others. I identified four factors which impacted negatively on vertical and horizontal group cohesion, including their sense of safety and belongingness to the group. 1) At times, therapists forget or did not use group members' names; 2) Group members seemed unsettled when they were not directly involved in the activity because the activity was a continuation from another day, when they arrived after an activity had started and they were not slotted in, when they left early; 3) If therapists focused on one or a few children, and did not listen to/address group members who remained silent; and 4) difficult interactions between group members and therapists.

2.4.-I will now consider my third research question: ***WHAT IS THE INTERSECTION BETWEEN MFT, GROUP COHESION AND LANGUAGE, INCLUDING INTERPRETERS' ROLES?***

2.4.1.-INTRODUCTION:

Considering both MFT sessions, I highlighted where I thought there were significant issues around the intersection between language and group cohesion. In the first MFT session there was one interpreter, and in the second MFT session there were three official interpreters and an unofficial interpreter (a family member). Throughout the sessions, the pace was very fast, which must have made it difficult for any interpreter to translate everything. It is interesting that the only time the pace was slower in session 1 was when the therapists focused on Yasar's(cm) family. I also noticed more silences during that time. As stated above, the voices of mothers with interpreters seemed silenced.

2.4.2.-INTERPRETERS:

Interpreters as co-therapists: There was a regular Arabic interpreter, who had attended the group with different families for a few years. She had a very active role which included sometimes helping out spontaneously with setting up the room.

The interpreters **did not always translate** what was said. For instance, when Emira(pf) was asked for feedback, the interpreter answered for her without consulting her*: "/The same thing happened with us* (Emira(pf) nods looking at Judith(T)). *When we asked him questions, he just give us short answers erm… He has to concentrate and listen more but he can't, he can't, he cannot stop moving, so that is the main problem. So…/ Judith(T): /And on the particular target of his listening within 10 seconds. Eastern European interpreter: One*". Similarly, I observed that the Eastern European interpreter did not translate the instructions on three occasions.

This did not seem to be noticed/addressed by the therapists. There were other times when interpreters replied without consulting with/translating to the mothers. The Arab interpreter shared her own views about group members: *"I really like that she is encouraging him"*.

However, there were other examples when the interpreters translated (Arabic and Sudanese interpreters). For example, when the therapists asked for feedback from parents, opened the floor to everyone, Kazima(pf) responded through the interpreter. The interpreter used the mother's voice: *"<u>She</u> thinks you are right*". Similarly, when asked to vote for something, the interpreter used Salma's(pf) voice: *"Salma said yes"*.

Additionally, I also noticed a few examples when the **interpreters had a more active role than parents,** who then remained silenced.

Therapists asked Salma(pf) to provide feedback about whether to give a child points for listening or not, but the Arabic interpreter answered for her without even translating. The therapists did not address this. In session 2, when Yasar(cm) was working on the table, the interpreter was involved in the work and his mother was not involved. Likewise, when they were about to start the speed-dating activity, Emira(pf) unenthusiastically grabbed the targets from her son. She then

gave the paper to the interpreter, who talked to the boy, and pointed to things on the paper, but she did not translate for his mother.

Even though Salma(pf) had an interpreter, **interpreters' roles were not clear to all participants.** Yasar(cm) did not understand the role of the interpreters. He was due to present and he was asked to get the group to be quiet, but as the interpreter was translating, he said that she was talking and should be quiet for his presentation. The interpreter replied that she was translating. Therapists did not respond.

Informal conversations and use of interpreters: I noticed that all the Arab women greeted each other, rather than other members, and also sat together during the speed-dating exercise. Interpreters were not 'used' during breaktimes and there were not many informal interactions between families who spoke different languages (apart from some acknowledgement of each other). I am unsure whether cultural differences in performing greetings is/was ever discussed explicitly in a MFT group, perhaps to develop a group culture of greetings, including addressing the lack of greeting of those who arrived late.

2.4.3-CHILDREN'S INTERPRETING ROLE/SILENCED MOTHERS:

As stated above, some parents seemed to be silenced. For instance, Paul(T) asked Salma(pf): "*So, which tribes do we have around here? Which tribes have we got?*". She did not answer this and seemed confused by his question, even though the therapist had been talking about each family tribe for a while. He then started asking the children- Ismail(cm), Yasar(cm), and Abdo(cm)- directly and they responded. It is unclear whether Paul(T) decided to ask the children their tribe because Salma(pf) seemed confused and did not respond, so he thought that the children would understand English better, or just because he was using metaphoric/playful language which might engage the children and be more easily accepted by them.

During the speed-dating exercise, some children gave the adults the targets (Yasar(cm) and Abdo(cm)), but Jonathan(cm) and Ismail(cm) read them out, with people who need an interpreter. When Emira(pf) got Yasar's(cm) and Abdo's(cm), she returned them to the boys rather than asking the interpreter to read them. I wondered whether, if these mothers are in a silenced, marginalised

position, then it might be difficult for them to ask the interpreters to translate when they are not doing so.

At times, children took on/were given "interpreter's positions" throughout the group session, Yasar(cm) was more vocal than his mother, who only spoke a few times, when she was addressed directly. He also answered some questions specifically asked to her. As mentioned in extract 1, when Yasar(cm) supported Eric(cm), Yasar(cm) told his mum: *"I ALREADY DID!".* It seemed that his mother had been supporting Alisha(pf) by prompting Yasar(cm) to encourage Eric(cm) to leave. However, she was not following the conversation, possibly due to its pace, or because the interpreter had not interpreted everything for her. So, she was not aware of the details. Yasar(cm) replied to his mother that he was 'fed up', because she was not aware of what he had already told Eric(cm).

It would be interesting to know if Salma(pf) collaborated by proxy. If that was the case, it is not clear if this was because: she thought that Eric(cm) would listen to him more, she felt silenced and she did not feel that her voice would be heard through an interpreter, or she felt she could only speak when she was addressed directly or she did what happened outside of therapy: putting Yasar(cm) in an "interpreter's position" (being her voice) out of necessity.

Likewise, it was also noticeable that even though Salma(pf) had an interpreter when she was asked something directly, Yasar(cm) was then immediately asked the same thing or he spontaneously replied for her. For instance, when they asked her about how they managed the Xbox, Yasar(cm) said: "*My mum said that I can play with my Xbox"*. Similarly, when Judith(T) asked her: "*So, Salma you learned something about your husband?"*, Yasar(cm) replied: "*He just put a lot of glue everywhere, glue on there, and he put SO much glitter all over…".* The therapists did not notice this, and they asked Yasar(cm) more questions: Judith(T): *"What was it like for you doing it with your dad?"*. Yasar(cm): "*erm, funny!!"*. Similarly, Judith(T) asked Salma(pf) to give feedback about the speed-dating exercise: *"Ok, Salma's tribe. Yasar(cm), what tribe are you?"*. She was not given a chance to reply. Instead Judith immediately asked Yasar(cm), who took the paper from his mother and said: "*Let me see".* He said the name of the tribe and then the interpreter gave the feedback, but she did not seem to be interpreting when she gave the feedback. Salma(pf) seemed silenced by everyone and no one noticed this.

2.4.4.-Conclusion: These findings highlight not only the importance of speaking at a slower pace in conversations with families who need an interpreter, but also of creating a space where everyone's voices can be heard, in particular those of silenced/marginalised parents. However, this seems more difficult when a group is involved, as therapists have to manage more people speaking at different paces. Therapists also need to pay particular attention to whether interpreters are doing their job, including during breaktimes and not being more active than families.

CHAPTER 3-CONCLUSION

In this chapter I have explained in detail my analysis of the Multifamily sessions, focus-group and the therapists' interview.

I first considered: *What do Multifamily therapists do in dialogue to create a context for horizontal and vertical group cohesion between multilingual and monolingual families?* In the MFT sessions I noticed that therapists switched between a position of power and collaboration, which impacted on group cohesion. Therapists used a collaborative voice, but they also held an inherently powerful position in their relationships with group members, which was influenced by how group participants positioned them, and their own positioning, task and by implicit/explicit contextual/external factors. Dialogically, therapists had quantitative, semantic, and interactional dominance in both sessions dialogues. From this powerful position, Multifamily therapists created the structure of the group, managed enactments, tension or criticism and listened to group participants. This conveyed that therapists could be trusted and had expertise. They seemed not to respond on purpose at times, encouraging group members to respond and support each other. It is interesting to note that there were not many examples of group members using dialogical language.

I analysed two exemplars in detail, which supported the idea that power shifts within interactions as part of a dynamic process between therapists' powerful positions and collaborative voices. I identified six instances when a collaborative voice/message was immediately followed by another message which undermined the collaborative utterance from a powerful position and positioned the parents as powerless/non-agentic. It was not clear whether these instances had a negative

impact on group cohesion, including group members' sense of being valued by the therapists and the group and being put in a vulnerable/non-agentic position, but I assume it did. This is particularly relevant to the type of families referred to Multifamily therapy groups, often described as 'multi-problem-families', who are already in marginalised positions in society. In brief, I described this as a recursive relationship, where therapists' powerful position made them feel entitled to be dominant in the dialogue and this interactional dominance involved a performance of power, which in turn positioned group members as having less power than the therapists and as non-agentic.

Additionally, therapists made collaborative gestures, and it is likely that group members perceived them as "genuinely caring". Similarly, when they made self-disclosures, they were more likely to be perceived as similar to the group members. Adopting a playful stance made the sessions less formal and therapists easier to connect to, especially for children. All of the above encouraged vertical group cohesion.

Therapists encouraged positive bonding relationships between group members and a sense of belongingness, despite their individual differences (horizontal group cohesion) by: organising a group with similarities, using participants' names, listening to them, valuing their input, focusing on their areas of interest, sharing the children's individual/family therapeutic goals, involving group members who were not the focus of or directly involved in the tasks by giving them roles (which encouraged them to remain focused), supporting each other, encouraging both formal and informal interactions between participants, and being part of a 'community of help', where therapeutic achievements were celebrated spontaneously. Therapists particularly focused on enactments of group members in a vulnerable position and 'pulled in' quiet clients by asking the group to help them, supporting them and reflecting together about similar/different experiences, learning from each other and showing that they 'genuinely cared about each other'. This embedded them in the group and created a space for empathy and curiosity towards each other, and for group cohesion to develop, including emotional and physical connection.

Therapists encouraged a positive working relationship, and remained focused on the therapeutic task, by inviting group members to participate in dialogues, organising activities, being curious, empathic, listening to each other and constructing a supportive community of help, in which group members could share ideas and difficulties. Likewise, when they organised Multifamily group

activities, such as the 'speed-dating' or 'the masked ball' activities, they seemed to create a space for participants' 'withness' interactions and group cohesion (through dialogical language), as group members were focused on the children's targets (working together), and were encouraged to support and reflect about each other (positive bonding relationship). The focus group seemed to foster group cohesion by focusing on positive experiences, i.e. 'significant cohesive moments'.

In summary, dialogical language seemed to create a space for 'withness' interactions between group members, and more group cohesion. Theoretically, over time, positive connections/interactions facilitate change rather than negative interactions/connections. It appears that there is a link between dialogue and positive bonding relationships. Dialogue may be a way of 'performing' positive bonding relationships and experiencing positive relationships, which may in turn make it more possible to have a dialogue. It seems that the focus group enabled group cohesion, as participants focused on their positive experiences and interactions as a group, including significant moments in the group. I assume that their sense of self-value, group-value and belongingness probably developed even further.

I then considered my second question: *what do therapists do that might hinder group cohesion between monolingual and multilingual families and across generations?* I identified some difficult interactions with therapists and four factors which impacted negatively on vertical and horizontal group cohesion, including group members' sense of safety and belongingness (such as at times not using members' names, not listening to them, group members not being directly involved in the activity due to group arrangements, focusing on one or a few children, or the fact that some group members were hardly addressed and remained silent). I identified a lack of trust of group members by the therapists, as they were not fully trusted to manage difficult situations or speak for themselves or focus on the work, putting them in a powerless/non-agentic position, which would possibly have a negative impact on the positive working relationships and bonding relationships (vertical group cohesion). I observed that during informal interactions, when aspects of group cohesion might show and develop, group members hardly greeted each other. So, these interactions were not maximised.

Finally, I considered my third question, *the intersection between language in Multifamily therapy and group cohesion.* My findings highlighted not only the importance of speaking at a slower pace in conversations with families who need an interpreter, but also of creating a space where

everyone's voices can be heard, in particular those of silenced/marginalised parents. However, this seems more difficult when a group is involved, as therapists have to manage more people speaking at different paces. Therapists also need to pay particular attention to interpreters, as not only did they not interpret throughout the session (including breaktimes), but they were also more active than families at times. Often mothers using interpreters did not seem to understand what was being discussed in the group. Finally, children often responded for their mothers or were asked directly by the therapists instead of addressing their mothers. It is unclear whether this is a pattern repeated outside of the group. I wondered about the impact of these children being more proficient in English than their mothers in terms of their parenting and positioning in the group and society. I also wondered whether there were cultural expectations for these mothers about how to behave with figures of authority.

Participants fed back in the focus group that they felt that they could communicate at a basic level without an interpreter during the informal parts of the session. Even though I did not observe many informal interactions between people that spoke different languages, I observed group members supporting one another as 'informal interpreters' for a father who spoke English as a second language. This possibly had an impact on group cohesion as he felt listened to and supported by them and he also supported them in response. I propose that doing activities, such as the 'masked ball', encouraged all members to join in and, by 'doing' something together, they connected, rather than 'talking' together, which requires more language skills.

SECTION F-SELF-REFLEXIVITY ISSUES

In qualitative, systemic, social constructionist research, it is essential for the researcher to maintain self-reflexivity around his/her own beliefs, personal/professional experiences and understandings of the world throughout the research process. Apart from the research outlined in the literature review, the following experiences have shaped me personally, professionally and as a researcher: my own experience of running Multifamily groups; being a woman in early adulthood (at the start of this doctorate); white middle-class; privileged as a professional; the child of a migrant (whose first language is Portuguese), and who went to a French school; being a migrant myself, for whom English is her second language and who has experienced being silenced (even though I have lived in the UK for more than 20 years); and is interested in promoting connections, integration, equality, social justice, cross-cultural therapy and multilingualism. In my family, I experienced how my father fully integrated into Venezuelan society by learning Spanish and speaking like 'another Venezuelan' and also how my grandmother did not integrate, as she continued speaking Portuguese and mainly interacted with the Portuguese community in Venezuela. When I moved to the UK, I concentrated all my efforts on learning English 'properly', possibly attempting to emulate my father, and I feel I have immersed myself in British society, but, in my eyes, I have not felt integrated to the same extent that my father did, because with my accent, I do not sound like 'another British' person and I am often reminded of this. In light of these experiences, I believe that I am more sensitive and attuned to the difficulties encountered by multilingual and minority families. As a result, I am particularly mindful of feeling a need to give a stronger voice to these families rather than to families without migration and/or integration difficulties. Obviously, I am also aware of the benefits of being multilingual (including hybridisation, different constructions of self, switching between different perspectives, Burck, 2005).

As Akhtar (1995) stated:

> L*eaving one's country involves profound losses. Often one has to give up familiar food, native music, unquestioned social customs, and even one's language. The new country offers strange-tasting food, new songs, different political concerns, unfamiliar language, pale festivals, unknown heroes, psychically unearned history and a visually unfamiliar landscape. However, alongside the various losses is a renewed opportunity for psychic growth and alteration* (pp.1052).

As a migrant, not only am I frequently reminded of these losses, but also: every time I speak in English I am reminded of the language differences; when I think about what I want to say and cannot translate; when others sometimes respond differently to me because they notice that I am 'different'; when I write (such as this research); and when I question my eloquence in English at such a high academic level.

Considering that in the four years prior to starting the research my professional role was mainly been an 'expert', a challenge I faced in the research was balancing the 'expert' and 'non-expert' positions. As a researcher, I wanted my role to be collaborative with these families and, at some point, I considered action research, but given the limited time I had to gather the data before going on maternity leave, I decided against this idea. I aimed to be aware of these positions throughout the whole process, making sure that I did not overcompensate for my 'expert position' at the time by mainly using a non-expert stance. However, as my new identity as a mother started to develop, the 'non-expert position' became more prevalent in my life, both personally and as a researcher.

Since I collated the data, due to professional and personal reasons, I have not run MFT groups. Therefore, I have not been able to use these ideas in MFT groups but, of course, many of these are also applicable to single-family therapy and I have often thought about them in connection to different sorts of groups, such as choirs, sports teams, including the CAMHS team I currently work in. This experience has not affected my motivation to complete this research, both due to my personal qualities (perseverance) and because I fully appreciate the power of this model and would like to be able to use it in the future again. Independently, my learning has been immense over the time spent undertaking this research. This includes a focus on the more intricate relationship between therapists' power and collaborative positions to create safe therapeutic contexts, with a sense of belongingness to a group, which works together well and how we, as therapists, might inadvertently position others in powerless/non-agentic positions; or as voiceless, such as when working with interpreters or with children who speak more English than their parents.

Throughout the whole research processes, the two areas that I feel I struggled with the most were choosing the method of analysis and carrying it out. There are a few possible explanations for this, including having studied psychology as my core profession in Venezuela, where I was taught from a modernist epistemology perspective to use the scientific model of research. Prior to embarking

on the doctorate, I had used Narrative and Discourse Analysis, and both of these methodologies seemed to have some sort of structure. None of the methodologies I already knew seemed to fit my data and research questions, so, I found it difficult to choose one. When I finally chose a suitable methodology, I had to learn everything by myself, and because it is a relatively new methodology, there were not many articles/books available to learn from. Finally, during these two stages, I had also recently become a mother of one child and then two children, which not only took some of my focus away from the research, but also affected my professional identity, including my identity as a developing researcher.

During the data analysis, I often wondered what effects my bilingualism had on the focus group conversation. I was also aware that having the experience/position of being bilingual invited me to focus not only on the topics of this research, but also on those members of the group for whom English was a second language or needed an interpreter. In my therapeutic work, I have always (rightly or wrongly) believed that being bilingual gives me an additional skill that I can use to connect more with clients for whom English is a second language, and who might be in a marginalised position, as I might understand their difficulties, slow down or find different ways to communicate. Even from my own privileged position as a professional and a middle-class parent, this marginalised position was highlighted when my older daughter started school and we were talking Spanish between ourselves in the playground and one of her 5-year-old friends told us: “we speak English here in the school!”.

On the other hand, my epistemological position is postmodern (Social Constructionist), whereby knowledge is uncertain and constructed in relationships, but I have also considered Critical Race Theory. Even after spending many hours on this study, as a researcher and clinician, I remain willing and able to have my knowledge challenged and I offer it tentatively, not as 'truth', but as ‘food for thought’. Additionally, as Burck (2005) observed, I understand the research accounts and observations as "constructions, not transparent accounts of what individuals have 'really' experienced, but productions in the context of social science research interviews" (p.34). In this respect, the researcher has a vital ethical role, which includes being aware that, simply by his/her presence, epistemologies impact on the research process from design and data collection to analysis and discussion.

I took a very cautious approach to the analysis and discussion, remaining mindful of trying not to make the therapists involved in the research feel that their work was being criticised. I am aware that, even with this in mind, they might still feel this way. In the first broad analysis, I noticed some differences between what the therapists did and what we did when I ran MFT groups. To address this, I considered the different contexts of the groups, which helped me to take a different view/position. Additionally, I am also aware of Rober and Seltzer's (2010) idea about therapists unintentionally acting as colonisers. This highlighted the potential for me to act as a coloniser in my privileged researcher position. I do not intend to suggest how therapists ought to be in Multifamily therapy, but to highlight what therapists did in their therapeutic dialogues with multilingual families and its implications. Additionally, the findings of this research are subjective, co-constructed, and grounded in the combination of my own understanding/experiences/interests and the research participants' opinions and presentation.

Something that became apparent after my analysis was an isomorphic process that involved my position as a researcher mirroring the MFT process. As a researcher, I have had to handle a vast amount of information from different sources, as a MFT therapist I also have to manage various tasks, activities, different group members talking, different developmental needs, cultural differences, maintaining safety, amongst other things. Both of these positions are labour-intensive, but doing this research allowed me to slow down to watch and re-view what the therapists did in the sessions and to create a reflexive space, both as a lone researcher and within the researcher/systemic community.

Finally, during the discussion, I struggled to develop the use of my own voice as a researcher. Again, some of my social GGRRAAACCEEESSS, and personal and professional experiences, have shaped this. Writing this self-reflective section has been really helpful, because it has made me think about my own biases, positions and experiences, and because it has prompted me to looking back at my reflections from when I started and how others have been very positive about the research by displaying very encouraging responses. The issues regarding working with interpreters were highlighted again when I attended a training session with a Spanish speaking presenter and an interpreter, where the interpreter changed the meanings of what the presenter said, and presented her own ideas, but other members of the audience did not notice because they could

not understand. The work with interpreters in therapy needs further development and I hope that my research contributes to it.

SECTION G-DISCUSSION

1.-INTRODUCTION

To start this chapter, I am inspired by the following quotation:

> *"a search for understanding is not to seek the undiscovered but to look at the familiar with scrutiny, with new eyes and ears, to see and hear it differently to understand it differently, to articulate it differently. The challenge is that sometimes we are so accustomed to the familiar that we miss the anomaly, the usually unnoticed, or the unarticulated expression (e.g. movement, a glance)… As Rorty suggests, something begins to happen spontaneously: the familiar begins to be talked about in unfamiliar or unusual ways, giving new meaning to the familiar to the usual"* (Anderson, 2007, pp.34).

In my analysis of the data, I looked at the familiar with scrutiny and curiosity. The aim of this section is to discuss my findings, share my new understanding and articulate the familiar differently, with new meaning, whilst also considering its clinical implications.

I have divided the discussion into seven sections. First, I summarise my findings. Then, I consider the relationship between group cohesion and outcomes. Next, I discuss how therapists' interactional/contextual/dialogical positioning impacts on group cohesion and group members. Then, I focus on gender issues of power. In the fifth section I discuss children's position in the group. The next section considers aspects of therapists' inherently powerful position, which encouraged group cohesion. The seventh section focuses on the intersection between MFT, group cohesion and language.

2.-SUMMARY OF FINDINGS

What do Multifamily therapists do in dialogue to create a context for horizontal and vertical group cohesion with multilingual families? A significant finding was that, in the MFT sessions, therapists achieved this by using a collaborative voice, but they also held an inherently powerful position in their relationships with group members, which impacted on group members' positioning and group cohesion, both in a positive and negative manner, as well as by building safe relationships between group members and therapists and between group members, who were part of a

'community of help', and developing a sense of belongingness. Dialogically, therapists had quantitative, semantic, and interactional dominance in both sessions dialogues, which positioned them as powerful. Dialogical language seemed to create a space for 'withness' interactions between group members, and in turn more group cohesion.

More specifically, the two exemplars analysed in detail endorsed the idea that power is dynamic and that the therapists' powerful position and collaborative voice are intertwined, and there is a recursive relationship between therapists and group members' positioning. At times parents were positioned as powerless/non-agentic.

Considering the question of *what hinders group cohesion* I identified the following factors which probably impacted negatively on it (including group members' sense of safety and belongingness): not using some participants' names; not responding to them; group members not being directly involved in an activity; therapists' interventions which conveyed a lack of trust of group members, putting them in a powerless/non-agentic position.

Regarding the *intersection between Multifamily therapy, group cohesion and language*, I did not observe many informal interactions between participants who spoke different languages, but I observed cohesion when group members became 'informal interpreters'. Activities, such as 'the masked ball', encouraged all members to join in (connect) by 'doing' something together, rather than 'talking' together, which requires more language skills. At times the pace of conversation was fast, making interpreting fully impossible. Children became/were positioned as their mothers' voices. The importance of creating a space where everyone's voices can be heard was highlighted in my research, in particular those of silenced/marginalised members

3.-GROUP COHESION AND OUTCOMES

When I started this study, I was attracted by the research literature around the association between group cohesion and the outcome of groups in different contexts, including therapy groups. However, it is unclear how these are associated. I was particularly interested in Burlingame, McClendon and Alonso's (2011) meta-analysis, which concluded that cohesion was reliably associated with inpatient and outpatient group outcomes, such as reduction in symptom distress or improvement in interpersonal functioning, across different diagnostic classifications.

They found that leaders who "purposefully try to enhance cohesion have a stronger cohesion-outcome relationship in their groups" (p.40). Relevant to this study, amongst other variables, they considered group structuring (e.g. sharing the rationale for the type of treatment, setting a group agenda, rules, roles and responsibilities); leaders' interventions (e.g. facilitating relationships with and between group members, showing understanding, maintaining active engagement in the group, fostering a climate of support and challenge, responding at an emotional level).

In dialogical therapy, dialogue is the process and goal, because it is believed to be associated with change. The primary aim is to create a space where joint processes happen in dialogue. Seikkula and Trimble (2005) examined what supported therapists 'as dialogical partners' in conversations, which included: creating new/shared language from multi-voiced conversation, shared emotional experience, and creating a community, "powerful mutual emotional attunement", and experiences such as: "strong collective feelings of sharing and belonging together; emerging expressions of trust; embodied expressions of emotion… [therapists] becoming involved in strong emotions and evidencing love" (p.473). I regard 'mutual emotional attunement', 'creating a community' where there is a sense of belonging/safety/trust, and showing 'genuine care' as 'moments of cohesion'. I argue that, when people have these experiences, it encourages their sense of connection, being recognised and agency in their lives, so change happens. Next, I will consider therapists' positioning and its impact on group members, including group cohesion.

4.-THERAPISTS' INTERACTIONAL POSITIONING: SWITCHING BETWEEN A POSITION OF POWER AND A COLLABORATIVE VOICE:

4.1.-CONTEXTUAL/EXTERNAL FACTORS WHICH POSITIONED THERAPISTS AS POWERFUL:

This MFT group had an agenda, both in terms of its remit (to prevent children from being permanently excluded from school) and its daily structure/organisation (activities). Most group members were part of marginalised groups in the wider social context (due to race, language, marital status). In my study, I found many contextual factors which contributed to therapists' powerful positioning, such as: the referral process; the institutions involved; being responsible for the environment, group processes, topics, activities and interactions; and managing enactments, tension and group members digressing. They were influenced by the "hierarchical context of

therapy" (Gonçalves and Guilfoyle, 2006). These factors conveyed that therapists could be trusted and had expertise, which fostered vertical group cohesion.

In comparison with single-family therapy, the process of MFT is semi-structured and there are significantly more people involved. In comparison to Open Dialogue sessions, MFT therapists manage the structure of the group, run activities, and attend to parents and children whilst enabling dialogue. When therapists provide a structure, it emphasises and communicates their inherent power position. Watzlawick, Beavin, and Jackson (1967) postulated that *"we cannot not-communicate"* and that meaning is influenced by the context in which interactions take place. Timimi (2021) stressed that "we cannot escape that therapy/treatment exists in specific contexts, as do patients' lives", as we are all embedded in our own "peculiar cultural beliefs and practices" or contexts, for example, group participants being marginalised, being migrants and therapists' roles and the fact that they belonged to the dominant community. Krause (2012b) questioned whether "power, authority, and conflict *(could)* be eradicated from the therapy room when these processes exist in the wider social institutions that provide the context for therapy" (p.16). However, in systemic therapy the controversy over the concept of power is longstanding. Since Hayley and Bateson disagreed on its usefulness to describe problems in human systems (Carr, 1991), as Hayley "argued that human relationships were characterized by attempts of one party to influence another" (ibid, p.15) and Bateson described power as a myth, as there is mutual influence between parties. This was a challenging view, as families where there is violence could be seen as having mutual causal influence or that a victim would cause the violence. Bateson retracted from these views and then the concept of 'power' disappeared from the Systemic literature until feminists challenged this as dismissing power, denies inequality (Dell, 1989).

The founders of MFT in the UK were inspired by Structural Therapy, in which therapists had a directive and central role (Colapinto, 1982; Mitrani and Perez, 2003), and expertise. Then they were also inspired by Milan Systemic Therapy, similarly, theirs and their team's authority was unquestionable. Their aim was to shift to a less central role as group processes further developed, although therapists were still centralised by families. As new ways of working systemically have developed, such as collaborative and open dialogue, there is more openness, therapists running MFT groups have had to balance not only the two positions: being directive and collaborative, but also the "invisible" hierarchies in multi-family groups I am interested in bringing these two

theoretical frameworks together. I decided to focus on dialogical aspects of MFT, and specifically on the therapists' positions and interactions. Power processes are dynamic and multidimensional in nature. Bertrando (2007) described collaborative therapists as ambivalent about the following question: "Does dialogue entail power, or does it have to be located outside power relations?" (p.167). Collaborative therapists have attempted to address social/power inequalities by emphasising the idea that therapists and clients are "human beings involved in human interaction" (Anderson, 2007, p.53) and by developing concepts/practices such as 'not-knowing'. Ong, Barnes and Buss (2020) described how doubt, not-knowing, following clients' lead, uncertainty and collaboration are ambiguous and ill-defined concepts, which provide limited guidance about how to use them in practice.

Guilfoyle (2003) stressed that power cannot be managed within the therapist-client dyad, as there are multiple influences impacting on it. He concluded that, when dialogical therapists follow 'not-knowing' practices and uncertainty, "power is deferred and denied by the therapist" (p.331), which has a detrimental impact on the therapeutic relationship, because it is misleadingly believed that power disappears if control, domination, authority and hierarchical processes and monological discourses are not used. Watson (2017) stressed that even though therapists "orient towards minimising the potentially power*ful* impact of their actions in order to preserve the relationship" (p. 80), and try to remain collaborative, they still hold a powerful position. Guilfoyle (2003), Hare-Mustin (1994) and Ong, Barnes and Buus (2020) described power as an unavoidable factor common to all therapies and therapeutic relationships.

Ong, Barnes and Buus (2020) explained that "therapists have the authority or deontic status, inherited through their institutional role, to direct and guide a session" (p.3), but authority is relational and needs to be earned. Similarly, Guilfoyle (2018) stated that "our titles, our reputations, our office spaces, and the way we are treated by fellow therapists, all play a role in constructing the interactive positions we occupy. So, we cannot fully control the positions we inhabit" (p.436). He added that we can invite clients into certain positions, but our influence is limited, "regarding their endurance, their cross-situational performativity, and the range of power relations and dynamics they will have to contend with afterward" (ibid). Ong, Barnes and Buus (2021) explained that in Open Dialogue the role of power has been under-developed. Their findings

suggested that "deontic authority[50] and directing the course of a session are not necessarily contrary to the values of Open Dialogue, but rather something that is relevant, downgraded, and negotiated by participants to varying degrees" (p.13). They examined how, when therapists propose a transition to a reflective conversation in Open Dialogue, they occupied a position of high deontic authority, but they often made efforts to present a downgraded deontic stance, by prefacing their proposals with, "I'm wondering", asking permission to have the reflection, and by providing reasons for their proposals. They argued that:

> *It is clear that the therapist exerts some control over others' behaviour by selecting the speaker and the stance position for comment, while the client or family member, within these constraints, composes a responsive action. The activity of proposing, eliciting, and responding to stances occurs sequentially across a number of turns, with different speakers and in this way is an activity jointly distributed and co-constructed by therapists and families* (ibid, pp.13).

They found that therapists' exercising authority is not necessarily antithetical to dialogue, but it may be necessary to invite polyphony by eliciting multiple stances by providing recipients with multiple avenues for responding. The context impacts on whether this authority comes from personal history, social GRRAACCESSS, expertise, or institutional position. My findings highlighted how contextual/external factors and dialogical features positioned therapists as inherently powerful (high deontic status), in their relationships with group members and their impact on group cohesion (such as group members viewing the therapist as having helpful expertise and being trustworthy).

A central theme in the analysis was the therapists' powerful positioning and collaborative voice being intertwined. Brown (2020) describes the transformative power of paradoxes and holding opposites: "knowing that two things that feel competing and conflicting can both be true". I am interested in how therapists can maintain these two positions, holding the tension between being dialogical and holding a powerful/directive position. Therapists' awareness of authority and its

[50] Ong, Barnes and Buus (2021) described deontic authority as: "the rights of a person to determine future actions in a particular domain (Stevanovic, 2018; Stevanovic and Peräkylä, 2012). While power can be considered as the ability to unilaterally impose consequences, authority is seen as legitimate and obeyed by the subject of authority with free will (Stevanovic and Peräkylä, 2012). Deontics specifically refers to how power is expressed and negotiated by participants in interaction" (p.121-122).

negotiation, potentially contributes to collaborative relationships between therapists and clients or, conversely, it can hinder them. Ong, Barnes and Buss (2021) found that empirical investigation of these intertwined positions 'in real-life therapy sessions' is scarce. Vall *et al*.,'s (2016) study about dominance and dialogue in couple therapy for psychological Intimate Partner Violence concluded that it was crucial that therapists both position themselves as collaborative and directive, as "being responsive and at some critical points directive are both parts of complex dialogical processes" (p. 230). They claimed that, particularly at the beginning of the treatment process, being "at least adequately directive" was an important strategy which interrupted the escalation of violence, as each spouse became more accountable. They did not describe in detail what 'adequately directive' meant, but added that interactional dominance "allows the therapists to regulate the speech and minimize the couple dominance and 'power and control game'" (p.230). Balancing powerful and collaborative practices is potentially difficult, but therapists need to remain reflective about these so that families are not positioned in non-agentic/powerless positions. Sempere and Fuenzalida (2017) explained that coordinating MFT groups means that, although therapists have authority and power, they need to guide group processes without being directive. They suggested that therapists' moment-by-moment self-reflexivity is necessary to encourage group responses and to control their own. Laitila's (2016) research focused on the importance of minor shifts by the therapist, introducing novelties. He concluded that therapists are able to move 'to and fro' (closer to and more distant from clients) or more or less central role in the therapy (or a powerful position and a collaborative voice). However, even when therapists have a responsive nonchallenging joining and attuned interaction with clients, they cannot remain neutral. He emphasised that therapists must actively position themselves as agents of change.

I identified sequences when a collaborative voice giving authority/power to a parent was immediately followed by another message from a powerful position which positioned group members as powerless/non-agentic and did not position therapists as agents of change. Those utterances might be received/perceived differently to how they were intended. The responses of a new and a longstanding group member or a marginalised member of society, might differ. I wondered, whether these instances had a negative impact on group cohesion, including group members' sense of being valued by the therapists and the group and being put in a vulnerable/non-agentic position or feeling ashamed. Is feeling ashamed a barrier to group cohesion? However, in a MFT group, children constantly disclose with their behaviour and this could position their parents

in such a way that they might feel ashamed. This shame may be lessened by being with others whose children were also 'difficult to manage', but heightened when it was their own child who was being 'difficult' in the presence of others.

According to Brown (2020), shame "is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love, belonging, and connection". In simpler terms it "is the fear of disconnection". This is particularly important because, as Brown also stresses, we are all "hard-wired for connection, love, and belonging", concepts that are strongly related to that of group cohesion. Dana (2020) observed that "belonging to a group or being part of a tribe has been a survival strategy throughout evolutionary history" (p.26). Therefore, when group members feel ashamed, they stop feeling connection, or sense of belonging (group cohesion) and even lose their ability to self-observe in the presence of others due to shame (Kivikkokangas, *et al.,* 2020). Kivikkokangas *et al.,* (2020) highlighted the importance of experiencing a relationship to a significant helpful other, who does not shame/ridicule/mock, as vital for change, "where the emergence of such availability seems to go hand in hand with the evolving self-agency" (p.111). Regarding what might mitigate these shameful feelings in MFT groups, I suggest either being prepared for each person potentially feeling exposed or vulnerable as part of the therapeutic process, and/or creating a 'community of help', which I described as a responsive, non-judgemental therapeutic group that shares similar therapeutic goals and where 'genuinely caring' relationships develop in a supportive manner such that they provide feedback and participants learn from each other whilst contributing towards each other's goals. Being part of a 'community of help' provides participants not only with support, but also a sense that they are not alone and there are others 'like them'.

Rober and Seltzer (2010) stated that "therapists often unwittingly and unwillingly become accomplices in networks of normalizing power, positioning families or its members as helpless and shameful" (p.4). Bearing in mind the type of families referred to Multifamily therapy groups, often described as 'multi-problem-families', who are already in marginalised positions in society, therapists' ability to generate alternative interventions and maintain their self-reflexivity to avoid putting group members in shameful or powerless/non-agentic positions is important. Based on Miller's (1976) work, Walker (2004) described a *power-over culture*, as:

> *One where those with more power act in ways that maintain the power differential, undermining any movement that threatens the status quo. The powerful behave in ways that engender conflict but simultaneously move to suppress its expression in relationship...Traditional psychotherapies arise from this larger culture* (pp.13-14).

She emphasised that therapists should ensure there is no abuse of power due to inherent power differentials in the relationship. Krause (2012b) suggested using a relational-cultural therapeutic frame, where therapists are attentive to power dynamics within therapy.

To conclude, George and Stith (2014) explained that, in therapy, different forms of power co-exist (i.e. power differentials between partners and between the couple and their therapist). The whole therapy arrangement increases therapists' power, by easily replicating "the functions of the power-over culture" (p.186). They based this description on a third-wave-intersectional position, which emphasises social justice, and where a wider range of aspects of identity (social GRRAACCESSS) are considered in an anti-oppressive therapeutic frame, which might include explicit empowerment through "consciousness raising" or using "socio-political education" (Monk and Gehart, 2003), or "activism through countering" or "activism through collaborating" (D'Arrigo-Patrick *et al.,* 2017). Afuape (2016) emphasised that, in groups, it is important to reflect on the complexity of power and privilege, thereby creating "richer, more varied and deeper forms of social action, based on greater understanding of different types of oppression" (p.55). These are difficult conversations, "partly because people do not always feel powerful or privileged and thus their social position may be at odds with how they view their personal experiences" (p.53), but they have wider contextual implications.

4.2.-DIALOGICAL FACTORS WHICH NURTURED GROUP COHESION AND WHICH POSITIONED THERAPISTS AS POWERFUL:

MFT therapists invited group members to participate in a dialogue, thereby encouraging a positive working relationship, and to remain focused on the therapeutic task and positive bonding relationship between all of them by organising activities, being curious, empathic, listening to each other and being part of a supportive 'community of help', which shared ideas and difficulties. Multifamily group activities, such as the 'speed-dating' or 'the masked ball' activities seemed to create a space for participants' 'withness' interactions and group cohesion (through dialogical

language). Other factors/strategies which fostered group cohesion included: being focused on the children's targets (working relationship); being encouraged to be supportive by reflecting about each other (positive bonding relationship); 'being touched' in close contact with others' words (Andersen, 1995); thereby inviting what Hoffman (2007) called "stifled or withheld voices" to emerge.

In my analysis, I observed that, at times, therapists seemed not to respond to group members' utterances or behaviours on purpose, as therapists have a less central role in MFT. I assume that their intention was to encourage group members to respond to and support each other. However, this might have been experienced by participants as 'aboutness' (monologic)-talk. Overall, most group members' utterances were monological and the dialogue was unbalanced. Therapists often decided when to continue or interrupt a topic. They had quantitative, semantic, and interactional dominance in most of their turns in both sessions, which I described as a performance of power and as positioning group members as less powerful, and this suggests that they might not always be responsive to clients' utterances as there was a significant amount of 'aboutness' talk/thinking. These findings indicate that group members' sense of belongingness, safety, and feeling heard or recognised would be affected, which are likely to hinder dialogical/collaborative exchanges and group cohesion. Sundet *et al.,* (2016) emphasised that, when monologue dominates, there are fewer possibilities for newness and change. Olson, Seikkula, and Ziedonis (2014) observed that the hierarchical context of therapy seems to maintain monologic talking/thinking, when therapists introduce the topics of conversation and are irresponsive to others' utterances.

Falicov, Nakash and Alegria (2020) explained that, when there is not a shared dialogue between the multiple voices present, there is a lack of "balanced exchange of talk time"[51]. They argued that "verbal dominance appeared to be a more suggestive indicator of speech entitlements and possible power differences" (p.8) in primary care visits, as shown by a lack of spaces for responses or asking clients' opinions, and clinicians presenting meanings from their powerful position as expert without generating new meanings through dialogue. Regarding quantitative dominance, I assume that, as there were so many group members, it would be difficult for individuals to exert quantitative dominance as the talk time was shared by many. However, in the case of semantic, and

[51]Falicov, Nakash and Alegria (2020) explained that "the person who initiates topics usually shapes the direction and content of the conversation, often unwittingly conveying ownership over the verbal space" (p.7).

interactional dominance, I argue that, as therapists held powerful positions and group members were more often in powerless positions, they did not feel entitled to interrupt therapists or introduce new topics. Stratford (1998) highlighted that overall therapists control the conversational floor, asking most questions and deciding on the topics, while clients tend to describe their experiences/difficulties over time. She concluded that "reciprocal assumptions about professional power and the control of the conversational process and topic change the shape and relative balance of power of the conversation in favour of the therapist" (p.387). Different social/cultural expectations might also have a bearing on this.

I argue that, to create a therapeutic context which facilitates dialogues, newness, collaboration, listening to everyone, 'responding and reflecting[52]', and where there is "balanced exchange of talk time", group members are active, and therapists do not have semantic/interactional/quantitative dominance, therapists could pay more explicit attention to their own positioning and positioning of others as powerful/valued and with agency.

Finally, in MFT, reflections are complex. Similarly, to single-family therapy, MFT therapists initiate reflections, but the difference is that responses and reflections are provided by other group members rather than therapists. Therapists' responses through 'reflections' included inviting/listening to everyone's voices and managing group interactions, which further developed participants' experience of being heard, understood, recognised and acknowledged. Ong, Barnes and Buss (2020) noticed in their Conversation Analysis study of Open Dialogue sessions that the transitions to reflections were "entirely therapist-initiated and predominantly therapist-negotiated activities" (p.5) and these were often presented as a 'downgraded deontic stance', by either asking permission using polar (yes/no) questions, giving a justification for their proposals or by downgrading practices, such as using phrases like, 'I'm wondering'. I propose that, in a MFT group, asking for reflections from other group members mitigates therapists' deontic authority and encourages 'withness' group cohesion between them.

[52] Olson, Seikkula, and Ziedonis (2014) described 'responding and reflecting' as the most essential therapeutic skills in dialogic practice.

5.-GENDER ISSUES OF POWER:

In the analysis I identified that, although both therapists had interactional/semantic dominance, Paul(T) shaped most of the dialogical content and he always presented the activities to the group. He asked rhetorical questions and invited others to be curious. I am unsure why Paul(T) had more interactional dominance, but I am curious about the impact of gender issues of power on group members of both genders, as this was not clear from my analysis. I assume this conveyed to others that he had more power within the therapists' subsystem. Vall *et al.,* (2016) found in their study that "male clients showed more quantitative dominance, whereas semantic dominance was more present in the female client, and therapists used more interactional dominance" (p.223). This might be related to dominant discourses of power and gender. Sutherland, LaMarre and Rice (2017) stated that "by leaving undisturbed the social processes through which gendered and other subjectivities and relations of power are produced, therapists may inadvertently become complicit in the very dynamics of power they seek to undermine" (p.669). Sutherland, LaMarre and Rice (2017) stated that "by leaving undisturbed the social processes through which gendered and other subjectivities and relations of power are produced, therapists may inadvertently become complicit in the very dynamics of power they seek to undermine" (p.669).

In terms of intersectionality[53], Paul(T) had an inherently powerful position by being a white British male therapist in a multi-racial group. From a feminist perspective, I wondered, how we, as therapists, enable the development of a different society in the therapy room, for example adopting an 'intersectional stance'[54].

[53] Butler (2016) referred to the origin of this term introduced by Crenshaw (1989) as a "theory to capture how different types of discrimination intersect to oppress people in multiple and simultaneous ways, contributing to social inequality and systemic injustice" (p.583) and human rights issues. Coaston (2019) described it as "a prism to bring to light dynamics within discrimination law that weren't being appreciated by the courts,"

[54] Adames *et al.,* (2018) described a visual model of both weak and strong intersectionality, which explicitly "considers the ways in which overlapping systems of oppression impact on well-being, health and resources available to clients", supporting therapists to conceptualise intersectionality in practice: either focusing on multiple identities or multiple forms of systemic oppression. They proposed that "culturally responsive and racially conscious psychotherapeutic work requires that therapists recognize the ways clients are impacted by their multiple marginalised identities and by systems of oppression (e.g., racism, ethnocentrism, sexism, heterosexism, and nativism). Attending exclusively to clients' marginalised identities (i.e., weak intersectionality) may drive therapists to only focus on internal, subjective, and emotional experiences, hence, missing the opportunity to consider and address how multiple socio-structural dimensions (i.e., strong intersectionality) may be impacting the client's presenting problems. Alternatively, focusing solely on the impact of socio-structural dimensions on the lives of clients may miss the more nuanced and variable individual personal experiences" (p.73).

Stratford (1998) stated that:

> *The emergence of power in conversations seems not to be based primarily on gender or power per se but on a subtle interplay between the two. The conversational power inherent in being a male has been shown to be insufficient in itself to establish dominance in mixed-sex conversations. When given information that allowed them to be expert within a conversation, males tended to dominate female conversationalists by talking more and interrupting, but did not do this with other men. In the same circumstances, women 'experts' responded with collaborative and supportive verbal behaviours (Leet-Pellegrini, 1980; West, 1990)* (pp.385).

6.-CHILDREN'S POSITION:

The analysis evidenced that children's voices offered as peer support were well received by other children, and better received than adults' voices. This responsiveness indicated horizontal group cohesion in dialogical interactions between children. Children seemed to be one of the most significant links interconnecting adults and fostering group cohesion. Adults often talked to children and even spontaneously managed children's behaviour when they misbehaved. Children also interacted more as a group during breaktimes. They shared both English, as a common language, and interests (football).

How was dialogue enabled with children in the MFT group? It is clear that therapists decided on a number of activities to involve children in therapy and dialogue. Children's position in the MFT group was both implicit and explicit. Explicitly, children were the target, who needed to change. Goals were created for them and these were reviewed regularly. Goals were shared and group members were encouraged to support children and parents by providing feedback or cross-parenting through mutual-support. This is similar to Anderson's (2012) notion of 'mutual inquiry', which she described as "in-there-together process in which two or more people put their heads together to address the reason for the conversation" (p.15). Children were also expected to participate in the activities. Implicitly, their voices were seldom invited/responded to. However, their voices were invited during reflections, as they fed back to the wider group, but my analysis showed that, even when the group focused on a particular child, his/her voice/opinion was not necessarily sought, nor those of other children. This positioned children as powerless/non-agentic, not only because it was unlikely that it had been their choice to attend the MFT group, but also

because they were rarely responded to/recognised/valued. This suggests that this positioning is informed by dominant discourses of power, such as Eurocentric constructions of childhood and parenting.

I suggest that this indicated a kind of 'pseudo-involvement' of children in therapy. Parker and O'Reilly (2012) described how, in family therapy sessions, children often had 'pseudo-presence' or 'pseudo-absence', as interactions had a quality of institutionally 'gossiping' in front of the children, as many therapists do not feel they have the necessary skills to manage children in therapy. Reimer (2001) also raised concerns about marginalising children in family meetings. He stressed the relevance of power issues as "children are usually brought to therapy by their parents, are often defined as the problem, and communicate in ways which adults find hard to understand" (p.53). He argued that children should be provided with information about therapy in their own language and should be actively involved. I am unsure whether therapists discussed MFT processes/aims with children prior to starting.

Children's positioning is particularly relevant in MFT, where the importance of peer support has been shown to be significant, as they learn from each other, think together about their problems and suggestions come from another person in a similar situation rather than a professional. This seems to have a positive effect not only on the specific participants involved, but also on the group as a whole (group cohesion) as they connect emotionally, a 'community of help' is created, participants feel valued, not alone, and they develop a sense of self-efficacy/agency, all of which impact on their therapeutic goals.

On occasions, children had more agency when they did not listen to their parents and the group stopped whilst their behaviour was managed in the group. When therapists responded to children's ideas, this positioned them as valued members of the group/community, improving their self-worth, and showing belief in their problem-solving skills. It is likely that this encouraged group cohesion as children probably felt recognised, safe and that they belonged, thus increasing their sense of agency.

Children sometimes seemed to have been used as a proxy for their own parent, which was connected to language issues. However, this also meant that children sometimes seemed to have

more power than their mothers, as they were listened to whereas their mothers were not. At times, throughout the group sessions, children took on/were given 'interpreter's positions'. In the sessions it was noticeable that even when mothers had an interpreter, and they were initially asked directly, their children would then be immediately asked the same question, without the mothers being given a chance to reply, or the children would spontaneously reply for their mother. Children took on and were positioned in agentic positions in these situations. This is counterbalanced by Burck's (2005) study, which highlighted how stressful and difficult it is for children "when expectations of who should take responsibility in the family were disrupted through a move into a new language and culture" (p.124). She added that parents believed that their own competence as parents "could be perturbed in subtle ways because of their uncertainty in the new language and culture… a parent could be profoundly responsive to and organized by their children's contempt, which contributed further to an unbalancing of family relationships" (p.126). I assume that these issues would also have a negative impact on the mothers, who did not seem to have a voice of their own and were positioned as powerless/non-agentic.

Sometimes, it seemed that therapists had pre-conceived ideas about children and their interactions were based on these; at other times there were many things happening simultaneously and their utterances were unnoticed and/or power differentials also seemed to play a role.

I agree with Gerhart (2007) about the importance of creating a space for children's voices to be heard as relevant, and for a collaborative and playful approach when working with children and their families. Hoffman (2007, p.74), asserted that an essential feature of collaborative dialogues is:

> *An aspiration that the conversation be 'without rank' a concept of Bakhtin's who, in his description of dialogism, talked about the "the development of familiar and intimate forms of address… more or less outside the framework of the social hierarchy and social conventions, 'without rank' as it were* (1986, pp.97).

In a MFT context, there is a need for structure, but I argue that children's voices as well as adults' voices should be sought/listened to more in MFT sessions, 'without rank', which in turn would impact on group cohesion.

7.-ASPECTS OF THERAPISTS' INHERENTLY POWERFUL POSITION AND COLLABORATIVE POSITION/VOICE WHICH ENCOURAGED GROUP COHESION:

7.1.-'BUILDING RELATIONSHIPS':

7.1.1.-'Community of help'

Building relationships in a therapeutic group is very complex. Johnson *et al.,'*s (2005) study found that group members' perceptions of their therapeutic relationships with group leaders were unidimensional (i.e. positive, negative, or neutral), possibly as leaders were more consistent, but their perception of their relationships with the other group members or the whole group had more dimensions or texture, as there are more relationship permutations. There are even more dimensions in MFT as the permutations of relationships are emotionally more complex as members of the same family are together with other families. Fostering a 'community of help' should be encouraged, both at vertical and horizontal group cohesion level. In my analysis, I divided this section between creating a 'safe context', and a space where group members felt 'belongingness'. I then looked at what therapists did, with regard to each, to encourage vertical or horizontal group 'cohesion.

I argue that dialogues may be a way of 'performing' positive bonding relationships and that experiencing a positive relationship may make it more possible to have a dialogue. I based this idea on Anderson's (2007) description of dialogue as "a relational and collaborative activity" (p.34), influenced by multiple wider contexts, discourses and histories around it, which creates connection by inviting participants to develop a 'sense of mutuality' with 'genuine respect' and 'sincere interest' in the other. Additionally, I considered Norcross and Lambert's (2018) assertion that "the alliance in individual therapy and cohesion in group therapy never act in isolation from other relationship behaviours, such as empathy or support" (p.312).

Toseland and Rivas (2005) explained that cohesive groups "satisfy members' need for affiliation" (p.75), as they not only acknowledge members' accomplishments, but also, their participation is valued and they feel they are "well-liked", providing members with a sense of security,

competence and feelings of collective self-efficacy, which impact on actual performance. These experiences are even more significant for marginalised/isolated members of society, including BAME groups, who have often had negative experiences, such as racism and discrimination. In a 'community of help', change is more possible, as there are more connections, support, and 'genuine care' shown, and members experience less isolation.

7.1.2.-'Creating a safe context':

The analysis evidenced that therapists did several things to facilitate the creation of a safe therapeutic context, both in their relations with group members and between group members, creating a 'community of help', where 'genuine care' could be shown.

Porges (2015) emphasised that humans are on "a quest to calm neural defence systems by detecting features of safety" (p.122). He described safety as a prerequisite to enable humans to achieve their full potential in various domains: social behaviour, play, and accessing the higher brain structures which allow humans to be creative and generative and healthy. If "the environment is appraised as being safe, the defensive limbic structures are inhibited, enabling social engagement and calm visceral states to emerge" (p.119). A critical aspect of therapy is the absence of evaluation or judgement, as it avoids a neuroceptive[55] state of danger.

Friedlander, Escudero and Heatherington (2006a) defined safety as:

> *The client viewing therapy as a place to take risks, be open, vulnerable, flexible; a sense of comfort and an expectation that new experiences and learning will take place, that good can come from being in therapy, that conflict within the family can be handled without harm, that one need not be defensive* (pp.110).

Families who become vulnerable and take risks in the presence of a therapist develop a new sense of intimacy, trust, and optimism. Friedlander *et al.,* (2006a) emphasised that vulnerability is closely related to therapeutic change and most therapists consider it an essential part of the therapeutic process, but we cannot assume that therapy is a safe place for all clients. Overall, the major threats

[55] Neuroception is a survival, outside of consciousness, "neural process, distinct from perception and sensation, capable of distinguishing environmental (and visceral) features that are safe, dangerous or life-threatening" (Porges, 2004, in Porges, 2015, p.119). Neuroception "enables humans and other mammals to engage in social behaviours by distinguishing safe from dangerous contexts. Neuroception is a plausible mechanism mediating both the expression and the disruption of positive social behaviour, emotion regulation and visceral homeostasis" (ibid).

to safety come from within the family system itself, in the form of conflicts, tensions, and intimidation, but also from the therapist's person, style, confidentiality threats, or not adapting therapy to the needs of the family. In a MFT group, this process is even more complex due to relationship permutations, but there are also more opportunities for 'mutual-support' and 'mutual inquiry' (Anderson, 2012).

7.1.2.1-Which encouraged vertical group cohesion?

I found that therapists' powerful and collaborative positioning/voices created a safe context, which nurtured vertical group cohesion by offering a group structure, using a playful stance, managing enactments, tension or criticism, listening to group participants responsively, using touch, humour, showing empathy and making self-disclosures. Therapists were perceived as caring, approachable experts and similar to group members (e.g. also being a parent). This is in accordance with Friedlander, Escudero and Heatherington's (2006a) description of therapists as a significant person in the client's life and the relationship being based on affiliation (being warm, down-to-earth, secure, humorous, and on the same wavelength; e.g. similar life perspectives, values, personality styles), trust, genuine caring, concern and understanding with the therapist and the belief that therapists' wisdom and expertise and optimism were valuable.

Some of the qualities/factors I identified, were also identified by Edwards' (2001) delphi study which included: being non-judgmental, understanding, a listener, having empathy, and flexibility. Edwards emphasised that the ability to be directive is very important, "when necessary, to encourage and respect group members' perspectives, to establish a safe environment, to effectively collaborate as a team member with co-therapists to support both the MFGT as a whole and various components, and to attend to the group process" (p.47). In relation to the group, therapists should "be supportive, affirming, have humour, maintain boundaries, display leadership, and develop sound judgment as to when to intervene directly with the clients and when to trust the group process" (p.49).

The process of developing therapeutic alliance is not fully clear in any modality. However, one clue to it might be a key feature of dialogical therapy, which is emphasising the present moment[56].

[56] Seikkula and Trimble (2005) described 'the present moment' as "how feelings are expressed by the many voices of the body: tears in the eye, constriction in the throat, changes in posture, and facial expression" (p.468).

Seikkula and Trimble (2005) recognised: "the importance of shared emotional experience for healing…calm, respectful conversational moves are paced to allow full experience and expression of feelings in the meeting" (p.468). Laitila (2016) expressed the view that "dialogue in the 'here and now' is emphasized in most family therapeutic orientations" (p.34). Stern (2004), a psychoanalytic theorist, described psychotherapy as a series of present moments, where sharing mutual experiences allows the creation of a new intersubjective field between therapists and patients which changes their relationship and focus, enlarging their shared intersubjective field. He defined these as important 'moments of meeting', where change happens by rewriting past experiences with the influence of present behaviours. In the MFT group 'moments of meeting' were observed, not only when there were enactments and therapists managed these in the session, but also during 'cohesive moments', such as the use of touch, metaphors, adopting a playful stance, managing enactments, tension or criticism, listening responsively, showing empathy, sharing food and making self-disclosures. Therefore, I propose that collecting 'cohesive moments', that is intersubjective experiences between group members and therapists, helps to develop group cohesion in MFT groups.

These recursive patterns of conversation might be rooted in our innate conversational, dialogical ability, as pointed out by Colwyn Trevarthen (2001), which paves "the way for acceptance that human mental development begins with anticipation of shared purposes and interests through rhythmic mirroring of expressive movements" (p.99), known as 'communicative musicality'. Babies synchronise their body movements, facial expressions and gestures with their mothers'. Itävuori and Korvela (2015) described synchrony as the "simultaneity of embodied functions", developed through intersubjectivity[57], and as "human nature's tendency to attune with each other to share the mutual understanding and meaning in interaction" (p.2). Seikkula *et al.,* (2015) noticed a complex phenomenon, where therapists and clients synchronise, as "fully embodied human beings, and therapy is much more than an exchange of words and ideas" (p.11). Seikkula *et al.,* (2018) claimed that:

> *Synchrony is not an accidental phenomenon related to the general flow of the therapy sessions; rather, it indicates how individuals regulate their affective arousal in attunement with each other. It can be said that in person-to-person situations we live*

[57] Through intersubjectivity new meanings are created (Auletta, 2012).

> *in a state of similar affective arousal with each other, meaning that we do not merely have an empathetic understanding of the other's position regarding the matter under scrutiny, but also similar embodied responses* (pp.860).

They concluded that therapists should try to avoid too much stress for clients and that respectful reflections are vital. These findings are in accordance with what I argue in relation to shame and feeling judged in therapy. I propose that 'cohesive moments' occur in a 'safe context', show synchronicity between group members and that these contribute towards group cohesion. Paulick *et al.,* (2018) used video-based measurement methods to investigate the association between non-verbal synchrony, the therapeutic relationship, therapy outcome and drop-out rates. They found a link between the "amount of nonverbal synchrony and therapeutic success; patients with non-improvement and consensual termination showed the highest level, improved patients a medium level, and non-improved patients with drop-out the lowest level of synchrony at the beginning of therapy, even when controlling for the therapeutic relationship" (p.367). Similarly, Ramseyer, and Tschacher's (2011) study concluded that "higher nonverbal synchrony characterized psychotherapies with higher symptom reduction" (p.284).

Laitila (2016) found that conversations were opened up by the therapist's responsive nonchallenging style and use of metaphoric communication by all the participants. This seemed to convey that clients' own expressions/interests were accepted and thus encouraged them to share more. Connecting children and adults is significant, but it can also be challenging. I observed therapists using metaphoric language, such as talking about football, or Legochima, which contributed towards group cohesion. This was a common language for both children and adults and, it seemed, a shared interest. Onnis *et al.,* (2007) observed a long tradition of the use of metaphors in family therapy. Bateson (1987) explained that "psychotherapy itself is a context of multilevel communication, with exploration of the ambiguous lines between the literal and metaphoric, or reality and fantasy, and indeed, various forms of play, drama, and hypnosis have been used extensively in therapy" (p.230).

My analysis showed that safety (group cohesion) was nurtured through responsive listening and empathy through dialogical dialogues. Listening has been described differently by different authors. Haarakangas *et al.,* (2007) expressed the view that, when compassionately and

"empathically listening, therapists are sensitive to both worded and wordless emotional messages" (p.230). Bertrando (2007) described therapists as "compassionate listeners". Campbell (2012) talked about "empathic listening", based on the positioning model, and his idea of "semantic polarity conversation", which involves starting a conversation assuming that the other person will take a different position within different semantic polarities. He thought it advisable not to "rush too quickly into a conversation aiming for connectedness" (p.46), but instead to focus on the separateness/uniqueness of the other person's position, which invites each individual to seek connectedness between their unique positions and creates a new/third position.

7.1.2.2.-Which encouraged horizontal group cohesion:

It is likely that creating 'truly engaging conversations'[58] in polyphonic dialogues nurtures horizontal group cohesion. Through activities and reflections, therapists created a space for the development of polyphony, 'withness' and horizontal group cohesion. By creating a 'community of help', where group members supported each other and therapeutic achievements were celebrated spontaneously, horizontal group cohesion was nurtured. To achieve this, therapists embedded group members in a vulnerable position and 'pulled in' quiet clients by inviting the group to support and learn from each other, showing emotional and physical connection through vulnerability, empathy and curiosity towards each other. By supporting others, group members developed a sense of self-efficacy, which strengthens their resilience (Bender and Ingram, 2018). When empathy was shown between group members, emotional connections and reciprocal social engagement were developed and shared lived experiences and emotions were jointly created in the group. I assume that if there was no cohesion, and in particular a sense of safety, there would not be empathy between group members.

Bakali (2013) stated that mutual influences between group members (through universality, acceptance, and altruism) nurture specific group processes. At a later stage of a group's self-disclosure, interpersonal feedback, and group confrontation contribute more to cohesiveness. Some of these features were also identified by Edwards (2001).

[58] Katz, Shotter, and Seikkula (2004) stated that: "such joint- or dialogically-structured activities cannot easily be characterized...to the extent that the temporal unfolding of intertwined activity in this realm is shared in by all, it is non-locatable; it is neither 'inside' people, but nor is it simply 'outside' of them; it is 'spread out' or distributed amongst all those participating in it...we could say that they all have their being 'within' it – such, for instance, is the character of all our truly engaging conversations" (p.42).

To conclude, my analysis and the studies described above support the idea that the creation of a safe space, in all its aspects, is an essential part of MFT groups and enables social connections to be formed and strengthened both between group members and with the leaders (horizontal/vertical group cohesion).

7.1.3.-CREATING A SPACE WHERE MEMBERS FELT BELONGINGNESS:

The other significant aspect of 'building relationships' was that therapists created a space where participants could feel belongingness to the group, despite their individual differences. Sempere and Fuenzalida (2017) also highlighted the importance of belongingness. When group members experience and value meaningful relationships, these encourage risk-taking and change. However, group members' sense of belongingness (group cohesion) is dynamic, and so there are moments of cohesion/connection and moments of detachment between group members. In a similar vein, Marková *et al.,* (2007) argued that individuals and groups are "two sides of the same coin, with moments in which the individual tries to detach him-or-herself from the group, and moments in which he or she seeks to merge within the group" (p.44).

Therapists encouraged a sense of belongingness by using personal names, focusing on members' interests, actively involving them and encouraging them to develop relationships between themselves during formal and informal interactions, supporting one another in a 'community of help' through both similar and different difficulties, where change was treated as a shared task, as children's targets were shared and achievements celebrated.

Dana (2020) described how a sense of belongingness is developed when we are "predictably cared about", while Brown (2010) defined belonging as one of our 'most primitive survival instincts':

> *The innate human desire to be part of something larger than us. Because this yearning is so primal, we often try to acquire it by fitting in and by seeking approval, which are not only hollow substitutes for belonging, but often barriers to it. Because true belonging only happens when we present our authentic, imperfect selves to the world, our sense of belongingness can never be greater than our level of self-acceptance (*pp.26).

So, I am left wondering how MFT therapists can show that group members are accepted for whom they are, so that they can develop a sense of authenticity. Within a multicultural/multilingual group this might be more difficult as aspects of group members' identity might be not acknowledged, such as their language/race. Race is often seen as a taboo topic and hence not talked about. Talking about race in the focus group, I sensed some tension and discomfort amongst some group members. I also observed participants whispering to each other. I propose that these topics should be introduced by therapists to encourage all aspects of the individuals to be accepted. From the very beginning, it should be communicated to all group members that racism would not be tolerated. This could be done as part of the group rules discussions. I believe that it is also important making clear that therapist would talk about racial issues, due to the impact of these issues on people at very different levels, such as their mental/physical health, education, careers and also about anti-racism. A discussion with everybody about how to make it safe to talk about race in the group, including how the group will manage if somebody becomes upset about something someone else has said and how to repair. Acknowledging the inevitable lack of expertise around these issues and also white privilege biases (if therapists are white). Group members should also know that it will be respected if they do not want to talk about these issues or that they could talk to therapists separately. When group members speak, validation and admiration should be expressed for speaking about issues which feel unsafe to be talked about in public. If mistakes occur, which is likely to happen, then these need to be acknowledged, and repaired with an apology and trying to learn by doing something different.

7.1.3.1.-In relation to vertical group cohesion: MFT therapists nurtured belonging, thereby showing that group members were seen/heard/valued (e.g. using their names or focusing on their interests, and actively involving group members who were not the focus of or directly involved in the tasks). Dialogical therapy emphasises the clients' own words and stories. Therapists focused on creating a common language (targets, goals) and larger narrative about the client's life by focusing on their interests.

I chose the concept of 'recognition' to understand the relevance of emphasising the clients' own words and stories. Taylor (1994) explained that:

> *Our identity is partly shaped by recognition or its absence, often by the misrecognition of others, and so a person or group of people can suffer real damage, real distortion, if the people or society around them mirror back to them a confining or demeaning or contemptible picture of themselves. Nonrecognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being* (pp.25).

I propose that when group members experience 'moments of recognition' from therapists, a sense of belongingness begins to develop. This increases vertical/horizontal group cohesion and collaboration, inviting co-creation of meaning. Therapists' 'recognition' of others forms a key part of the therapy process. Shotter (2009) explained that "'listening into' the other...is fundamentally an ethical issue" (p.21). Dialogical therapists create a context that invites dialogue in the way they respond. Weingarten (2016) explained that "collaboration toward recognition" allows intimacy to develop from the co-creation of meaning and might involve 'radical listening'[59], good reflection, compassionate witnessing, and reconsolidating memories.

7.1.3.2.-In relation to horizontal group cohesion:

Therapists invited and expected group members to participate in dialogue and in the activities, which created a context for possible moments of synchrony/cohesion. Anderson (2007) emphasised that, when "talking with, not to, each other" all conversation participants develop a sense of belongingness, which "invites *participation*, which in turn invites *ownership.* Ownership, in turn, invites *shared ownership"* (p.47). She described therapists' curiosity[60] as contagious. I also noticed that curiosity was contagious in MFT, so when therapists encouraged group members to comment or ask each other questions or were curious about the participants' utterances, group members became curious too. I suggest that this increased the connection between group members.

[59] "It is the kind of listening that neither judges nor prejudges, that hears what is absent as much as what is present, that pauses when words fail, and that discerns when the speaker is off centre, unable to share her story authentically (Weingarten, 1995, 2010b)… Radical listening entails hearing when something is said formulaically and identifying the discourses that have shaped the speaker's "packaging" of experience. Opening up these constraints in conversation, deconstructing them, complements radical listening. Both radical listening and deconstruction are ethical practices" (Weingarten, 2016, p.198).

[60] Cecchin (1987) described curiosity as a therapeutic stance, which encourages "exploration and invention of alternative views and moves, and different moves and views breed curiosity" (p.405).

By choosing group members who had similar difficulties, sharing children's individual targets, and creating a 'community of help' they encouraged participants to develop relationships between themselves, including a sense of belongingness to the group. Voriadaki *et al.,* (2015) found that sharing similar experiences and identified problems facilitated cohesion and change, as "parents were relieved to realize that they were not alone" (p.12), and that they could support and learn from each other, and 'the group' was described as a source of knowledge, inspiration and support. My study showed that MFT groups provide an opportunity to create a 'village'[61] of relationships; a 'community of help' where multiple families' voices could be heard and different views invited.

As stated previously, Seikkula *et al.,* (2015) found that the synchronisation of body movements is a key element of achieving shared goals when adults work together. Itävuori and Korvela (2015, p.2) explained that "moments of synchrony happen 'here and now', usually last a couple of seconds and are very context sensitive" (p.2). These are shared moments, 'moments of meetings' (Laitila, 2016; Stern, 2004), or 'cohesive moments', such as moments of laughter/silence/mutual smiling which happened spontaneously in the MFT groups. The use of activities allowed group members to synchronise and collaborate with each other. The accumulation of 'moments of synchrony', or 'cohesive moments' joins group members in synchronicity and enables their sense of belongingness to develop and invites them to work better together.

Finally, in the focus group, participants reported that the activities facilitated their interactions and that these were a vehicle for communicating and establishing relationships, allowing them to show that they 'genuinely cared' about each other. As group members focused on positive experiences and significant moments, their sense of self-value, group-value and belonging seemed to develop even further. I suggest that talking about group cohesion in the focus group functioned as a way of performing group cohesion, thereby fostering it.

7.2.-'WORKING TOGETHER'- From a powerful position, therapists actively:

My analysis showed that therapists actively invited group members to remain focused on the therapeutic task and working together by using different techniques, such as encouraging them to

[61] Hrdy (2009) emphasised that it takes a village to raise a child.

focus on the present moment, the activity itself, and on what was relevant. Therapists also provided joint focused activities, within which it was hoped that connections and dialogue would take place. Spoken dialogue often happened in the form of 'reflections' after activities, where therapists used more relational and open-ended questions as, in MFT, parents and children from different families are together, and dialogue is complex, not only because therapists need activities to get the children focused and involved, and thus pitch their language to different developmental levels, but also because different therapeutic processes are happening simultaneously, where not only do group members speak/act out in front of their own families (with their own history and understanding), but also in front of others, which might provoke shameful experiences. Focusing on a joint activity in a large group with members of different ages is a difficult task, as some children acted up or lost focus. Therapists often included group members who were not directly involved in a task by giving them a role. Involving everyone is particularly hard when the expectation is for all of them to focus only on one or two people. It was unclear whether group members engaged in these focused reflections because there was an implicit agreement that eventually they would all have a turn at being the focus of the group and receive support. However, if that was the case, how would therapists keep track of the allocation of focus?

Friedlander, Escudero and Heatherington (2006a) described the therapeutic alliance as a *'shared sense of purpose within the family'*: "the degree to which family members are cohesively invested in therapy… working collaboratively in therapy to improve family relations and achieve common goals" (p.126), and valuing this time. Quoting Kuhlman (2013), Laitila (2016) highlighted the significance of focusing "on collaboration, therapeutic alliance, client agency and the significance of client feedback for the therapeutic process right from the outset" (p.33). This clearly shows how complex this part of therapy is, as different factors are involved and, without a 'shared sense of purpose', therapy becomes a rudderless ship. In single-family therapy, the family's shared sense of purpose evolves not only from what the family brings to therapy and their interactions with the therapist, but also from the observations of others' behaviour in the therapeutic process, which is amplified in MFT, where the permutations of interaction are larger.

Making participants feel that they were important in supporting children's targets had the effect of joining parents together in their parenting tasks so that they would have a mutual investment in each other's development, as active participants in this process, as well as being recipients.

Cross-parenting and sharing ideas allowed family members to feel “in-there-together” (Anderson, 2012) and also gave them the chance to hear confirmatory/challenging reality check views from others (Springer *et. al*., 2010).

As in any therapy, in MFT sessions there are many occasions when therapists follow different threads or lose focus due to getting distracted by something/someone, which could be experienced as ruptures. In the analysis it was evidenced that distractions stopped group dialogues. I was curious about whether there is isomorphism between children’s distraction and group distraction, and if distractions could be used as enactments. I observed how some ruptures were bridged by group members and how, at times, therapists invited group members to remain involved, but there were also times when this did not happen, such as with latecomers. I will discuss ruptures and negative relationship factors in the next section.

7.3.-NEGATIVE RELATIONSHIP FACTORS/ ‘NON-COHESIVE MOMENTS’

In the analysis of informal interactions, when aspects of group cohesion might show and develop more, it was found that most adults hardly interacted with each other. The reasons for this are unclear. Similarly, therapists remained largely separate too. Conversely, children played football together and seemed to interact well.

I identified some negative relationship factors/‘non-cohesive moments’ in the interactions between therapists and group members. Four factors seemed to impact negatively on vertical and horizontal group cohesion, and group members’ sense of safety and belonging: group members disengaging when not directly involved in an activity; not being addressed/listened/responded to; forgetting/not using members’ names; and difficult interactions between group members and therapists, all of which could possibly have a negative impact on their sense of self, positive bonding relationships (sense of safety and belonging) and working relationships (vertical group cohesion).

The analysis showed that children seemed more disengaged. In both sessions, group members focused on one child for a considerable period of time. During these times, some children asked their parent repeatedly whether they would finish soon. I am not sure if this was a sign of needing a break or feeling disengaged/bored. As stated earlier, when children’s voices are not invited, this

indicates their 'pseudo-presence' (Parker and O'Reilly, 2012). There were many incidents when group members were not addressed or responded to. One child was interrupted and not responded/listened to by the therapists on various occasions. It seemed that the therapists' preconceived ideas about him shaped their interactions with him rather than being able to be open to discovering something new/changing/changed about him, in an "unavoidable monologue" (Bertrando, 2007). Even though therapists' intention was to refocus him, it seemed that this was experienced as a rupture, as he seemed less involved afterwards. These episodes may have provoked him to feel shame, a feeling which conveys: 'I am unlovable', and 'I don't belong' (Brown 2020), which can be particularly traumatic for children. Stratford (1998) noted that, "irrespective of whether family members are consciously aware of being interrupted by the therapist, they may be left feeling angry, disqualified, not listened to, or believe themselves to have little to contribute to the therapeutic conversation and be disadvantaged as a result" (p.388), but they might also experience it as part of their role. I perceived these as therapeutic ruptures. Martinez Guzman *et al.,* (2014) emphasised that ruptures not only reflect an interruption in collaboration, but it also negatively affects the quality of the relationship, and can be observed when clients confront therapists or are affectively detached from them. I observed members disengaging when part of the group had started an activity and then completed it on another day with a new group of people, and with latecomers. Ruptures are important because they have a negative impact on dialogues and therapeutic change.

Rober (2016) explained that the 'dialogical space' "refers to the virtual environment of expectations and entitlements about what can be talked about" (p.29) and that therapists not only contribute to opening the "dialogical space", but they also close it. He found that "closing dialogical space may create some stability in an uncertainty and tension filled dialogue, as it constrains what can be talked about in the present moment of the given conversation" (ibid). When therapists feel that group members have strayed off track, they might close those conversations, which benefits others, but they also need to remain reflexive about opening the dialogical space for ALL group members. Some participants only spoke when directly spoken to. The voices of mothers with interpreters seemed to be silenced. They were hardly addressed directly and they participated minimally in any dialogue. Involving all group members (including members who might not be willing to participate or who do not speak English), and inviting a polyphonic dialogue, is an

essential therapeutic task. I argue that these examples could be seen as ruptures, which would have an impact on group members' sense of belongingness (group cohesion).

Equally, when group members' names were not used or when moments of connection between therapists and families were unequally distributed, this probably had a negative impact on group members' sense of belongingness, and feeling valued/recognised. In a study about group climate, Kivlighan and Tarrant (2001) found that not only were members less satisfied with the group, but also benefitted less from it, when the leader focused on individual group members. Treatment benefit was related to a safe environment and being increasingly active, as well as an engaged, warm and supportive climate. Considering the importance of group processes in change processes, if group members were sensitive to the imbalance of individual attention, this would impact on group cohesion, and cause them to feel not 'recognised' (Taylor, 1994).

So, 'how therapists keep tuned in after a rupture' and 'how repair happens in MFT groups' are important questions. Elaborating on and/or repairing the rupture in the alliance can promote therapeutic change. Timimi (2021) stressed that "getting feedback as to whether what happens in the session is matching what works for them and being alert to possible 'relational ruptures' are important aspects of building alliances". Based on the Coordinate Management of Meaning model, and its primary question: "what are they making together?", group cohesion could be understood as a 'relationship' and ruptures as an 'episode' or 'situation' (Pearce, 2002, 2004) so, when group members feel an overall sense of group cohesion, or belonging ('relationship'), it might be easier for them to tolerate ruptures ('episodes'). Lo Coco *et al.,* (2019) found that repairing ruptures in groups is very complex because, even when group members are not directly involved in the rupture, they still have to process it. They highlighted:

> *The importance of therapists' abilities to identify alliance ruptures, to see how the ruptures have a ripple effect across members of the group and across sessions, how repairing a rupture can increase cohesion and trust in a group, and how failure to repair a rupture may lead to poorer processes and outcomes* (pp.67).

Porges (2017) described therapy in itself as evaluative and explained that if therapists convey to clients a need to change and be different, clients feel they are being evaluated, and thus not in a

safe state. Therapists have to manage evaluative judgements made about families which led to the referral. An MFT therapist would therefore also need to consider this as part of their self-reflexivity and relational reflexivity, paying particular attention to not conveying to clients that they or others in the group are evaluating them, to avoid ruptures and facilitate safety. Despite therapists' best attempts, some members might still perceive that they are being evaluated due to their previous experiences, such as trauma.

7.4.-CONCLUSION:

It is interesting that, in the focus group, none of the group members responded to what might hinder group cohesion. This might be because when they were discussing this topic in a group with the therapists, they might not have felt able to make negative comments due to power differentials, and maybe because they were concerned about the impact of this on therapy. In hindsight it would have been useful to interview some members individually to get honest/anonymous comments about these issues.

In this section, I described different potential ruptures which impacted on group cohesion and could inform MFT therapists and therapists in general, in their moment-by-moment self-reflexivity and relational-reflexivity, such as making sure that all voices are invited/responded to, showing that participants are recognised and that everyone is involved and attention is distributed equally. As Pakslahti (2006) advocated, I would like to "hear a polyphony of voices in space and time".

8.-MFT IN-SESSION AND REFLECTIONS DIALOGICAL/INTERACTIONAL ANALYSIS–INTERSECTION BETWEEN LANGUAGE AND GROUP COHESION IN MULTIFAMILY THERAPY

In my study, I found several examples where these elements intersected, including how group participants seemed silenced due to not speaking/understanding what was being said/happened. It was more difficult to notice this in a MFT group, but I assume that it would have had an impact on group cohesion. Päivinen and Holma (2016) stressed that it is vital that, in intercultural couple therapy, therapists remain aware of the marginalised and silenced cultural discourses. Therefore, clinicians need to self-evaluate and self-critique their practices and cultural values and redress power imbalances between clinicians and clients, especially in light of Grau *et al.,*'s (2020) observation that: "migrant patients are by definition in an asymmetric relationship. They belong to a minority culture, after all, and are seen in facilities affiliated with the majority culture" (p.9).

Tervalon and Murray-Garcia (1998) developed the construct of “cultural humility”, which they described as a life-long commitment to self-evaluation and self-critique to redress power imbalances and embrace mutually beneficial relationships.

Therapy is a meeting of cultures, a “political encounter calling for acute responsibility and openness on the part of therapists” (Pare, 1996, p.28). Frosh (2009) warned that ‘otherness’ cannot be colonised as ‘same’. Citing Frosh, Flaskas (2012) talked about the hope of making connection alongside attempts to honour the “‘incorrigibility of otherness’. How this is negotiated in any therapeutic relationship is always specific to that relationship and its embeddedness in the realness of histories and present social contexts” (p.67). Consequently, the realness of histories and present social contexts of group participants need to be an essential part of MFT group dialogues. Therapists need to validate the significant role that race plays in the client’s life, both in and outside the therapy room (Hardy and Laszloffy, 1994), considering the part therapy plays within “a living history of oppression” (Flaskas, 2012) and therapists’ roles as colonisers (Rober and Seltzer, 2010). Therapists and clients “bring with them not only their personal developmental histories but also the cultural history of the groups with which they are socially identified” (George and Stith, 2014, p. 187). In relation to working with others with a history of adversity, Brown (2015) asserted: “it is necessary to hold in mind that making the other present may also bring the past into the room. Yet, sensitively met in the context of unfolding utterance and response, the potentiality of the dialogue that may emerge in therapy or research is increased” (p.197).

Falicov, Nakash and Alegria (2020) highlighted that the “subject positioning of therapist and client is an inevitable aspect of the societal contract implicit in the relationship” (p.14), and so therapists need to consider the type of relationship sought by the clients, as some cultures/clients prefer clinicians to use authoritative directness, which is culturally congruent for them. Clinicians need to assess each case individually and reach agreement with clients, according to their preferences. They suggested that, in situations where intersectionality (due to race, class, gender, education, ethnicity, immigration status, and/or positional hierarchy) increases the “unequal relational power inherent” in the client-therapist positioning and interactions, it is even more necessary to examine what facilitates/hampers ‘in the moment’ client-led interactions. They described different critical approaches which regard power as central within the therapeutic relationship, and urge reflexivity about power inequalities between clinicians and clients so that these clients do not experience

discrimination or unequal treatment, and therapists to consider how socio-political stressors impact on the family's distress/presentation, such as racism. Bava (2020) described racism, and other forms of subjugation and supremacy, as "systems that dehumanize not only the people who get marginalised but also the people who benefit from the system. We may experience dehumanization in the form of emotional dysregulation, anxiety, depression, relational problems, some of which could also manifest physically. Helping our 'psyche' isn't enough if we are not helping the social fabric that holds us up. We can't 'support' the fight against racism as a 'cause' but must recognise it as part of our social, collective set-up". She stressed that actively undoing the "native invisibility and anti-Blackness, dismantling white supremacy, resisting colonisation and racialised capitalism practices and honour our intersectional and interconnected lives", focusing on our responses and how we orient towards others, are vital.

Campbell (2012) believed that, even though therapists are unable to shape the 'system' where racism is created and maintained, in therapy, "we can still scale things down and make the issue relevant for therapeutic work by exploring what it means to the therapist-client relationship evolving in front of us" (p.46). Therapists have an ethical responsibility to respond to, involve and recognise more of those members of society who are already marginalised (including due to language differences). De Haene and Rober (2016) stated that remaining "ethical therapists despite our social blindness" is necessary so that the therapeutic relationship becomes a "healing space within an unjust wider societal climate" for those who have experienced pervasive marginalisation in their host societies- a therapeutic space that might become healing by creating a 'welcoming place' that is open to clients' otherness, "a moment of hospitality with the larger social fabric, a space of welcoming and holding divergent stories of suffering in a community divided by a shared history of violent conflict" (p.108), in which healing and violence are simultaneously intertwined and balanced in therapy and hope and despair are voiced in an ethical position. De Haene and Rober (2017) suggested that in the face of the clients' suffering, therapists are responsible for disrupting their clients experience of "otherness". They added that "such understanding clearly moves beyond the emphasis on establishing a non-hierarchical, collaborative therapeutic relationship, and it even denies that such a therapeutic relationship would in practice be possible" (ibid, p.388).

Falicov, Nakash and Alegria (2020); Seikkula (2002); and Seikkula and Trimble (2005) stressed that consistently seeking all family members' perspectives about treatment reduces inequality in the mental health care of low-income families. However, when clients are mandated by formal institutions from the host country, such as schools, this becomes more difficult, as fear may interfere with their interactions. I argue that we need to show equal recognition by listening to clients' voices more, because if we do not, we repeat linguistic imperialist practices, which as Taylor (1994) highlighted, is detrimental to others, as misrecognition does not just show a lack of due respect, "it can inflict a grievous wound, saddling its victims with a crippling self-hatred. Due recognition is not just a courtesy we owe people. It is a vital human need" (p.26). In Bakhtin's (1986) words: "for the world (and, consequently for a human being), there is nothing more terrible than 'lack of response" (p.127). Pocock (2012) explained that:

> *Recognition of the other as a subject requires one's conscious and non-conscious assumptions to, at least partly, break down (the arrival of news of a difference). Without this, the other remains an object, a projection of the self. No alliance or collaboration is possible, without some mutual recognition (each 'feeling felt'); participants will simply talk past each other* (pp.83).

One way to show responsiveness is by what Linell (2009, cited in Rober 2015, p.110) called sharedness/difference, where, in relation to the previous voice each new voice takes either a 'sharedness' position: 'I'm like you'; or a 'difference' position: 'I'm not like you'. Rober explained that there might be some dialectical tension in inner dialogues or between interlocutors. Based on Buber's work, Brown (2015) explained that including other interlocutors means that they simultaneously remain connected to their 'felt reality' and experience the other's position. She noted that there is some evidence of a "progressive momentum in the process of inclusion", from imagining the real: 'I notice you', which is dependent on interlocutors turning toward each other; to making the other present: 'I recognise you', where interlocutors recognise difference and uniqueness; to confirming the other in what they are, and what they are called to become: 'I accept you'. Quoting Czubaroff and Friedman (2000), she further elaborated that "making the other present in family therapy and research involves a focus on the quality of what is said, what is emerging for the saying and the silences of the not-yet-said" (p.197). She explained how confirming the other in family therapy or research may encourage growth and empowerment in

the other, and stressed the need to attune to the silent voices of the other, since these voices emerge in moments of 'dialogic surprise and uncertainty' rather than monological soliloquies.

Burck (2005) warned that if, in relationships, individuals' other languages are ignored "significant aspects of their experiences and of themselves might never be brought forth in the relationship" (p.131). This happens as multilingual individuals have "multiple and broad identifications-belonging to a broader world" (p.90-91) and "doubleness" challenges interconnection. She added that being in a multiracial group validates 'multiplicity'. With reference to the process of change, her research found that "encountering a context which had resolved individuals sense of their polarized identifications or validated their sense of their multiplicity was identified as crucial to developing a changed sense of self" (p.74). Therefore, it is vital that therapists validate group members' multiplicity, so that its absence does not have a negative effect on their sense of self and therapeutic change. Accepting the other fully with all the different parts of their identity is essential in any therapy, but I argue that doing so in MFT is particularly significant, because it is witnessed by others, like 'outsider witnesses' (White, 2007). I argue that its effect on individuals is even stronger in this context and it contributes to group cohesion. Furthermore, in a multicultural MFT group it is even more significant, because such groups can function like a mini-society[62] and the "news of a difference" is even bigger, being witnessed by others, both from the host country and other countries.

On a practical level, Grau *et al.,* (2020) found that, in culturally diverse groups (including therapists) and therapists' self-disclosure about elements of their own culture, professional and personal experience, clients were invited to share multiple narratives about their own culture and other stories which might have been difficult to share individually. This also created a better balance, which contributed to the creation of a safe, empathetic and compassionate therapeutic space, facilitating the therapeutic alliance. I believe these ideas are applicable to group cohesion.

8.1.-CROSS-CULTURAL THERAPY/INTERPRETERS:

As evidenced in my analysis, I identified a few issues with the interpreters, such as acting as co-therapists, not always translating what was said, not everyone being aware of their role, and not being used during informal conversations. At times interpreters had a more active role than

[62] Yalom (1995) described *groups as a social microcosm.*

parents, for instance, sharing their own views and not the mothers'. Moreover, due to different levels of language proficiency, some parents seemed disempowered in relation to their children and some parents seemed to be silenced. Children took on/were given "interpreter's positions" (e.g. therapists asked children directly rather than asking their mothers). Guregard (2009) explained that, paradoxically, when interpreters are involved, children are often in an advantageous position, as they often understand what is said before their parents. Therefore, they play more of a central role rather than being marginalised. I suggest that these issues positioned mothers as silenced and non-agentic. They did not voice this, but it is very likely that felt unable to do so. I assume that these issues would have an impact not only on their own sense of group cohesion, but also on their personal feelings of (not) being 'recognised' (Brown, 2015; Daniel, 2012; Pocock, 2012; Taylor, 1994), thereby affecting their own self-image as women, mothers, members of society and emotionally, as they experience it as oppression. I argue that this kind of non-agentic positioning impacts negatively on group cohesion.

De Maesschalck (2012) concluded that language barriers in the consulting room have a negative impact, which manifests in: "the less thorough understanding and 'recall' of the diagnostic and therapeutic information provided, a higher risk of misunderstandings, medical complications and errors, as well as a lower degree of satisfaction among the patients. Patients with limited language knowledge are given fewer explanations by their physician" (p.32). Clinicians were less friendly, respectful and empathic in these relationships. Interpreters are essential for families who do not speak English but, as was evident in my analysis, even when interpreters are provided, group members do not necessarily communicate. De Maesschalck stressed that interpreting services are vital to foster their access to health care services. However, many "still consider interpreting services as inefficient and too time-consuming" (p.40), presumably also because they are expensive, meaning that these services are then rarely used.

As evidenced in my analysis, having an interpreter does not necessarily increase accessibility, which was difficult to monitor in MFT as there were many people involved. Interpreters' roles were not clear to everyone and they did not translate during breaks. Unfortunately, some therapists believe that having an interpreter is enough to create full access to mental healthcare, but there are other issues to consider. Bauer and Alegria (2010) highlighted that using ad hoc interpreters may be a barrier to disclosing sensitive material and can contribute to distortions/errors. Anderson (2012) believed that interpreters can either function as interference or an instrument of

therapeutic communication. She felt that interpreters should be self-aware, psychologically mature, and committed to supporting the therapeutic relationship, otherwise, they might interfere with the therapeutic communication, through clarifying at inappropriate times, questioning the therapist's practice, and disrupting therapeutic silences. Raval and Maltby (2005) proposed a 'co-worker model' between interpreters and therapists as an essential precursor to an effective therapeutic relationship, in which building trust between the interpreter and therapist is an important precursor to the therapeutic relationship between the client and therapist. Grau *et al*., (2020) found that interpreters play a "central role in providing the feeling of a safe place, in containing the family through language, in supporting parental functions and in offering a role model to the adolescents" (p.9). They suggested that the presence of "an interpreter and the possibility of going back and forth between the languages" (p.10) supported the therapeutic process. I argue that these issues would have a negative impact on group cohesion.

8.2.-ENGLISH AS A SECOND LANGUAGE:

Communicating in a second language is more complex, as languages have different rhythms, which are difficult to emulate. As Iversen (quoted in Levitin *et al.,* 2020) asserted: "different languages instil certain rhythmic preferences in their respective speakers, and that these preferences affect the way that the speakers actually hear rhythm", because our language ability is underpinned by having a sense of rhythm. One can assume that bilingual speakers use a different rhythm when speaking, in comparison to a native speaker, which might impact on attention and synchronicity. In light of Trainor's (quoted in Levitin *et al.,* 2020) research, which showed that "when two people move in synchrony with each other, they are more likely to feel connected to one another and, consequently, are more likely to help each other", it seems likely that these issues could affect social interactions and cooperation, to which Trainor (2020) had the following response: "initially it might well affect social interaction and cooperation. On the other hand, people are flexible, and we get used to different accents (and their rhythms) so it might disappear after some familiarization". I assume that this would depend on the person's openness to 'others'.

Kokaliari and Catanzarite (2011) observed that it was widely unrecognised by psychotherapists when those who spoke English as a second language struggled to communicate efficiently. In the focus group, participants fed back that they felt that they could communicate at a basic level

without an interpreter during informal parts of the session. However, I did not observe many informal interactions between people who spoke different languages, although differences in language fluency created closer connections, as group members supported one another as 'informal interpreters' during formal interactions. Burck (2005) found that those who speak English as a second language viewed their first languages as "enjoying special qualities, constructed as expressive, nuanced, creative and productive, described as language with flavour, to be used for poetry, for intimacy, for play, for 'authenticity', for truth and for jokes" (p.93). In practice, families from a variety of cultural backgrounds and levels of English proficiency are expected to be playful, creative and intimate in MFT and any other psychotherapy modalities, using talking therapy rather than more action-oriented therapies.

To conclude, speaking different languages could facilitate group cohesion, but it could also hinder it, as some voices remained marginalised in the sessions and many people did not interact. This section also showed the complexities of working across cultures/languages in a MFT group; the significance of working alongside interpreters and ensuring that they translate throughout the session; and the importance of therapists remaining reflexive about their roles, rebalancing power in therapeutic relationships and creating hospitality, whereby marginalisation can be avoided, for instance, by relying less on language and more on actions and embodiment.

SECTION H- CLINICAL IMPLICATIONS

The concept of group cohesion has theoretically and clinically been recognised as very important. Group cohesion facilitates therapeutic change, but research on it is limited in MFT and with multilingual/monolingual groups. This research indicates that developing more awareness about it, including what therapists could actively do to enable it, is therapeutically useful. I will now draw out the clinical implications of my research.

1.-THERAPISTS' INTERACTIONAL POSITIONING: BETWEEN A POSITION OF POWER AND A COLLABORATIVE VOICE:

Therapists unintentionally placed some group members as voiceless by hardly asking them any questions directly or mistrusting them, thus putting them in a powerless/non-agentic position. This could possibly have a negative impact not only on their sense of self, but also on vertical group cohesion: positive bonding relationships (sense of safety and belonging) and working relationships. I stress that this is particularly relevant to the type of families referred to MFT, who are often already in a marginalised isolated/discriminated against/silenced position in society and frequently described as 'multi-problem-families'. In dialogical therapy, clients' own words and stories are emphasised, as well as therapists' listening to these. MFT groups are very busy, so it is harder to listen to everyone, but when group members are listened to/recognised/valued, they develop a sense of belongingness and safety, which encourages them to work together (group cohesion). Therapists' self-reflexion and relational reflexivity in their moment-by-moment interactions is vital, as is focusing on what positions they invite group members to take (such as powerless/non-agentic positions or powerful/agentic positions), whilst trying to be supportive/collaborative. However, I argue that relational reflexivity and therapeutic relationships are more complex in MFT, as therapists need to consider multiple relationships simultaneously.

Ong, Barnes and Buss (2021) explained how dialogical approaches create a potential dilemma for therapists between being collaborative and directive, and that they need to remain reflective about these positions. Vall *et al.,* (2016) advocated being "at least adequately directive"; this is an important notion, which therapists could reflect in their moment-by-moment interactions. A significant, but expected, area where therapists showed their position of power was being in charge of the group, which facilitated vertical group cohesion, a sense of safety and increased

closeness. This particular MFT group had an agenda, both in terms of its remit (to prevent children from being permanently excluded from school) and in its daily structure/organisation (including structuring conversations, asking most questions, setting activities, and providing feedback to school about group members' behaviours). Therapists' powerful position was strengthened by contextual/external factors and the fact that therapists had most quantitative/semantic dominance. Although both therapists had interactional/semantic dominance and I assume that they decided on the activities together, overall Paul(T) shaped the content of the dialogues, including always presenting the activities to the group, which conveyed power. Additionally, he had an inherently powerful position by being a white British male therapist in a multi-racial group. Hierarchical differences between therapists' and clients' positions, due to socioeconomic and educational status, have a negative impact on centring the voice of clients as power challenges may dominate the relationship. Despite our best intentions to be respectful of others and act with equality, we all fall into patterns of interacting with others. I suggest that therapists need to be mindful of how their intersectionality (gender, race, culture, class, language) is perceived by the group, as this would impact on group cohesion.

When participants were not responded to, therapists' powerful stance seemed to interfere with dialogical interactions. I assume that therapists' intention was to encourage group members to respond to and support each other's 'withness' (dialogic)-talk between group members (horizontal group cohesion). However, this might have been experienced by participants as 'aboutness' (monologic)-talk in their interaction with therapists (impacting negatively on vertical group cohesion). Therefore, I propose that therapists need to balance 'withness' (dialogic)-talk between group members responding to each other, and responding responsively themselves, in order to nurture horizontal and vertical group cohesion respectively. I argue that to foster group cohesion, MFT therapists need to create a context which facilitates dialogues, i.e. interactions in "balanced exchange of talk time" (Falicov, Nakash and Alegria, 2020) and exercise their 'professional responsibility' (Stratford, 1998), thus allowing others to have semantic/interactional dominance by inviting and listening to everyone's voices, waiting for their turn to speak and/or when introducing a new topic. I propose that, as part of a team, therapists could divide their roles into one being more active and in charge of the structure, and one taking a meta-position with regard to processes such as paying attention to semantic and quantitative dominance, who is being listened to and how.

What other interventions could therapists use to invite dialogue without putting group members in a powerless/non-agentic position? For instance, they could ask members: *"would you want to manage this by yourself?", "would it be helpful for the group or us to help you with this or not?", "would it be helpful to think together about this?".* Falicov, Nakash and Alegria (2020) suggested that by using tentative language of possibilities such as: *"I don't know if I am right about this, but it occurs to me..."* and "shared decision-making concepts and tools", therapists emphasise clients' voices/agency in their exploration of solutions, and that clinician's statements can be questioned, or rejected, thereby acknowledging unequal power positions. They identified some communicative practices among clinicians which may facilitate or hinder therapeutic collaboration. In my analysis, I found that similar practices were relevant in relation to group cohesion, for instance, 'shared agenda' (*targets*), 'balanced or unbalanced amount of talk time' (*interactional/semantic dominance, balanced attention to all families*) and 'collaborative meaning making' (who chooses the meaning of behaviours).

Finally, one has to be cautious with tentative language (therapists "downgrading their high deontic stance", Ong, Barnes and Buus, 2020), as using it does not mean that power disappears from the therapeutic relationship, but reflecting about these issues within the therapeutic relationship itself might help to negotiate power within therapy (Guilfoyle, 2018).

2.-'COMMUNITY OF HELP':

In relation to a collaborative position, a significant aspect of creating group cohesion is developing a 'community of help'. It is the foundation of creating a sense of safety. I assume that, in a MFT group, safety is even more complex than in single-family therapy and we cannot assume that therapy is a safe place for all clients. So, how do we create a safe context? Porges (2017) emphasised that this was facilitated by having a warm facial expression, prosodic voice and using touch, while Taylor (1994) stressed the significance of recognising others. From this research, I will add the following 'therapy imperatives' in relation to creating safety in a group: accepting group members, appreciating and inviting their participation in dialogues and activities, fostering their sense of agency and self-efficacy so that they do not feel judged/ashamed, providing a group structure and grounding, adopting a playful stance, managing enactments, tensions or criticism, showing empathy, being flexible, using engaging metaphoric language, and conveying that

therapists can be trusted, are approachable, and that group members are 'genuinely cared for', or "predictably cared about" (Dana, 2020).

Informal interactions increased the chances of moments of cohesion. Through activities and reflections, therapists created a space for polyphony ('a vehicle to communicate'), connections ('establishing relationships') and a 'community of help', where there is a 'sense of mutuality', 'genuine respect/care' and 'sincere interest' in the other, which were appreciated by group members. Please see appendix 24 for a list of activities to engage families, whilst promoting group cohesion across languages and cultures. Even when group members were not directly involved in a task, therapists often (but not always) included them by giving them a role, such as being in an observer position. Also, by having a group which share similarities, it is more likely that group members will work together, become stronger and more intimate relationships will be developed (Dana, 2020) and they will experience greater life satisfaction.

Therapists developed a 'community of help' in a recursive process, where 'cohesive moments' showed 'synchrony' between group members and these contributed towards group cohesion, as it is created through an accumulation of 'moments of synchrony' or 'cohesive moments'. Briefly, when the MFT group created a 'community of help', new possibilities emerged in dialogues and change was mobilised through creating a warm/empathic/supportive/safe therapeutic context.

3.-MULTILINGUALISM AND CHILDREN'S POSITIONING:

In a MFT group, many things are likely to be overlooked due to the complexity of running such groups, as therapists have to manage more permutations of interactions, tensions, enactments and practical issues; there are multiple therapeutic goals and ways of learning; people speak at different paces and simultaneously; and not everyone's voice is listened to. Some of the information that might be missed relates to whether interpreters were 'doing their job' throughout the sessions and breaktimes and not being more active than the families themselves. I am unsure whether MFT therapists had conversations with the interpreters about their roles in a MFT group prior to the work starting, for example giving them guidance about the above issues. Similarly, I am unsure whether interpreters' roles were explained to other group members.

Mothers using interpreters were often marginalised. Sometimes, they did not seem to understand what was discussed in the group and at times interpreters did not translate. Throughout the sessions, the pace of conversations was very fast, and that would have made it difficult for any interpreter to translate everything. This would have a negative impact on vertical/horizontal group cohesion. Group members who needed an interpreter or spoke English as a second language were sometimes positioned as physically present, but absent from the group's discussions. I argue that when group members are in a silenced/powerless/non-agentic position, then it might be difficult for them to ask the group to slow down or to ask the interpreters to translate when they are not doing so. I propose that it is important to be explicit with interpreters and with everyone else about interpreters' roles, and to invite everyone's voices to be listened to. I suggest that it is not just the responsibility of the therapist in a meta-position to keep track of the interpreters' roles and work, but I also propose that everyone in the group should be encouraged to ask others to slow down when appropriate. This should be a group responsibility, which would then encourage group members to adopt an agentic position and be respectfully aware of each other (empathic). If the responsibility is placed solely on the family who needs an interpreter, it is likely that this will not happen, because they often feel or are positioned as powerless, not only in the therapy room, but also in the wider social context. This might also be affected by cultural expectations about how to behave with authority figures.

I also noticed mothers' positioning in relation to children, who often responded for their mothers or were directly asked questions that therapists had originally asked their mothers. It is unclear whether this was a pattern repeated outside of the group, as children might be 'their parents' voice' in other contexts, when they do not have an interpreter with them. I wondered about the impact of these children being more proficient in English than their mothers in terms of their parenting and positioning in the group and society. I suggest that children taking on or being given 'interpreter's positions' should be avoided. Although children's language brokering might be beneficial both for the family and child, it involves role-reversal and positions them as parentified (Byng-Hall, 2002, 2008), which might affect them negatively, as Piller (2015) highlighted, perhaps causing stress (The Pásalo Project). Although, therapists and interpreters are key in this, it is the therapists' responsibility to brief interpreters and families, both prior to the work starting and during it. I argue that therapists need to maintain self and relational reflexivity in their moment-by-moment interactions to include the voices of group members who are already marginalised due

to language/cultural/racial differences, without using children as their parents' voices, for instance by focusing on who answers questions (repeating these if needed) and making sure that interpreters translate when expected. These strategies would enable marginalised group members to engage with others, thereby nurturing group cohesion and their sense of agency/self.

I argue that to help children to become engaged in the group and encourage group cohesion, it is important for therapists to involve them prior to therapy and throughout all the stages of therapy using age appropriate language (Reimers, 2001). In terms of social justice, responding to children's voices is important. Even though children were the identified/referred person, I observed that their voices were often not responded to or encouraged, which indicates their 'pseudo-involvement' (Parker and O'Reilly (2012). This is particularly relevant in MFT, where the importance of peer support has been shown to be so significant, both because peer support is easier to respond to and also because, by helping others, they could develop their own sense of self-worth/agency and confidence in their problem-solving skills, including about their own difficulties, which in turn would encourage group cohesion, as children would be likely to feel recognised/safe and that they belonged. In my analysis I noticed that peer support seemed to be better received by children. I suggest that, by including children's voices more (such as during reflections, asking their opinions and feedback about each other) their 'pseudo-involvement' can be avoided. Therapists would benefit from maintaining self and relational reflexivity within such interactions to ensure that children are not only listened to, but also that their voices are invited without preconceived ideas about them and their suggestions taken seriously, responded to, reflected upon and possibly accepted.

Finally, I suggest that ensuring that families' multiple identities are welcomed and validated in a MFT group fosters group cohesion, for instance by ensuring that therapists use individuals' names rather than their roles ('mum/dad'). Therapists also need to be aware of hierarchies of languages, as the first language of the multilingual families was only used during informal interactions and not necessarily invited/welcomed in the group, where the only language used publicly was English. I propose that, if there a few group members who speak the same language, MFT clinicians could explicitly tell them to do some of the activities together in their first language (if they wanted to do so) and then feedback in English. Giving them permission to speak in their first language would have an impact on their self-esteem, and make them feel validated/valued, as part of their identity

(language) is recognised and accepted, which would impact on group cohesion. Another benefit is that first languages are likely to be the language of intimacy, emotional expression, and authenticity, which foster closeness (Burck, 2005) and group cohesion. However, I would not suggest that they do this all the time, because then it would probably have a negative impact on their integration into the wider group and horizontal group cohesion.

4.-WIDER CONTEXTUAL IMPLICATIONS:

I argued that MFT functions as a micro-society, a fertile context where new voices/ideas/practices can be heard and tested in a safe environment. Kivlighan *et al.,* (2020b) found that groups are social microcosms as group members replicate "their everyday (intersession) interpersonal behaviours in group sessions and new behaviours, learned in the group (in-session)" (p.1) are replicated in their everyday life. From my point of view, therapy should ideally have an impact on the different contexts that individuals attending therapy are involved in. Therapy should be a platform for social justice and a catalyst for social change. As Laitila (2016) emphasised, therapists must actively position themselves as 'agents of change' (p.42). Similarly, Knudson-Martin, McDowell and Bermudez (2017), McDowell, Knudson-Martin and Bermudez (2019) promoted third order therapy through a socioculturally attuned Family Therapy Model. So, how can Multifamily therapists create a context where families are recognised/accepted, become "agents in the joint negotiation of their relationships" and change the contexts in which they are involved, so that they become more vocal and less marginalised? First, everyone's voices should be heard and invited; their identities should also be accepted and welcomed, to foster group cohesion. I propose that therapists have an ethical responsibility to explicitly invite/welcome difficult conversations, such as about racism and experiences of discrimination, and to be aware of their own intersectionality issues. I suggest that therapists need to introduce these topics themselves and be open about not tolerating racism in the group. This would need to be done both by therapists from dominant and marginalised backgrounds. Its impact on group cohesion might not be clear, but it might avoid racist interactions in the group, and ensure that group members' identity is acknowledged. As Afuape (2016) stated: "the group's ability to reflect on its relationship to the social, cultural, political and historical milieu seems to be the key to its potential for social transformation" (p.48-49). However, some people, who might have racist views, might feel more disconnected from the group.

Finally, therapists of different genders working collaboratively together, without anyone, either male or female, dominating the session would enable (from the therapy room) the development of a different, more equal, wider society. My suggestion for co-therapists to swap roles regularly (e.g. with one taking charge of activities and the other maintaining an awareness of process), might also help with their collaboration.

5.-DEVELOPMENT OF FEEDBACK-INFORMED MFT:

I found that the focus group discussion provided significant information and feedback. This appeared to be a way of performing group cohesion as group members focused on their positive experiences and interactions, including significant moments and explicitly talking about therapeutic processes. I assume that this conversation fostered their sense of self-value, group-value, and belongingness, and it encouraged group members to benefit even more from their time together. I argue that this is a very important foundation for the development of group cohesion, which is similar to 'talking about talking' (Fredman, 1997), but in relation to MFT is more concerned with 'talking about the group processes'. Given its significance, I suggest that this is a format that can be used more regularly in MFT groups to review group cohesion; to acknowledge significant moments; to understand interpreters' roles, giving permission to everyone to ask others to slow the interpreters down to translate; and to make participants aware of the significance of: breaks, informal interactions and hearing everyone's voices; what happens with latecomers and how they join in; and raising difficult topics such as mutual-respect, non-judgement and racism. I argue that this added element would contribute towards the effectiveness of MFT, as Feedback-Informed Treatment has been found to be highly effective (Bertolino, Bargmann, and Miller, 2011; Mahon, 2020; Tilsen and McNamee, 2015).

6.-NEGATIVE FACTORS AFFECTING GROUP COHESION:

Regarding some of the negative factors relating to group cohesion, if informal interactions or moments of connections between therapists and families are unequally distributed, or if personal names are not used, then this would probably have a negative impact on group members' sense of belongingness, and feeling valued/recognised (group cohesion). I propose that therapists would need to find ways of remaining reflexive, noticing how they address group members, and balancing to whom they pay attention over time, which might include writing down which families they have

focused on, as a way of keeping track of how attention is distributed over time. This could be another role for the therapist from a meta-position.

I argue that, ideally, admitting latecomers or allowing members to leave early should be avoided, as this is very likely to create a rupture in group cohesion, both in terms of participants' sense of belongingness and being valued/respected, and on positive working relationships. I propose that the impact is bilateral, i.e. it has an effect on the latecomer or member leaving early as well as on the rest of the group, not only because it involves 'disruption', but also because it might also impact on their sense of safety, when disclosing something significant. If it is impossible to avoid this, it would be useful to find a way to manage it, for example a member of the team (e.g. the less active therapists, or students) could be responsible for welcoming and integrating them into the group, by explaining what they had been doing, and what they should do when they arrive late or what happens when they leave early. Focusing more on the children seemed to be a priority, as they appeared to struggle more both to integrate with and to leave the group. This could also be agreed when discussing ground rules, to ensure that they would feel valued and recognised and that it is worthwhile attending the group even if they are late. I would also suggest that, whenever possible, therapists should try to complete activities on the same day.

I argue that shame-provoking situations might create a potential barrier to group cohesion, as group members stop feeling connected and belonging and, as Porges (2015) stated, once we believe we are being evaluated, we are basically in defensive states/not safe. Walker (2004) suggested that therapists need to be attentive to power dynamics within therapy and responsibly ensure that no abuse of power occurs from their inherently powerful position, thus minimising the "potentially shaming impact" on clients' felt powerlessness. In MFT groups avoiding shame-provoking situations is complex because often children misbehave and, when they do, they put their parents in a difficult/disclosing position (having to manage their children's behaviours in front of others). This could also be pre-empted, however, by normalising it as part of the therapeutic process, prior to the group starting, as well as by addressing (individually or as a group) issues when evaluative shame-provoking comments are made or 'shame-provoking' behaviours are displayed by children.

Additionally, in a multicultural MFT group, there might be cultural differences around shame. I propose that MFT therapists would need to be aware of these in order to address them. Silfver-Kuhalampi (2009) highlighted that the research on individual differences in shame proneness in different cultures is very limited. She explained that this could be partly due to the variety of definitions of shame that exist in different cultures, which makes it difficult to measure. For instance, in comparison to individualistic cultures, in collectivistic cultures, shame is experienced as an acute, short-lived emotion, and it is perceived to have a less negative effect on self-esteem and social relationships. Sznycer *et al.,* (2012) proposed an approach to understanding cross-cultural differences and similarities in proneness to shame. In a multicultural group, it would be impossible to predict/recognise and manage members' shame-provoking experiences. I therefore propose that it might be helpful for therapists to attune to cultural issues connected with shame. Therapists would also need to maintain self-reflexivity and relational reflexivity, paying particular attention to not conveying to clients that they or others in the group are evaluating them. It is important to help group members to manage shame-provoking situations or feelings of vulnerability by creating a responsive and respectful 'community of help', where group members support each other without judgement.

To **conclude**, I have stressed the importance of therapists' self-reflection and relational reflexivity in their moment-by-moment interactions in order to nurture group cohesion and group members' sense of agency/self. Some of the areas they could focus on are: what positions they invite group members to take (such as powerless/non-agentic positions or powerful/agentic positions); their own position and who has semantic/interactional dominance in the dialogues; balancing the distribution of individual attention over time; avoiding and managing evaluations of others and shame; ensuring that everyone's voices (including those group members who are already marginalised due to language/cultural/racial differences and children's voices, without expecting them to answer for their parents) are listened to without preconceived ideas about them, and that different parts of their identities are welcomed.

I suggested that therapists working together could take different positions in the group, and that these could change during/between sessions. One could take a lead and another could take a meta-position by overseeing some of the group processes, such as: monitoring who has semantic and quantitative dominance in the dialogue, keeping track of balancing individual attention given

to each family over time and whether interpreters are doing their job, both during the sessions and at breaktime, who answers questions, helping latecomers (especially children) to slot in and supporting people leaving early. The importance of a 'community of help' was also highlighted, plus the development of Feedback-Informed MFT.

SECTION I-STRENGTHS AND LIMITATIONS OF THE STUDY

This research, as far as I know, is the first of its kind. This is an innovative study, as the research around MFT processes is limited. Video analysis of MFT sessions is something that not many people have done previously. This allowed me to consider moment-by-moment interactions. Like all types of research, it has its limitations. My analysis only covers a snapshot of a point in time of two sessions involving a MFT group which had run for many weeks: a focus group and interview with the therapists. Despite aiming to remain reflexive, my analysis of the data is limited by my personal and societal contexts through the research, my own cultural discourses, and personal and professional experiences.

As described above, there are many significant findings that could be applied to MFT, single-family therapy and other contexts, such as: considering therapists' interactional positioning between a position of power and a collaborative voice in moment-by-moment interactions; creating a 'community of help', where group members feel safe and a sense of belonging to; focusing more on children's position and on interpreters; slowing down conversations; considering wider implications; and reviewing group processes. To include group members who do not speak English fluently and also to connect group members, I propose using activities, such as the making of masks, to encourage all members to join in where, by 'doing' something together (such as music[63], play, art), they connect, rather than 'talking' together, which requires more language skills.

In my opinion, one of the main limitations is that I would have liked to incorporate more clients' voices in the research. If I had had a chance to engage participants more fully in the research, their voices would be even more present. I would have liked to share the results of the research with the therapists and for group members to have a dialogue about them and include their views or even some of their inner dialogues. This would allow a "true (less colonising) dialogue", as described by Bertrando (2007).

[63] I considered the following studies prior to making this suggestion: Yehuda (2002): Multicultural Encounters in Music Therapy (https://voices.no/index.php/voices/article/view/1585/1344); Shoemark (2016) How Can Music Foster Intimacy? (https://voices.no/index.php/voices/article/view/2314/2069)

If I did the research again, I would not include therapists in the focus group or I would interview some members individually, including interpreters, so that they could be more open about what might hinder group cohesion and about their views on/experience of working with interpreters. I would have liked to interview interpreters and/or discuss some of my findings with them. This would have allowed me to hear their voices from an 'outsider witness' perspective too. Even so, their answers would have probably been affected by the fact that I am not British and I speak with an accent.

Regarding further investigation, even though I found the data extremely rich, it might be useful to analyse more sessions to be able to understand more about how change occurs over time and whether they all had a turn at being supported by the group. I would also suggest that it might be useful to look into the gendered interactions between participants and therapists, and those from a cultural perspective, in future research. Finally, it might also be relevant to consider how group cohesion is expressed in different cultures.

SECTION J-FINAL CONCLUSION

I started this research aiming to find out what MFT therapists do to facilitate group cohesion in multilingual groups, because group cohesion has been found to enable change processes. In my research, I have been able to identify and analyse small sequences of interactions, dialogical patterns and group processes. My research illuminated some of the hazards of managing multiple demands in MFT groups. Moreover, it has evidenced how complex it is to run a MFT group, as therapists have to manage and interweave between a large group of adults and children, who use different languages. Furthermore, this group was specifically for parents and children with behavioural issues, who attended voluntarily, but had been referred by staff from a powerful institution- a school. These factors added an extra level of complexity.

It is hoped that this research will engage and inspire other therapists or clinicians working with groups to be more attentive to some MFT/group therapy processes. My study has illuminated significant issues that therapists need to consider in MFT processes, such as creating a community of help, setting goals agreed by and supported by everyone, the importance of listening, of group structure, informal interactions and developing a sense of belongingness, safety, creating a warm/supportive environment and talking about group processes in the groups. In relation to power it has highlighted: therapists' positioning/voice (switching between powerful and collaborative), and semantic/interactional dominance, clients' powerlessness/non-agentic positioning, and gender issues between therapists. With regard to children's positioning, responding to and including children's voices were also discussed. Regarding language/culture, validating and recognising families' multiple identities and including everyone's voices without marginalising anyone was highlighted, as was considering interpreters' roles in MFT. The importance of addressing everyone by name, equally distributing moments of communication with therapists, and avoiding unintentional shame-provoking situations in groups were also discussed. I suggested that, by therapists paying attention to these issues, this will hopefully contribute to group cohesion in multilingual groups.

I hope that my research contributes to the field, and alerts all of us, as family therapists/Multifamily therapists, to maintain our self-reflexivity during moment-by-moment interactions. In exploring cohesion in MFT groups I identified 'cohesive moments' that show

synchrony[64] between group members and demonstrated that their accumulation contributes towards group cohesion in a recursive process. When empathy was shown between group members or they supported each other in different ways, not only were emotional connections and reciprocal social engagement developed, but also lived-experiences and emotions were jointly created and shared within the group. Without cohesion, and in particular, a sense of safety, there would be little empathy in the group setting. I have come to understand group cohesion as the process which joins group members in synchrony, developing their sense of safety, belonging and inviting them to work better together, and even compensating for negative experiences. This could occur in any type of group. When I next work with a MFT group I will attempt to be more sensitive to facilitating families to find their "shared humanity" (Rober, 2012), including taking everyone's voices into account, particularly those of marginalised members of society and children, and will try to assist them with assuming agentic/powerful positions.

[64] Itävuori and Korvela (2015); Itävuori, *et al.,* (2015); Seikkula *et al.,* (2015); and Seikkula *et al.,* (2018) described synchrony as complex innate intersubjectivity moments, which happen in the 'here and now' and are the origin of dialogue and co-regulation between people.

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APPENDICES

APPENDIX 1.- KEY ELEMENTS OF DIALOGICAL PRACTICE

KEY ELEMENTS OF DIALOGIC PRACTICE:

Following the overview of Dialogic Practice, I will now explain its key elements, which have also been described as the 'fidelity criteria':

1. Responding and reflecting: These are the most fundamental therapeutic skills in Dialogic Practice. Anderson (2012) emphasised that responding collaboratively should involve "participating in the conversation, not steering it" (p.16). Olson, Seikkula, and Ziedonis (2014) explained that responding involves three steps and that, "while defining the quality of the therapist's action, one has to look at: (1) the client's initial utterance; (2) the therapist's response to that utterance; and (3) the response to the response given. How does the therapist's response further the experience of each participant in being heard, understood, and acknowledged? How do these three steps generate dialogically responsive interaction?" (p.6). As a further step, following on from responding, in Dialogic Practice, reflection refers to the manner in which professionals share their ideas with families and other professionals (i.e. openly, transparently and without using jargon).

2. Monological and dialogical communication/ Participation of Family and Network: Both monological and dialogical communication are included in Dialogical Practice, as we oscillate between the two. Olson, Seikkula, and Ziedonis (2014) reported that, to be effective, around a third of the conversation in an Open Dialogue meeting should be monological. They added that this term is different to 'monological discourse', as this implies an 'institutional way of talking', where there is an expert speaking and a less privileged listener, which limits new ideas. In monological utterances therapists initiate the topics of conversation and do not respond to others' utterances. Gonçalves and Guilfoyle (2006) stated that "complete monologism is impossible in human interaction" (p.251). However, the hierarchical context of therapy might support monologism, so, they listed a number of therapists' and clients' beliefs that maintain this position, such as: "I'm responsible for client change", "What I say is more important than how I say it", "the client is resisting change"; and, from the client's perspective: "I want to be happy and the therapist

knows the recipe for happiness", "small changes are no changes at all", "I am driven by forces beyond my control", "If therapist X doesn't change me, then change is not possible".
Shotter (2006, p.600) differentiated monological and dialogical communication when he referred to *withness* and *aboutness* thinking. He explained that *Withness (dialogic)-talk/thinking:*

> *Occurs in those reflective interactions that involve our coming into living, interactive contact with another's living being, with their utterances, with their bodily expressions, with their words, their 'works'…They both touch and are touched, and in the relations between their outgoing touching and resultant incoming, responsive touches of the other, the sense of a 'touching' or 'moving' difference emerges—a difference that makes a difference (that matters to us) (Bateson, 1972).*

This creates a context for the emergence of new possibilities/connections. Similarly, Tom Andersen (1995) talked about people 'being touched', in close contact with their words. Anderson (2012), following Bakhtin and Shotter, described it as 'relationally responsive practice'. On the other hand, Shotter, (2006) described *aboutness (monologic)-talk/thinking* as "unresponsive to another's expressions; it works simply in terms of an individual thinker's 'theoretical pictures', which they must try to 'get across' to us in their talk—but, even when we 'get the picture', i.e., *their* picture, we still have to interpret it to suit *our* circumstances, and to decide, intellectually, on a right course of action... Such talk leaves us 'cold'" (p.599). Sundet *et al.,* (2016) emphasised that, when monologue dominates, there are less possibilities for newness.

3. <u>Using open-ended questions:</u> Open dialogue network meetings regularly start with the clinicians asking the following open-ended questions: 'what is the history of the idea of coming here today?', 'who would like to start?', 'what would be best way to begin?', 'how did others learn about this idea?' or 'how would you like to use this meeting?'. Moreover, other open-ended questions are used throughout the meeting "so that clients can take the initiative both to speak about what they see as important and in the way that they would like to discuss it" (Olson, Seikkula, and Ziedonis, 2014, p.13). Its aim is to invite all participants to speak in a 'reflective voice', describe the context of the referral and what is relevant for them, rather than therapists introducing the topic.

4. Responding to clients' utterances: Olson, Seikkula, and Ziedonis (2014) stated that "there is evidence that therapists' responses are effective when, for instance, there is change experienced during a meeting in the direction of a calmer atmosphere. The conversation has pauses, silences, and more shared exploration of-reflection about issues and concerns in a dialogical ebb and flow" (p.14). They added that part of the therapeutic attunement is to allow silences in the conversation, as these offer "a creative prelude for untold stories and the emergence of new voices" (p.15). They also emphasised that "it is crucial to pay close attention to what is being communicated through body-based channels as well as words" (p.14) in order to understand the meaning of the client's communication. Therapists create a context that invites dialogue in the way they respond, which involves: responsive listening (without an agenda), which invites clients to share stories that are not yet told; therapists' using the client's own words in their utterances.

5. Emphasising the present moment: Laitila (2016) observed that: "Dialogue in the 'here and now' is emphasized in most family therapeutic orientations" (p.34). Bakhtin (1984) noted that a human being has embodied participation in dialogue, "wholly and throughout his whole life: with his eyes, lips, hands, soul, spirit, with his whole body and deeds" (p. 293). However, there is very little research concerning how we participate in dialogue with our bodies in everyday clinical practice. Olson, Seikkula, and Ziedonis (2014) explained that "the task of therapists is to make space for their emotions in a safe way, but not to give an immediate interpretation of such emotional, embodied reactions" (p.16). This isinvolves shifting from 'explicit knowledge' to 'implicit knowing' in the embodied (wordless) experiences in the present moment and being aware of our internal experiences prior to us giving them words (Seikkula, 2011).

6. Eliciting multiple viewpoints: polyphony: In Dialogic Practice, multiple points of view and voices (polyphony) are encouraged (even when there is tension within one person or between people). Moreover, "voices of the patient and family members usually represent the most intimate connection to the conversational themes in treatment meetings, given that family members are their best experts in their own lives. Each person's voice reflects the multiple positions each person simultaneously holds in life" (Haarakangas, *et al.*, 2007, p.226). In outer polyphony, therapists create a dialogical context, where everyone's voices are respected, including incorporating incongruent language. In multiple inner polyphony, clinicians listen to and engage all the voices from each person in the therapeutic conversation.

7. Creating a relational focus in the dialogue: In dialogical therapeutic conversations, relational questions are used to understand the presenting problems within a relational context, thereby opening "new pathways for voice and expression" (Olson, Seikkula, and Ziedonis, 2014, p.20). Anderson (2012) described 'mutual inquiry' as an "in-there-together process in which two or more people put their heads together to address the reason for the conversation" (p.15), and added that it entails what Derrida calls 'unconditional hospitality'.

8. Responding to problem discourse or behaviour as meaningful: Therapists focus on "normalising discourses" rather than pathologising discourses. Clinicians emphasise an understanding of the symptoms/problem behaviour as meaningful within their context, as a 'natural' response to difficult circumstances by listening "for the meaningful and 'logical' aspects of each person's response" (Olson, Seikkula, and Ziedonis, 2014, p.22). This element is similar to the positive connotations and exploration of unique outcomes/exceptions.

9. Emphasising the clients' own words and stories-not symptoms: There is a focus on creating a common language and larger story about the client's life, experiences, thoughts, feelings, and not just focusing on reporting symptoms. Furthermore, "severe symptoms may be understood as embodying inexpressible or unspeakable dilemmas" (Olson, Seikkula, and Ziedonis, 2014, p.23). These may be accessed by focusing on the small details in the stories told or on what happens as the person is telling their story.

10. Conversation among professionals in the treatment meeting: The reflecting process, making treatment decisions, and asking for feedback: Similarly to reflecting teams' conversations, in open dialogue network meetings, professionals talk to each other in the presence of the family and other participants, but do not directly talk to them. When doing so, they are advised to look at and talk to each other and not at the family or any other participant. Olson, Seikkula, and Ziedonis (2014) explained that there are three parts to this conversation: The reflecting process between therapists about their own thoughts, images and associations; Therapists talk to the other professionals about the understanding of the problem, the treatment plan, and recommendations; Finally, the family comments on the previous conversations between professionals. The first two steps are exchangeable, but the third step is always last.

11. Being transparent: When clinicians reflect, they are transparent with the treatment options (e.g. hospitalisation, medication, treatment models, who is invited to the next meeting and when it is organised) as these are shared with everyone in the network meeting. They do not make a professional recommendation, as the options are open for discussion. Anderson (2012) highlighted the importance of therapists 'being public' about their 'inner conversations'.

12. Tolerating uncertainty: Olson, Seikkula, and Ziedonis (2014) stated that "tolerating uncertainty is at the heart of dialogue. It is thus a specific element and an element that defines the other elements" (p.27). A basic aim of Open Dialogue is to create a shared understanding of the crisis, which involves tolerating uncertainty. Additionally, Anderson (2012) explained that "a therapist's ability to trust uncertainty is important and involves taking a risk and being open to the unforeseen" (p.19).

APPENDIX 2.- FOCUS GROUP/THERAPISTS' INTERVIEW GUIDE QUESTIONS

Group interview topic guide questions

Version 2.0 23rd February 2014

This is an interview guide, as the specific questions will be tailored according to the participants' responses, but they will be around the following areas:

What do you think group cohesion is?, or, What do you think connecting with a group means? What might you see as an observer that would make you think….?

What difference does it make to a group, if its members connect well or not?

What helps a group to work well together?

In terms of a group connecting well, what are the challenges faced by the group?

What about when its members speak different languages?

Does it make any difference to their ability to work well together?

What might be the advantages or disadvantages of group members speaking different languages?

Do MFT activities and meetings help with a group connecting well or not?

I will show them some clips of the session previously recorded, that I had identified as cohesive or disconnected moments:

I will then ask them:

What do you make of the clip?

Were the participants connected?

What helped that moment?

Was it something you or someone else did?

What about the therapist?

What about the interpreter?

Can you think of another moment when you felt connected or disconnected in this group?

Was it something you or someone else did?

What about the therapist?

What about the interpreter?

Do you think that therapists have a part to play in the group working well or not?

What do you think they could do to encourage groups to gel?

Anything different if its members speak different languages? Nvc, relationship with therapists

Do you think that interpreters have a part to play in the group working well or not? Including nvc

- As an interpreter, have you thought about the impact of your role on group members gelling?.

What do you think you do to facilitate this?

Or could do?

- What challenges might an interpreter face that might impact on a group connecting well or not?

- What are the advantages and disadvantages of a group where its members speak the same language? Does it make any difference to a group gelling?

- Are emotions expressed in the same way in different languages/cultures?

- Are you able to be as playful in different languages/cultures?

- How confident do you feel about asking questions? What about asking for help?
AND GIVING

- What difference do you think it makes to the group if a group gels, in comparison with one that doesn't gel? (i.e. your individual goals, group attendance, involvement in the group).

- What do you think are participants' characteristics that might facilitate a group gelling or not?

- We think it is beneficial working with families of different cultures. What do you think?

- What changes would you suggest for MFGs?

APPENDIX 3.- PHRASES USED IN FOCUS GROUP TO DESCRIBE GROUP COHESION- raw data (focus group)

Families' descriptions of GROUP COHESION	Frequency	My description of GROUP COHESION	Frequency	My observations
		Group working well TOGETHER	1,1,1,1,1,	
		Feel connected to a group	1	
		Get on well together	1,1	
We all got same, similar problems	1			
Being in the same boat	1			
		Sharing a journey together	1	
		Connect with each other		
Sit with each other	1	Sit with each other	1	
		Similarities (features, lang, race)	1	
Gravitate to… at breaks-race	1			Interpreter as part of the team, she gets consulted how long a family has been coming.
		How getting on with someone new		
Get on well with parents of children in secondary school	1			
We are closer	1			

AS: Work well together	1,1			
AS: Connect	1			
Common Aim- Same aim	1,1,1,1			
Want the same end result	1			
		Similar goal	1	
GENUINELY CARE… about their child and each other… if not genuine no point	1,1,1,1,1			
Want your child and their child to do well	1			
You kind of build relationships with the parent and their child	1			
		Caring for each other- showing you care		
AS: do footballers genuinely care for each other?	1,1,1			
Footballers, not sure if they like each other or not	1,1,			
To reach same goal they like each other	1			
Act as a team together,	1			
Work together … in order to (football)	1			
Practice together				
Here, good teamwork needs good communication	1,1,1,1			

absolutely	0			
it's the key	0			
We spend so much time together				
It's a lot of time	1,1,1			
		Activities—difference to how they work as a team		
		Connect better together		
Work together	1			
Work together as a team	1,1			
Help each other along the way	1			
		Activities getting you to connect with each other.		
Getting to know each other (disclosure)	1,1			
Understanding each other's good and weak points.	1			
As parents we work together	1			
You HAD to participate	1			
You HAD to communicate with people	1,1			
You HAD to come out	1			
Connected more strongly	1,1			

Makes relationship with people even more formal	1			
Like a family experience	1,1			
EXACTLY	0			
Communication stronger	1			Doing not just talking, stronger relationships
Make people work with each other, makes relationship between parents stronger				NN: we have been talking really fast
		Activities to connect to group		
Sit together and think together about our problems, really gives me practice for myself				People don't need to be speaking to be involved
Feelings or things we discuss, to clear stuff (only adults)				
		Activities that bring you together as a group		
Always play football together				
Knowing someone before coming here				
Outing- doing something enjoyable together	1,1,1,1,1,1,1			
Best activity	1,1,1			

We had a really good time	1			
Really enjoyed that	1			
		Videos: FEEL you were connected to or disconnected from each other		
		A lot of touching (patting, shaking hands)		
		Touch, cultural		
		Touch may play part in connecting with each other		
Our culture we shake hands				
We touch a lot				
		A lot of touching within each family, lots of cuddles		
		Warmth		
		Touch helps group work well together or working well then you touch		
Touch shows that we work well together				
				Physical closeness: sit next to me (video)
		Feel comfortable- part of the group		Accepted

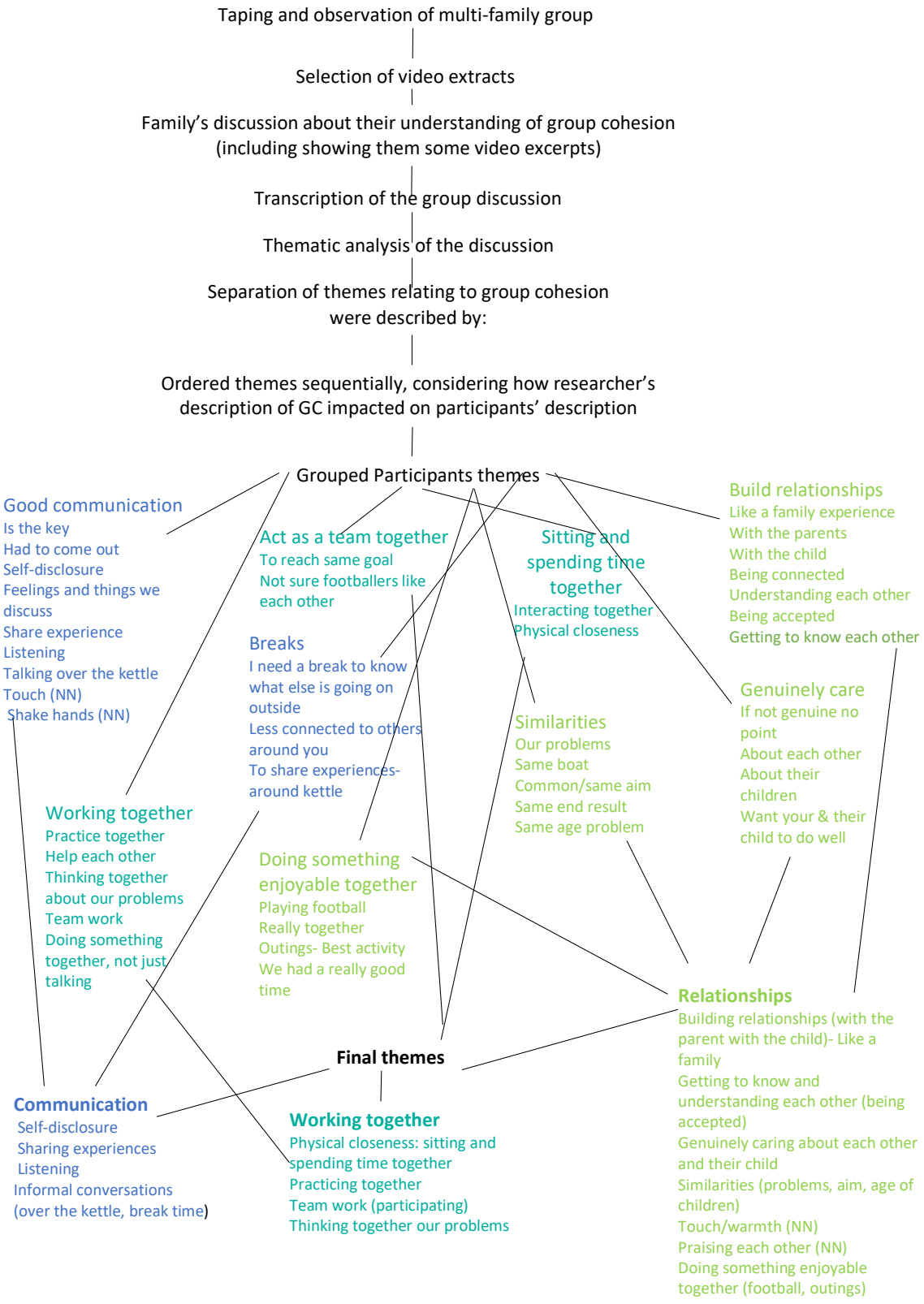
				Acknowledging someone's presence outside of the group (SP)-touch
				Use of humour (I'm going bold)
We work well doing presentations				Doing something together
Teamwork (ch)		1		
Clapping				
Listening				
PHONES				Ruptures, disconnections, break time
Antisocial behaviour				
		Phones--Connecting or disconnecting from each other		
Connect with social media				
Intensely focused on the group (being so like into group and stuff)	1			
100% inside the room, not connected to the outside world	1			

You are 100% in the group	1			
Break- what else have I got to do outside of here	1			
It's only the break time- when I can connect with the outside world	1			
Family rule: spend time with each other. Good opportunity to interact and work well together.	1			Salma(pf) speaks voluntarily for the first time
SP: REALLY listening				
Phone less connected to people around you, more connected to the people on phone		Connect with people here, it feels quite intense, need a break.		
2 hours here like 4 hours				Intense
I need a break to know what's going on				
		Salma(pf) was saying break times good to get to know each other		
Break time sometimes yes to share experiences… especially when we come as adults together, we talk more freely.				
Sometimes I don't use my phone, if I don't have messages.				

Sometimes I make tea and we gather around the kettle.				
We have a word				
We go out and play football				
		How do you work as a group if you are on your phones during break times?		
SP: MY experience… over the years. WE FEEL THAT the break time, the talking over the kettle IT is REALLY valuable. We always had that feedback… enough of a break	1,1			
		Get to know each other, some people make friends after being part of these groups		

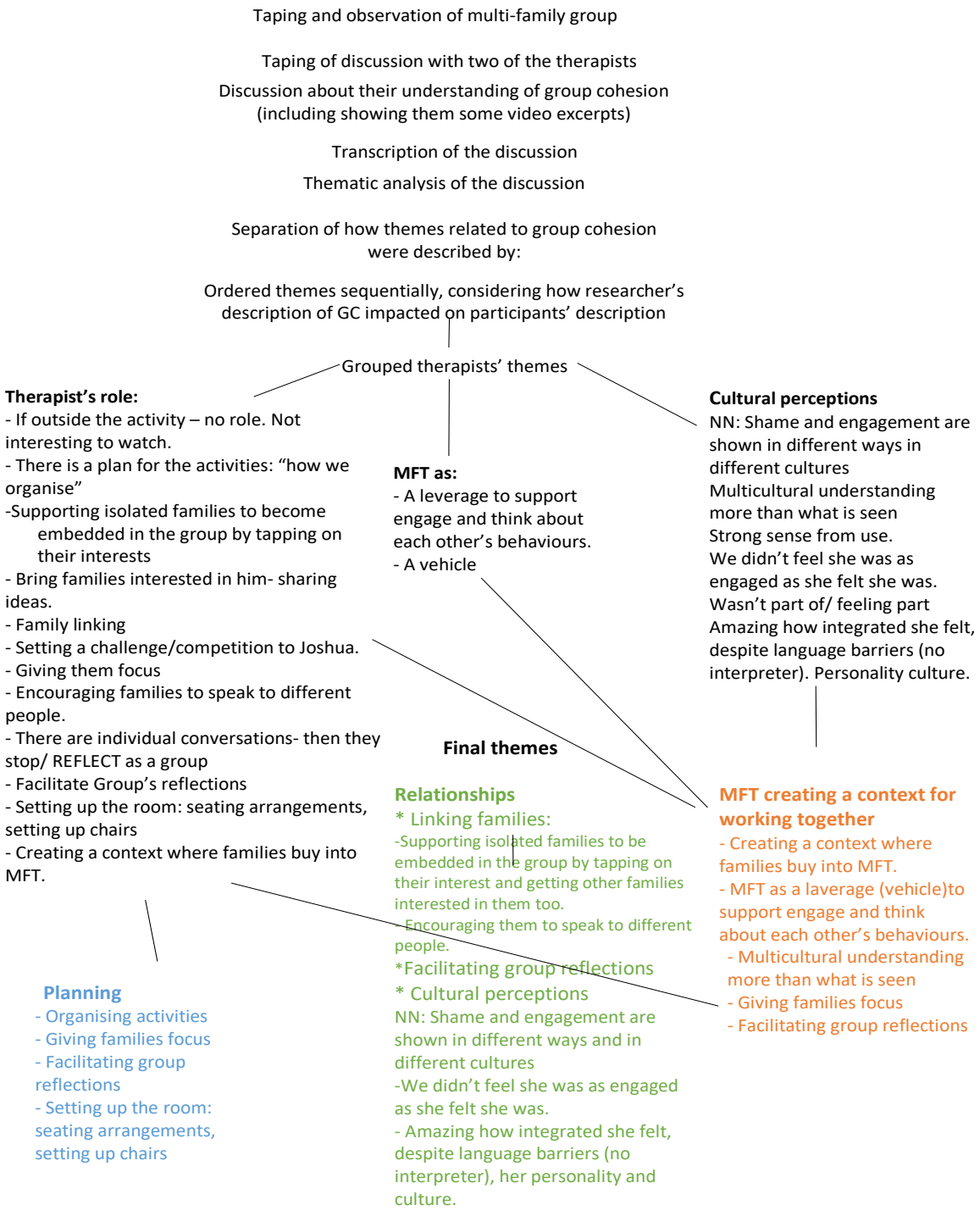
APPENDIX 4.- MAIN THEMES- Focus group- PICTURE 3

APPENDIX 5.- FLOW-CHART OF THEMATIC ANALYSIS PROCESS OF FOCUS GROUP: Main themes/sub-themes-PICTURE 4



APPENDIX 6.- FLOW-CHART OF THEMATIC ANALYSIS PROCESS OF THERAPISTS' INTERVIEW:

Main themes/sub-themes-PICTURE 5



APPENDIX 7.- PHRASES USED TO DESCRIBE GROUP COHESION-raw data (therapists)

Therapist's role:

- If outside the activity – no role. Not interesting to watch.
- There is a plan for the activities: "how we organise"
- Child's INTERESTS "REALLY into xxxx"
    - Embed him into the group
    - Supporting isolated families.
- Bring families interested in him- sharing ideas.
- Family linking
- Setting a challenge/competition for a child.
- Giving them focus
- Encouraging families to speak to different people.
- There are individual conversations- then they stop/ REFLECT as a group
- Facilitate Group's reflections
- Setting up the room: sitting arrangements, setting up chairs
- Creating a context where families buy into MFT.

MFT as:

A leverage to support, engage and think about each other's behaviours.

A vehicle

Group's role:

Supportive

Acceptance

Friendly

Helping each other

Feeling comfortable.

Cultural perceptions

NN: Shame, engagement in different ways in different cultures

Multicultural understanding more than what is seen

Strong sense from use. We didn't feel as engaged as she felt she was.

Wasn't part of/ feeling part

Amazing how integrated she felt

Despite language barriers (no interpreter). Personality culture.

APPENDIX 8.- MAIN THEMES-Therapists- PICTURE 6

APPENDIX 9.- E-MAIL INVITATION TO RESEARCH

- Invitation e-mail -

27th March 2014

Re: Request for research participants.

Multilingual Multifamily Therapy groups

Dear colleague,

I am writing to invite you, some of the families you work with and their interpreters to take part in a research study I am doing as part of the Doctorate in Systemic Psychotherapy at the Tavistock Clinic, jointly run with University of East London. This is an exploration of "*Group Cohesion in Multifamily Therapy with multilingual families*". This study has been reviewed and given a Favourable Opinion by the NRES Committee East Midlands - Leicester.

Many of us are running Multifamily Groups, with participants who speak a number of different languages. I am interested in researching processes that enable group cohesion in multilingual groups.

If you and the families you are working with are willing to take part, I would like to video record a Multifamily therapy session. A little later I would like to interview all the participants (i.e. family members, their interpreters and therapists) in a group interview to explore what they think facilitates group cohesion, or not. This would comprise watching video excerpts of the session they attended and then reflecting on these. This group interview would probably last 90 minutes and itself would be video recorded. Both you and the participants will be anonymised in the research data when presented and written up.

If you are interested in taking part in this project, please contact me at this email address: n.nascimento@nhs.net. I am very happy to discuss the research further. Once you decide you would like to participate in this research, please inform the families and interpreters in the group you are running that I am interested in carrying out this research to see whether they would be interested in

taking part. It will obviously be important that any potential participant feels free to refuse without feeling this will jeopardise their therapy with you. Please share this email with the families attending the group (and their interpreters). Additionally, I could come to the group to explain it personally to them.

I look forward to hearing from you.

Many thanks in advance for your help, I really appreciate it.

Kind regards,

Natasha Nascimento.
Family and Systemic Psychotherapist - Researcher
Marlborough Family Service

APPENDIX 10.- INFORMATION SHEETS

Information sheet

(children aged 6 to 10 years)

Study title: *"Group Cohesion in Multifamily groups with families that speak different languages".*

What is research? Why is this project being done?

Research is a way we try to find out the answers to questions. We want to see what helps group members to connect with each other when its members speak different languages. We want to learn from you what we could do differently.

Why have I been asked to take part? Did anyone else check the study is OK to do?

You are in a group where families speak different languages. Before any research is allowed to happen, it has to be checked by a group of people called a Research Ethics Committee. The National Research Ethics Services (NRES) Research Ethics Committee has checked this project. They make sure that the research is fair.

Do I have to take part?

It is up to you and you can choose if you don't want to answer any question.

What will happen to me if I take part in the research?

I will video record one of the group sessions you attend with your parent and another day I will interview all the members of the group to think about what helps groups come together. Your parent/carer will give consent (permission) to this.

Might anything else about the research upset me?

It is unlikely you will get upset with the research, but if you do, we will make sure that we can support you.

Will the information I give be kept private if I take part? Will anyone else know I'm doing this?

Apart from the other families attending the group, no one else will know of your participation unless it is necessary. Others in the research team might watch some video clips of the group meetings.

What if I don't want to do the research anymore?

If at any time you don't want to do the research anymore, just tell your parents, group leader or researcher. They will not be cross with you.

Information sheet

(11 to 15 years old)

Title of Study: *"Group Cohesion in Multifamily Therapy with multilingual families".*

Part 1

Invitation

We are asking if you would join in a research project to find the answer to the question, what helps Multifamily groups where families speak different languages to connect with each other? Before you decide if you want to join in, it's important to understand why the research is being done and what it will involve for you, so please read this letter carefully. Talk to your family, friends and [NAME OF CLINICIAN] if you want to.

Why are we doing this research?

As a Multifamily Therapist, I am interested in exploring what families, interpreters and therapists think could be done to improve group cohesion (how a group members connect with each other) when they speak different languages. I am particularly interested in getting your ideas about what we could do differently, so that we can put these ideas into practice with other groups and improve our practice with these families.

Do I have to take part?

No. It is up to you. We will ask you for your consent and then ask if you would sign a form. We will give you a copy of this information sheet and your signed form to keep. You are free to stop taking part at any time during the research without giving a reason. If you decide to stop, this will not affect the care you receive.

What will happen to me if I take part?

You will continue being part of the Multifamily group you are already part of with your parent. I will not ask you any personal information, apart from your name and what language(s) you speak. You can always choose not to answer any question you like.

With your permission, I will video-record one of the Multifamily Therapy sessions you attend.

Later on, I will watch this video-recording and select some video clips where it seems that group cohesion and languages have been relevant. Another day, but on the same day you regularly have the group, soon after you finish the group we will meet. I will show you these video clips to get your ideas about what helps or doesn't help group members to connect and what you think we should do differently. I will also video-record these discussions so that I can transcribe (taking out the names and any information that might identify you) and analyse the transcripts later. I will stay after the group has finished in case you would like to share anything with me individually. After this meeting, your involvement with this research will end and you will continue attending the group. These recordings will be safely stored at the Marlborough and destroyed once the research has finished.

Contact details

If you would like further information, please contact me on 020 7624 8605 ext 259 or n.nascimento@nhs.net.

Thank you for reading so far – if you are still interested, please go to Part 2

Part 2

More detail – information you need to know if you want to take part.

Who do I ask if I have any questions?

If you have any questions please ask me, your family or [NAME OF CLINICIAN] at any time.

What if there is a problem?

In the unlikely event that you become distressed during any of the conversations in the study, please let the researcher know and the conversation will be stopped and we will support you. If this is evident, the researcher will herself stop the conversation. Your therapist will also be available for you to discuss your concerns.

Will anyone else know I'm doing this?

We will keep your information in confidence (private) within the research team. This means we will only tell those who have a need or right to know. You will choose a different name, so that no one can recognise you in any written information.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee (National Research Ethics Services). They make sure that the research is fair.

Thank you for reading this – please ask any questions if you need to.

Participant information sheet

- Version 2.0 Adult –February 2014

REC reference number 14/EM/0071

Title of Study: *"Research on Group Cohesion in Multifamily Therapy with multilingual families".*

Researcher: Natasha Nascimento (Family and Systemic Psychotherapist).

Supervisor: Dr. Charlotte Burck, Consultant Systemic Psychotherapist, Tavistock Clinic.

We would like to invite you to participate in this original research project. This information letter is designed to give you more information about the study and tell you about your role as a participant. You should only participate if you want to. Choosing not to take part will not disadvantage you in any way. Please take time to read the following information carefully. We would suggest this should take 10 minutes. I will go through the information sheet with the group and answer any questions you have. Talk to others about the study if you wish, including other families, interpreters, and therapists in your group or anyone else. Ask us if there is anything that is not clear or if you would like more information.

I am a Family Therapist. I work at the Marlborough Family Service and I have run Multifamily therapy Groups for the last 4 years. I am doing this research as part of the Professional Doctorate in Systemic Psychotherapy at the Tavistock Clinic, jointly run with University of East London. It has received ethical approval from National Research Ethics Services (NRES) Research Ethics Committee.

What is the study about? As a Multifamily Therapist, I am interested in exploring what families, interpreters and therapists think could be done to improve group cohesion (how group members connect with each other) in Multifamily groups with monolingual and multilingual family members despite language barriers. I am particularly interested in getting your ideas about what we could do differently, so that we can put these ideas into practice with other groups and improve our practice.

Do I have to take part? This is entirely up to you to decide. The therapist running the group will

ask each group member individually whether they would like to take part in the study. If all of you agree to take part, we will then ask each of you to sign a consent form. You are free to withdraw from the study at any time, without giving a reason. This would not affect the standard of care you receive. If you are an interpreter, this will not affect whether we use your services in the future.

What will happen to me (and my child- if applicable) if I take part? You will continue being part of the Multifamily group you are already part of and no treatment will be withheld if you take part in this research or not, or if you withdraw from it. I will ask you some personal information, apart from your name, what language(s) you speak, place of birth, numbers of years living in the UK and your age. You can always choose not to answer any question you like. Your personal information will be treated confidentially and will not be disclosed in the final report. We are just asking for this information as it might help us with the analysis. I will not ask you why you have been referred to our service.

With your permission, I will video-record one of the Multifamily Therapy sessions you attend. I will watch this video-recording and I will select some video excerpts where it seems that group cohesion and multilingualism have been relevant in the group processes. Another day, but on the same day you regularly have the group, soon after you finish the group we will meet for about 90 minutes and I will show you these excerpts to gather your ideas about group cohesion, what facilitates it or doesn't facilitate it and what you think we could do differently. We will discuss this as a group and I will also video-record this discussion so that I can transcribe it (taking out the names and any information that might identify you or your child) and analyse the transcripts later. I will stay after the group has finished in case you would like to share anything with me individually. This meeting will not be a therapeutic meeting and it will be over and above your regular Multifamily therapy sessions. After this meeting, your involvement with this research will end and you will continue attending the group. If you decide to withdraw, we will not analyse any of the video excerpts in which you and/or your family members participate; however, we will need to keep the video recordings, as part of the group recording.

What are the possible disadvantages and risks of taking part? Although I do not anticipate any harm or risk arising from the study, distress may arise for participants. I will stop any discussion

immediately in the unlikely event that you show or express any distress. If there are questions that you find distressing or intrusive, you are free to not answer those questions or to withdraw from participating. We will make sure your child understands that if there are questions he or she finds distressing or intrusive, then she or he need not answer them and she or he can withdraw from participation at any time without penalty.

What will happen if I don't want to carry on with the study? You do not have to give any explanation if you withdraw from the study. If you withdraw, this will not have any negative effect on the treatment you receive, which will continue as regularly.

What if there is a problem? Distress: If you or any member of your family becomes distressed during any of the conversations in the study, please let the researcher know and the conversation will be stopped. If this is evident, the researcher will herself stop the conversation. Your therapist will also be available for you to discuss your concerns.

Therapist: you could address this with your clinical supervisor.

Interpreters: If you become distressed during any of the conversations in the study, you should talk to the researcher, who will be able to advise you where you could get some help to manage this.

Complaints: If you have any concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions [02076248605 ext 259]. You can also contact the Patient Advice and Liaison Service (PALS) for help and advice (pals.cnwl@nhs.net or 020 3214 5773). If the researcher has been unable to resolve your concerns and you want to make a formal or serious complaint you can write to the Chief Executive or the Complaints Manager at CNWL Trust Headquarters, Stephenson House, 75 Hampstead Road, London NW1 2Pl. You can also telephone the Complaints Office on 020 3214 5784 or 020 3214 5785, or email complaints.cnwl@nhs.net.

Harm: We do not anticipate any harm occurring as a result of this research. However, in the event that something does go wrong and you are harmed during the research and this is due to someone‘s negligence then you may have grounds for legal action for compensation against University of East London, but you may have to pay your legal costs. Additionally, the normal National Health Service complaints mechanisms will still be available to you.

Will my taking part in this study be kept confidential? All information collected about you during the course of the research will be kept strictly confidential within the limits of the law. It will be as securely kept as any of your medical records (in accordance with the Caldecott principles and appropriate legislation, including the Data Protection Act 1998). You will choose a pseudonym to replace *any* written information we have in the data file that identifies your name, your child's name, and any other contact details we have for you. The information that you and your child give us during the interview will be *completely anonymised* and linked only to the pseudonym.

All video recordings will be saved on secured computers in locked offices at the Marlborough, and they will also be saved in an encrypted[65] portable device, which the researcher will use to transcribe the interviews on her home computer. The video recordings will only be watched by the researcher and the supervisory team and will not be saved on the researcher's personal computer. The transcription of the video recordings will have your name and your child's name removed; only a pseudonym will be included so that you cannot be recognised. Research supervisors, peers and examiners will look at the anonymised transcripts. They may also be looked at by authorised people to check that the study is being carried out correctly**.** All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. The video recordings and transcripts will be completely destroyed once the research has been completed.

What will happen to the results of the research study? I am not sure how long this research project will take. I anticipate that it will be a couple of years, but if you are interested in the results of the research I could send you a summary of the results. You could either let me know at the beginning of the research or contact me on the above number/email. As I mentioned previously, you will not be identified in any report/publication, but I might include some anonymised quotes of what was said in the meetings. The results of the study will be written up. You will not be identifiable in the write up or any publication which might ensue.

Who is organising and funding the research? This research is part of my academic studies to obtain a Professional Doctorate in Systemic Psychotherapy. I am funding this project and no one

[65] Encryption is the process of encoding messages (or information) in such a way that third parties cannot read it, but only authorised parties can (Wikipedia).

is paying me to conduct this study. My Sponsor is Professor Neville Punchard from the University of East London.

Who has reviewed the study? All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a Favourable Opinion by the NRES Committee East Midlands – Leicester

Further information and contact details

If you would like further information, please contact me on 020 7624 8605 ext 259 or n.nascimento@nhs.net. Alternatively, you can also contact my supervisor: Dr. Charlotte Burck on 020 8938 2298, who is the Chief Investigator of this project

As a participant, you will be given a copy of this information sheet and the signed consent form to keep.

Many thanks in advance for reading this document and any support you might give me.

Name of researcher: Natasha Nascimento _____

Name of participant: _____ _____

Date: _____

APPENDIX 11.- CONSENT FORMS

ASSENT FORM FOR CHILDREN

6-10 year old Consent form

(to be completed by the child and their parent/guardian if appropriate)

Study title: *"Group Cohesion in Multifamily groups with families that speak different languages".*

If you would like to take part then please read the following statements. If you agree with them put your initials in the box following each statement.

Has somebody else explained this project to you?	
Do you understand what this project is about?	
Have you asked all the questions you want?	
Have you had your questions answered in a way you understand?	
Do you understand it's OK to stop taking part at any time?	
Are you happy to take part?	

If any answers are "no" or you don't want to take part, don't sign your name!

If you do want to take part, you can write your name below

Your name: _____

Date: _____

Parent: _____

The person who explained this project to you needs to sign too:

Print Name: _____

Sign: _____

Date: _____

Thank you for your help!

CONSENT FORM FOR YOUNG PEOPLE

11-15 year old Consent form

(to be completed by the child and their parent/guardian if appropriate)

Study title: *"Group Cohesion in Multifamily groups with families that speak different languages".*

If you would like to take part then please read the following statements. If you agree with them put your initials in the box following each statement.

Has somebody else explained this project to you?	
Do you understand what this project is about?	
Have you asked all the questions you want?	
Have you had your questions answered in a way you understand?	
Do you understand it's OK to stop taking part at any time?	
Are you happy to take part?	

If any answers are "no" or you don't want to take part, don't sign your name!

If you do want to take part, you can write your name below

Your name: _____

Date: _____

Parent: _____

The person who explained this project to you needs to sign too:

Print Name: _____

Sign: _____

Date: _____

Thank you for your help!

ADULT CONSENT FORM

Version 2 (Parent), February 2014

REC reference number 14/EM/0071

Title of Study: *"Research on Group Cohesion in Multifamily Therapy with multilingual families".*

Researcher: Natasha Nascimento (Family and Systemic Psychotherapist).

Supervisor: Dr. Charlotte Burck, Consultant Systemic Psychotherapist, Tavistock Clinic.

Please tick as appropriate:

		YES	NO
1.	I confirm that I have read and understood the information sheet dated ..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐	☐
2	I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the Marlborough Family Service, and by regulatory authorities from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐	☐
3.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐	☐
4.	I consent to use of video-recording, with possible use of verbatim quotes.	☐	☐
5.	I consent to showing excerpts of the video recordings only to supervisors of the research.	☐	☐

6. I consent to showing excerpts of the video-recorded session to the group, even if I am not able to attend the second group interview session. ☐ ☐

7. I agree to my _____ (insert number here) children taking part in the above study. ☐ ☐

8. I agree to take part in the above study. ☐ ☐

Name of Participant: _____ Signature: _____

Name of Researcher: Natasha Nascimento Signature: _____

Date: _____

APPENDIX 12.- PILOT INTERVIEW-TRANSCRIPT AND ANALYSIS

N- So you were saying just now, that comm/ Was all part of the plan?

B – Yeah

N – and somebody told you to come???

B– Yeah that's right, I was given this sort of plan of stuff to do and then I say in the middle of that it was towards the end of that was this Parenting Assessment you know. Come here and the thought of it, the thought of coming here to do this Parenting Assessment was really scary. I'll be honest I didn't really know, I didn't really ask any questions to find out what was involved in it, I just kind of thought you know I suppose. Which is true to a certain extent I was going to be assessed on how my parenting skills were, I mean Fred was in care, I think the thing for me was Fred's care and plus I had a daughter who was around 10 and then at this sort of stage in my life that I was being assessed as a parent it seemed quite strange you know because if I'm totally honest it's something I hadn't really thought about. I'd got through my life, I'd gone through my life not really thinking about much, not in great detail, kind of having a thought and not thinking long term and not really thinking too deep into stuff.

N – You hadn't thought about your parenting, you'd never ?????

B – No, and no one else had so it was kind of, you know, I say no one else had we had had some problems with my daughter so I was told about this plan, I was coming to the Marlborough and my son was in care and I could just sort of picture myself, I really felt under pressure

N - ???

B – Because I didn't really know myself, I didn't really know, I'd been having contact up until this point and I'm trying to think how old he was when he came here – he would have been just under a year.

N- 10 months to a year May

B – So the foster carer bringing him, just having to knowing how to do the handover, getting feedback, knowing

N – It's a practical thing

B – Yeah

N – And what helped too? What do you think helped?

B – There was other parents here, and that was sort of strange, we used to have this group in the morning and we would sort of have a little check in and at the time there was, it was a mixed group, a range of people from different backgrounds, but you know I'm not too sure what really helped, I just kind of stuck with it and I think I did ask questions and I got help from the people that worked here, they really, really helped and I kind of went with it. But I can just remember when I come in and like I said I spoke about that pressure but just sticking to Fred's routine and just by the clock I was really sort of ruled by that for some time really not wanting to get that wrong and then having to give Fred back.

N – That became difficult?

B – Yeah, like I say, I got to know him here, I got to know him

N - ???

B – Yeah, that's what I had to do?????/ see him at contact for a couple of hours a week. It was a big pressure, but you know it was something that needed to be done and just trying to think we had a check in with the groups and I'm trying to think how long I was here.

N – Usually it's 3 months or longer. You know it could be 3 months ?????? you could have a bit longer.

B – Yeah and I just got to enjoy it, I started to enjoy it, we used to do some different stuff. We worked in the group and got to know each other and it was great to be able to work with people.

N – So do you feel that working with other parents, having fun as well, checking in with each other.

B – Yeah that's it we sort of reassured each other, helped each other, little tips I was given. I think I sort of helped.

N – You also had a ????

B – Yeah but again like I say when you feel like you're being questioned, assessed it's like the spotlight's on you, you kind of freeze a bit and there was times where I felt a lot more comfortable and kind of went with it.

N – So what do you think would help other parents coming with similar experience to ???

B – It's difficult, but I suppose not to be so scared, maybe ask some questions beforehand so you can prepare yourself, use your mind a little bit and I've said it a few times I was given a lot of help and I think that was one of the main things that was here to help me. Again it was difficult to ask questions at first, it was only till I got into it and realised the process.

N – So you think ?????? knowing they can ask questions. Would that be helpful for them?

B– Yeah. It would have been for me, just to get your mind over this is here to help me, I learned that asking for help is not such a bad thing. Especially around parenting, again I'm no expert but you know I just think there is things you should know and there is a way to do it and you know all kids are different and it was great to get people's views.

N – As we said ?????

B – Well when I was here my Parenting Assessment went well, I was given Care of my son and just get more help, I come here for the group, I come here for some sort of help and therapy and it's just a great place to come and talk for me it has been. Ongoing stuff, to look at stuff – my family, how I was brought up and how that's affected me now, good and bad, the way I see stuff, the way I act. I can remember the therapist who done some work with my family. It really opened my eyes up to how the family behaves.

N - ???

B – Exactly, yeah it's just been a great journey really.

N – What do you think you have learned?

B– Laughs. I have learned loads. It's hard to pinpoint one thing. I got to know my son, I got to know other people, a couple of people I have kept in contact with and I see around.

N – and you said???????

B – Yeah it's been up and down and it's gone so quick. It is tough, what I've learnt is that with kids, you can't give up, you know you need to persevere and you need to be consistent and that's what I've been, that's what I've done. My son is starting school soon. He has been going to Nursery, just being able to see the change in him and the development in him it's just been brilliant.

N –

B – Talking about it, and again asking for help in areas that I needed help but mainly talking about it with professionals, with social services. Fred was placed in my care but he was under a supervision order and part of me has been up and down but it hasn't been that hard. I didn't really know much about that. I didn't really think about it too much, but now I can look at things from a different angle whereas before I had a blinkered vision of stuff and how society sees

things and how I was taught to see things. That's been one of the main things I have learnt – talking about stuff when it's difficult.

N -

B - Again it was tough there was many times in it, and that was a great ??? as well, I was pushed a little bit in a good way to kind of think about. One of my favourite answers was 'I don't know'.

N- I remember that.

B – and I was really pushed to challenge that. I was challenged and it was tough. I remember at one point there was one day in the garden and there was a child playing up, from what I could see it was someone that worked here with the child and I think the child was being very difficult. So again I was challenged and I approached them.

N – ?????Giving advice to somebody else???? What advice would you give them?

B – Ask a little bit of advice do some research, ask some questions and I think don't give up – just keep going no matter how tough it is.

B - Just asking about advice I would say do a little bit of research ask some questions don't be afraid to be assertive and I'll say ask why but, possibly you might know why you're coming but, just ask what it entails, you know what is gonna be asked of you and stuff like that. Just take part, try to enjoy it and for me I felt under pressure at certain times and I don't know whether it was different for me being a man or what, I'm not too sure, there was other men at times on the programme working with other parents, the Mums and Dads working together. I think there was a few times when Dads have come on their own. I think it was actually a challenging thing coming to a setting and like I say I had to.

N – Perseverance?

B – Perseverance, ask for help

N – and talk?

B – Yeah, express how you're feeling

PILOT INTERVIEW ANALYSIS

During the process of applying for ethical approval (six months before gaining ethical approval), I wanted to discuss the aims of the research and the questions specifically with someone who had been part of MFT, but was no longer involved. Therefore, I informally approached one of the group members that used to be part of one of the Multifamily groups I ran three years before, which I had felt had been a cohesive group. He is of White British origin. To maintain confidentiality, I will call him Ben. I was never involved directly with him and he had stopped the Multifamily work a few years ago. Ben was very keen to discuss the research. This interview gave me confidence in terms of my area of study (group cohesion), as he highlighted some issues concerning group cohesion without being prompted. Additionally, he also looked at the questions and he agreed with them.

In terms of what I learned by doing this pilot study, was how difficult this father had found it to ask questions about the process of the Multifamily therapy before it started. I understand that the context of his referral was different, as he had been mandated to attend the group, but I also believe that some, if not all, of the group members I recorded probably felt under pressure to attend, as they had been referred by this school. This might help some group members to motivate them to make changes. Considering this, I made sure that I explained the research process in detail in a number of ways (first, the clinicians explained it, then I presented the research to all of them as a group and then, on the day of the recording, I went through the information sheet and consent form with each of them individually, giving them space to ask any questions on any of these occasions) and I allowed group members to decide (without pressure) whether they wanted to participate in the research or not.

Contexts for making connections. Structure for communication.

The aim of this conversation was to establish what Ben believed had helped him in the group he had been part of. In this dialogue, it became clear to me that, without realising, he was also talking about group cohesion. He mentioned that something that helped him was “checking in” each morning, “sticking with it”, “asking questions”, “getting help from people that worked here… they really, really helped”. He reported that he was pushed a little bit himself in a good way and to help others. He added: “I just got to enjoy it, I started to enjoy it, we used to do some different stuff.

We worked in the group and got to know each other and it was great to be able to work with people... we sort of reassured each other, helped each other, little tips I was given. I think it sort of help". Ben explained that it was great to get people's views. I asked him what he would advise others attending a similar group. He replied: "just take part, try to enjoy it and for me I felt under pressure at certain times and I don't know whether it was different for me being a man or what, I'm not too sure, there was other men at times on the programme working with other parents, the Mums and Dads working together. I think there was a few times when dads have come on their own. I think it was actually a challenging thing coming to a setting and like I say I had to to do…. But, Perseverance, ask(ing) for help and express(ing) how you feel". Finally, he said: "I got to know other people, a couple of people I have kept in contact with and I see around. I think don't give up – just keep going no matter how tough it is".

Additionally, it is interesting that Ben described the group as a mixed group, with a range of people from different backgrounds, including other fathers. He also explained that "it was a big pressure, but you know it was something that needed to be done". Furthermore, he described some of his feelings. He said that he was scared and froze when he felt under` the spotlight'. He stated that "it was difficult to ask questions at first, it was only till I got into it and realised the process".

APPENDIX 13.- TRANSCRIPT'S NOTATION

(.)	Noticeable pauses of less than one second are indicated by a full stop in brackets
Œ	pauses of between 1 and 3 seconds are indicated by this symbol
(/)	Indicates interruption
(< >)	Indicates incidental contributions that were made by speakers during the other speaker's turn.
CAPITAL	Louder intonation
[ ]	Non-verbal

Transcripts were punctuated to facilitate reading.

Identifying details were changed to preserve the anonymity of participants.

APPENDIX 14.- PROVISIONAL OPINION LETTER DATED 10/2/2014

NHS
Health Research Authority

10 February 2014

Ms Natasha Nascimento Marlborough Family Service 38 Marlborough Place London NW8 0PJ

Dear Ms Nascimento

NRES Committee East Midlands - Leicester

The Old Chapel Royal Standard Place Nottingham NG1 6FS

Telephone: 0115 8839425

Study title:	**Group Cohesion in Multifamily therapy with multilingual families**
REC reference:	**14/EM/0071**
IRAS project ID:	**137821**

The Proportionate Review Sub-Committee of the NRES Committee East Midlands - Leicester reviewed the above application on 07 February 2014.

- The Committee noted this study relates to Multifamily therapy with multilingual families.
- The Committee noted this study involves qualitative methods and involves children.
- The Committee noted this study is towards a Doctorate in Systemic Psychotherapy.
- The Committee noted a number of families will receive therapy as a group, this group may comprise families who speak a number of different languages, the therapist(s) and any interpreters. They want to examine how group cohesion can be improved in such a group.

- The Committee noted the routine family therapy session will be video recorded, and that each person present must consent to the session being recorded. If 1 person does not agree then the session will not be recorded.
- The Committee noted Video recordings will be transcribed verbatim and all material will be anonymised.
- The Committee agreed this study is suitable for Proportionate Review and fits category 5.
- The Committee noted the complexity of the invitation email and noted it is very long so suggest this be simplified.
- The Committee noted the different Information Sheets and Consent/Assent Forms.
- The Adult Information Sheet is very long and the Committee suggest this be amended and someone from a participant perspective should read and comment it before it is resubmitted.
- The Committee noted the regulatory paragraph is missing from the Adult Consent Form and queried if this is required.
- The Committee queried point 3 of the Adult Consent Form 'use of verbatim' needs to be rephrased e.g. use of verbatim quotes'.

 The Committee queried point 7 of the Adult Consent Form and suggest this should include how many children will be taking part.

The Committee noted there are 7 points on the Adult Consent Form but only 6 boxes, and point 6 should be moved to be the last point on the Adult Consent Form.

The Committee noted a spelling error on the Group interview topic guide questions.

Provisional opinion

The Sub-Committee would be content to give a favourable ethical opinion of the research, subject to the following changes being made to the documentation for study participants:

1. All documents which will be given to participants need to state they will be printed on ‘headed paper'.
2. Please revise the Invitation email as this is too long and needs to be simplified.
3. Please correct the spelling mistake on the Group Interview topic guide questions.

The following changes are required to the Adult Information Sheet:

1. a) Please revise the Adult Information Sheet as this is very long and have a patient group review it.
2. b) Under the heading ‘who has reviewed the study?' Please add the name of the Committee who has approved the study. The last sentence should read ‘This study has been reviewed and given a Favourable Opinion by the NRES Committee East Midlands – Leicester.

The following changes are required to the Adult Consent Form:

1. a) Add the regulatory paragraph ‘I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from (company name), from regulatory authorities or from the NHS trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records'.
2. b) Change point 3 to say ‘I consent to use of video-recording, with possible use of ‘verbatim quotes'.
3. c) Change point 7 to say ‘I agree to (insert number here) children taking part in the above study'.
4. d) Move point 6 ‘I agree to take part in the above study' to be the last point.
5. e) Ensure there is the correct amount of boxes for each point.

When submitting your response, please send the revised documentation using tracked changes or otherwise highlighting the changes you have made and giving revised version numbers and dates.

Authority to consider your response and to confirm the final opinion on behalf of the Committee has been delegated to Professor Geoff Dickens.

Please let me know if you need any further clarification or would find it helpful to discuss the changes required with the lead reviewer.

The Committee will confirm the final ethical opinion within 7 days of receiving a full response.

Documents reviewed

The documents reviewed were:

14/EM/0071

Page 3

Document	*Version*	*Date*
REC application	137821/558350/1/836	30 January 2014
Investigator CV	Natasha Nasciemento	
Other: CV - Dr Charlotte Burck		
Other: Invitation Email	1	27 January 2014
Participant Information Sheet: Adult Information Sheet	1	27 January 2014
Participant Information Sheet: YP Information Sheet (11-15yo)	1	27 January 2014
Participant Information Sheet: Children Information Sheet (6-10 yo)	1	27 January 2014
Participant Consent Form: Adult Consent Form	1	27 January 2014
Participant Consent Form: YP Consent Form (11-15 yo)	1	27 January 2014
Participant Consent Form: Children Assent Form (6-10 yo)	1	27 January 2014
Interview Schedules/Topic Guides		

Evidence of insurance or indemnity	RSA	
Protocol	1	01 January 2014

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Yours sincerely

Professor Geoff Dickens Chair

Email: NRESCommittee.EastMidlands-Leicester@nhs.net

Enclosures: List of names and professions of members who took part in the

review

Copy to: Prof. Neville Punchard

Mr Pushpsen Joshi, CNWL R&D | Camden Provider Services

14/EM/0071 Please quote this number on all correspondence

NRES Committee East Midlands - Leicester

Attendance at PRS Sub-Committee of the REC meeting on 07 February 2014

Committee Members:

Name	*Profession*	*Present*	*Notes*
Professor Geoff Dickens	Research Manager & Head of Nursing Research	Yes	Chair
Mr John Baker	Radiation Protection Advisor and Senior Lecturer (retired)	Yes	
Mrs Valerie Webb	Nurse	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Wendy Rees	REC Manager (minutes)

APPENDIX 15.- FAVOURABLE ETHICAL OPINION DATED 3/3/2014

NHS
Health Research Authority

03 March 2014

Ms Natasha Nascimento Marlborough Family Service 38 Marlborough Place London NW8 0PJ

Dear Ms Nascimento

NRES Committee East Midlands - Leicester

The Old Chapel Royal Standard Place Nottingham NG1 6FS

Telephone: 0115 8839695

Study title:	**Group Cohesion in Multifamily therapy with multilingual families**
REC reference:	**14/EM/0071**
IRAS project ID:	**137821**

Thank you for your email of 28 February 2014, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Helen Wakefield, nrescommittee.westmidlands-edgbaston@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations

involved in the study in accordance with NHS research governance arrangements.
Guidance on applying for NHS permission for research is available in the Integrated Research

Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved by the Committee are:

Document	*Version*	*Date*
Evidence of insurance or indemnity	RSA	
Investigator CV	Natasha Nascimento	
Other: CV - Dr Charlotte Burck		

Other: Invitation Email	2.0	13 February 2014
Other: Group Interview Topic Guide Questions	2.0	23 February 2014
Participant Consent Form: Adult Consent Form	2.0	13 February 2014
Participant Consent Form: 6-10 Year Old Consent Form	2.0	23 February 2014
Participant Consent Form: 11-15 Year Old Consent Form	2.0	23 February 2014
Participant Information Sheet: Children Information Sheet (6-10 yo)	2.0	23 February 2014
Participant Information Sheet: YP Information Sheet (11-15 yo)	2.0	23 February 2014
Participant Information Sheet: Adult Information Sheet Form	2.0	23 February 2014
Protocol	1	01 January 2014
REC application	137821/558350/1/836	30 January 2014
Response to Request for Further Information	Email	28 February 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project. Yours sincerely

Mr Geoff Dickens Chair

Email: nrescommittee.eastmidlands-leicester@nhs.net

Enclosures: *"After ethical review – guidance for researchers" [SL-AR2]*

Copy to: Prof. Neville Punchard
Mr Pushpsen Joshi, CNWL R&D | Camden Provider Services

14/EM/0071 Please quote this number on all correspondence

APPENDIX 16.- FINAL FAVOURABLE ETHICAL OPINION DATED 23/4/2014

NHS
Health Research Authority

23 April 014

Ms Natasha Nascimento Marlborough Family Service 38 Marlborough Place London
NW8 0PJ

Dear Ms Nascimento

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

NRES Committee East Midlands - Leicester

The Old Chapel Royal Standard Place Nottingham NG1 6FS

Tel: 0115 8839436

Study title:	Group Cohesion in Multifamily therapy with multilingual families
REC reference:	14/EM/0071
Amendment number:	Substantial Amendment 1
Amendment date:	11 April 2014
IRAS project ID:	137821

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:
308

Document	Version	Date
Participant Information Sheet: 6 to 10 YO	4	04 April 2014
Participant Information Sheet: Adult	4	04 April 2014
Copy of IRAS Form		29 January 2014
Notice of Substantial Amendment (non-CTIMPs)		11 April 2014
Cohesiveness Scale		11 April 2014
Covering Letter		11 April 2014
Protocol	2	10 April 2014
Participant Information Sheet: 11 to 15 YO	4	04 April 2014

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

Yours sincerely

Professor Geoff Dickens Chair

E-mail: nrescommittee.eastmidlands-leicester@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Mr Pushpsen Joshi, CNWL R&D | Camden Provider Services Prof. Neville Punchard

14/EM/0071: Please quote this number on all correspondence

NRES Committee East Midlands - Leicester Attendance at Sub-Committee of the REC meeting on 18 April 2014

Name	Profession	Capacity
Mr John Baker	Radiation Protection Advisor and Senior Lecturer (retired)	Lay
Professor Geoff Dickens	Research Manager and Head of Nursing Research	Expert - Chair

17.- UREC ETHICAL APPROVAL LETTER DATED 1/4/2014

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa
Quality Assurance and Enhancement

01 April 2014

Dear Natasha,

Project Title:	**Group Cohesion in Multifamily therapy with multilingual families.**
Researcher(s):	**Natasha Nascimento**
Principal Investigator:	**Dr Charlotte Burck**

I am writing to confirm that the application for the aforementioned NHS research study reference **14/EM/0071** has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **01 April 2018**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NRES ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS ethical approval.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Catherine Fieulleteau
Ethics Integrity Manager
For and on behalf of
Professor Neville Punchard
University Research Ethics Committee (UREC) Research Ethics Office

Email: **researchethics@uel.ac.uk**

mpus, University Way, London E16 2RD
223 3322 Fax: +44 (0)20 8223 3394 MINICOM 020 8223 2853
uel.ac.uk

18.- CONFIRMATION OF UREC ETHICAL APPROVAL DATED 28/09/2016

Ms Natasha Nascimento

c/o Paru Jeram
Academic Governance and Quality Assurance Tavistock Centre
120 Belsize Lane
London
NW3 5BA

28th September 2016 Dear Ms Natasha,

University of East London/The Tavistock and Portman NHS Foundation Trust: research ethics

Study Title: Group Cohesion in Multifamily therapy with multilingual families

I am writing to inform you that the University Research Ethics Committee (UREC) has received your documents, which you submitted to the Chair of UREC, Dr Lisa Mooney. Please take this letter as written confirmation that your study has been dealt with appropriately by the NHS Research Ethics Committee and ethical approval was granted.

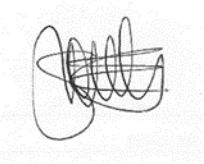
For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. If there are any other outstanding procedural matters, which need to be attended to, they will be dealt with entirely separately as they fall entirely outside the remit of our University Research Ethics Committee.

If you are in any doubt about whether, or not, there are any other outstanding matters you should contact Elisa Reyes-Simpson at the Tavistock and Portman NHS Foundation Trust (e-mail EReyes-Simpson@Tavi-Port.nhs.uk)

Yours sincerely

For and on behalf of

Dr Lisa Mooney
Chair, UEL University Research Ethics Committee



c.c. Dr Elisa Reyes-Simpson, Associate Dean, Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust
Mr David G Woodhouse, Associate Head of Governance and Legal Services Professor John Joughin, Vice-Chancellor, University of East London
Dr Lisa Mooney, Chair of the University of East London Research Ethics Committee
Dr Carlos De Luna, Head of the Graduate School

APPENDIX 19.- FULL LIST OF ALL THE EPISODES

MFT SESSION 1:

I identified the following **episodes in session:**

Setting up of the room **INFORMAL INTERACTIONS** greetings and sitting down in 2 circles (pre-speed dating exercise)

Setting up of the exercise (line 77): instructions and asking for group members' help

SPEED DATING TO REVIEW INDIVIDUAL TARGETS (line 192)

REFLECTIONS/FEEDBACK on speed dating exercise: instructions (line 326)

Presentation group 1 (lines 545- 741):

Pre-presentation: (line 545)

Presentation (line 580)

What's the [NAME OF THE GROUP]? (682)

Yasar(cm)'s listening (line 704)

Presentation group 2 (lines 744-840):

Pre-presentation (line 744)

Are they ready? (line 770)

Xbox (line 796)

Paul(T) asks about the use of the Xbox in their own family, not specific examples of group cohesion (line 842)

Presentation group 3 (lines 978-1282)

Pre-presentation (line 978)

Xbox again (line 1002)

You three go there (line 1047)

Parent presents (line 1113)

How they presented (line 1173)

Xbox again (line 1286)

BREAK (lines 1335- 1653)

Re-gathering after break (lines 1655-1696)

MASKS (lines 1701-2626)

Masks informal interactions (line 1701)

Setting up of the activity/ instructions/ staying or going (line 1769)

Beginning of Mask activity (line 1953)

1st Family's mask (line 1988)

Self-control (line 2321)

2nd Family's mask (line 2420)

BUTTERFLY PROJECT AND INFORMAL POST-SESSION INTERACTIONS (lines 2628-2816)

MFT SESSION 2

I identified the following **episodes in session:**

TARGET REVIEW by each family (lines 1-172)

INFORMAL INTERACTIONS: pre-speed dating exercise (lines 173- 195)

GROUP SPEED-DATING EXERCISE TO REVIEW INDIVIDUAL TARGETS (lines 196- 1192)

Setting up of the room and exercise (line 196): instructions and seating arrangements.

Instructions and choosing tribes (line 272)

Beginning of group review of targets (line 543)

REFLECTIONS: Review of child listening (line 726)

Challenging the idea of listening (line 1147).

FOCUS GROUP DISCUSSION:

I identified the following **episodes in this group discussion:**

- **SITTING DOWN** (lines 1-19)
- **STARTING** (line 20)

  Setting the scene (lines 24-92)
- **SIMILAR CHARACTERISTICS** (lines 93-115)

  MIGRATION (lines 116- 144)
- **MEMBER'S LENGTH OF TIME INVOLVED IN THE GROUP** (lines 145- 212)
- **LIKE A FOOTBALL TEAM** (lines 213-248)

  Genuinely caring about each other (lines 249-347)

- **REFOCUSING ON GROUP EXPERIENCES** (lines 348-701)
    - Communication (348-377)
    - Activities (lines 378- 527)
    - Addressing talking fast (lines 528- 581)
    - Addressing children's views on activities (lines 582- 701)
- **SHOWING THEM VIDEO CLIPS** (lines 702- 1285)
    - Reorganising chairs, introduction to videos (line 702-843)
    - Touch (lines 844- 895)
    - Good boy (lines 895-1065)
    - Mobiles (lines 1066-1285)
- **FINISHING** (lines 1285-1371)
- **LANGUAGE** (lines 1372-1452)
- **DIFFERENT CULTURES** (lines 1453-1488)

APPENDIX 20.- OTHER EXAMPLES OF SWITCHING BETWEEN COLLABORATION AND POWER

Other extracts from detailed analysis of therapists' powerful positioning with collaborative voices, considering its impact on group members and cohesion:

Extract 3: (lines 472-528)

Context of extract 3: In session 1, after the "speed-dating" activity to review each of the children's targets in a group format, participants were grouped by therapists into smaller groups to gather "the headlines" of the children's targets and then feed back to the rest of the group. They were given flipchart paper and pens.

Judith(T) *Has this group finished? (talking directly to Rosan(cf)'s group, not addressing any other group)* *power deciding who speaks*

?*: Yeah*

Paul(T) *We are done?* *power deciding when to stop talking*

Judith(T) *Brilliant…. Great*

Judith(T) (comes closer to get their paper)*: Somebody wants to be a* ***speech*** *person?* *power with collaborative voice - power deciding who speaks*

Rosan(cf): *Me!!*

Yasar(cm)*: Me!!!*

(Rosan(cf) and Yasar(cm) stand up and go to the clipboard together).

Judith(T) *Your first job is to get everyone's attention.* *power telling them what to do*

Rosan(cf): *Attention, ORDER!!*

Harriet(pf) continues talking and she points to Ismail(cm). It might be that she is telling him that he can present. From Rosan(cf)'s group someone moves the chair around to be able to see the board. Eric(cm) had run off. His mother grabs him by his arm and pulls him towards her for him to sit down next to her. He sits down.

Paul(T) Ok, EACH ... group are gonna have a chance to present their OWN IDEAS. We are gonna start with this group. You'll have to do it as we go along lads. *Power telling them when they stop talking*

(... 14 seconds silence)

(people still speaking, Asir(pm) turns his chair towards the board. Paul(T) and Judith(T) talk to each other. Rosan(cf) comes close to Eric(cm) and touches his hair and the tie that she had wrapped around his forehead. Eric(cm) ran away from the group).

Judith(T) OK THIS group, you are all going to try to get the attention from the rest of your class (smiles). *power telling them what to do*

Yasar(cm): (clears his throat)

Rosan(cf) and Yasar(cm): (who were standing up to present, knock on the flipboard to get their attention, but then a child does something, which distracts the group for some seconds, until Rosan(cf) tells Yasar(cm): *You can go on*

Yasar(cm): *OK! erm headlines.*

Once the groups finished discussing in smaller groups how the children had done in terms of their individual therapeutic goals, from a powerful position with a collaborative voice, Judith(T) asked a specific group: "*Has this group finished?"*, deciding who would speak first. It is unclear if this was based on her observation that they had finished or on the likelihood of them complying more easily (previous knowledge of participants). From a powerful position, Paul(T) checked that others had finished, but also indicated to them that they needed to stop talking: "*We are done?".* Similarly,

from a powerful position, Judith(T) specifically invited Rosan(cf) and Yasar(cm) to participate by asking them to present their groups' discussion to the wider group. She used a collaborative voice to ask them specifically to volunteer to present: "*Somebody wants to be a speech person?"*. Yasar(cm) and Rosan(cf) seemed keen to participate and they answered immediately that they would present. This suggests that there was a good working relationship between themselves and/or with the therapists, indicating group cohesion. Judith(T) showed interactional dominance when she positioned herself as a powerful/supportive/collaborative leader by telling them: "*Your first job is to get everyone's attention".* By doing this she used her power to help them to focus on this task, telling them what to do, and she also encouraged them to use their own power to manage the group (shedding power) by being collaborative. Rosan(cf) followed her advice and addressed the group by telling them*: "attention, ORDER!!".* However, the group did not respond to her.

Possibly due to the lack of response from the group, Paul(T) positioned himself as the powerful leader who needed to control the group. Paul(T) addressed the group in a directive way to encourage them to stop talking: "*Ok, EACH …group are gonna have a chance to present their OWN IDEAS. We are gonna start with this group. You'll have to do it as we go along lads",* thus showing interactional dominance. After he had used powerful language, he then used colloquial language: *"lads",* maybe positioning himself as their equal, using a more collaborative voice*.* Rosan(cf) was now in a powerless position. There was a pause as therapists gave the groups a chance to get ready for the presentation. Then Judith(T) talked from a position of power again, trying to support the first group to start their presentation by telling them: *"OK THIS group, you are all going to try to get the attention from the rest of your class (smiles)".* She addressed children and adults in the group, but only the children responded. She used symbolic language by calling the group 'class'.

In summary, in this extract, Paul(T) and Judith(T) mainly positioned themselves as powerful, and they often used a collaborative voice, which probably motivated group members to participate and also encouraged a good working relationship (group cohesion) with them. They also showed interactional dominance when they managed the group, by encouraging them to stop talking and when coaching Yasar(cm) and Rosan(cf) about what they had to do first*.* Not only did their own positioning impact on how others were positioned, but also the groups' responses impacted on

the positioning of other group members, so Rosan(cf) became powerless when others did not stop talking and Paul(T) intervened.

Extract 4: (lines 2132-2196)

In session 1, during Rosan(cf) and Trina's mask discussion a fly comes into the room and some children get distracted. Judith(T) focuses on the negative impact of the fly on the group.

Self-control dialogue:

Paul(T) The flips/ hang on, the flipside, I'm now getting confused. Can I ask everybody's help at the moment... How is it? That... Jamil(cm) is kind of sitting down and... I haven't seen him get distracted by the fly here (pointing towards Jonathan). *He hasn't got up to get a drink!* (pointing towards Ismail(cm)). *He's not done a mask* (pointing towards Rosan(cf)). *So, he is not directly involved in this activity. How is it that he's decided to make those choices?* (looking towards Salma(pf))

INVITES DIALOGUE FROM CURIOUS- QUALIFIES- POWER IN TERMS OF making meaning of the behaviour: He's decided to make choices. Interactional dominance, but he seems to be posing this question to Yasar(cm)'s mother too.

(Ismail returned walking behind the group and his dad called him over to sit down, he also pointed towards Jamil(cm)).

Paul(T) *...and whereas... it, it seems like some of the other children are… find it kind of tricky to, kind of... manage this. What is he doing? What's him doing that is kind of different? OBSERVER position, INVITING CURIOSITY*

Rosan(cf): (unintelligible) *The fly hasn't been by the wall*

Jonathan(cm)*: Innit? Because it's come around here and around here...* (unintelligible and making circling movements with his hands, maybe saying that the fly did not get close to him). *Something around here it cannot go around here.*

Paul(T) *But why?, what choices is he making there? CURIOSITY, BUT DEFINING IT AS CHOICES, INVITING CURIOISTY*

John(cm): *Because he cannot go around there*

Trudy(pf): *Self-control he's got.*

Paul(T) *You think he is got self-control. Repeats - listening*

(All talk at the same time- unintelligible).

Jonathan(cm): *It's annoying*

Asir(pm)*: But Paul(T) is talking in general, not only the fly maybe you are talking about the mask as well, what is, what is/*

Harriet(pf): (quietly) */It's not important to him, so he just sits there. CHALLENGES*

Paul(T) *So, what choices are you making in that moment there? Manages the challenge by dismissing it AND FOCUSES ON HIM-*

Harriet(pf)*: She is right he is using self-control*

Paul(T) *Somebody else mentioned it's about self-control/ Listening*

Asir(pm)*: Yeah* (points towards Trina)

Paul(T) */You think it's about self-control (pointing at Trina).*

Harriet(pf): (touches Jamil's(cm) thumb).

Asir(pm)*: I think this is good* (nods his head).

Jamil(cm) (smiles)

Paul(T) *I mean. WE KNOW that's something you have been working REALLY hard Jamil(cm)'s FOCUSES ON SUCCESS and therapeutic goal. Praises. DEFINE STRENGTHENING STORY OF SELF-CONTROL,*

Paul(T) *Would you sort of agree it is about self-control? have you got better at doing it? CURIOSITY FOCUSES ON SUCCESS and therapeutic goal. STRENGTHENING STORY OF SELF-CONTROL*

Jamil(cm): *Um hum (*looks down and shrugs his shoulders)

Paul(T) *He's been good dad! PRAISES AND COMMUNICATES TO FATHER*

Asir(pm)*: Yeah, I think, he has been working hard at it. Yeah, he is better at it!*

Ibrahim(pm): *I think Jamil(cm), he's decided to change... so to improve that he is been working hard on this*

(Ismail(cm) claps)

As in previous extracts, Paul(T) showed quantitative and interactional dominance. From a position of power (having interactional dominance) and using a collaborative voice he created a space for dialogue by being curious and inviting others to be curious: "*I'm now getting confused. Can I ask everybody's help at the moment... How is it? That... Jamil(cm) is kind of sitting down and... I haven't seen him get distracted by the fly here"*. Similarly, later on, from an observer position, Paul(T) invited others to be curious: "*and whereas... it, it seems like some of the other children are, find it a kind of tricky to kind of... manage this. What is he doing? What's him doing that is kind of different?". "But why? What choices is he making there?".* Group members responded to these invitations by reflecting and sharing their own ideas. Therapists listened to group members.

Additionally, from a powerful position, Paul(T) showed interactional dominance when he determined the meaning attached to the behaviour in focus: "*How is it that he's decided to make those choices?".* This meaning was followed by group members, even when Joe's mother quietly

challenged Jamil(cm)'s response: "*/It's not important to him, so he just sits there".* From this powerful position, Paul(T) managed the challenge by dismissing it, returning the meaning he had created, strengthening the story of 'self-control' by focusing on Jamil(cm)'s achievement, reaching a therapeutic goal and praising him in front of others. He said: "*So, what choices are you making in that moment there?"… "I mean, WE KNOW that's something you have been working REALLY hard Jamil's(cm)"*, *"Would you sort of agree it is about self-control? Have you got better at doing it?", "He's been good dad!".*

In summary, Paul(T) showed interactional dominance in this extract. He communicated with the group from a powerful position, but he also used a collaborative voice, which invited others into a dialogue by being curious. This was responded to by the group. He managed to challenge positively from a powerful position, focusing on Jamil(cm) achieving a therapeutic goal. Paul(T) nurtured a good working relationship by listening to group members' ideas. He focused the group on listening (Jamil(cm)'s target) which probably encouraged others to listen (possibly a shared target in the group). Finally, by praising Jamil's(cm) achievement, not only did he reinforce it, but he also communicated that he had noticed it and that he cared about Jamil's(cm) behaviour, all of which had a positive impact on group cohesion.

APPENDIX 21.- EXTRACT 1: DETAILED ANALYSIS INFORMATION: TABLE 3

TABLE 3	**Session 1- (lines 1714-1810)**	**Response categories**	**Voices (V), position (P), addressee (A)**
Judith(T):	*Alisha(pf), Eric(cm) is here with his mask. We KNOW...that you need to leave.*	Semantic, quantitative and interactional dominance	A: Alisha(pf)
Alisha(pf):	*Um hum.*		A: Judith(T)
Judith(T):	*What would you like him to do and how can we help you to do that?*	A: Eric(cm) (did not respond to Judith(T)) V: pleading P: powerless (Alisha(pf)) Powerful (Eric(cm)) Monological	A1: Alisha(pf) A2: group V: collaborative, *sharing authority* *P: Power (therapist)* P: needing help/powerless/ non-agentic (Alisha(pf))
Paul(T):	*Yasar(cm)! (signaling him to stop something).*	Interactional dominance	A: Yasar(cm) P: Power
Alisha(pf):	*Come on Er(…), Er, Eric(cm)*	Interactional dominance Monological	A: Eric(cm) (did not respond to Judith(T)) V: pleading

			P: powerless (Alisha(pf)) Powerful (Eric(cm))
	(background conversation stops-silence)	Alisha(pf) feeling on the spot Shameful experience for Alisha(pf)	
Alisha(pf):	*...Come on! Eric(cm)(...)*	Monological (Eric(cm) did not respond)	A: Eric(cm) (A did not respond to Judith(T)) V: pleading P: powerless (Alisha(pf)) Powerful (Eric(cm))
Judith(T):	*I guess what we can also say is that people that have not made masks they will be making them and there will be another time to show the masks to everybody. You can join. So there will be/*	Semantic, quantitative and, interactional dominance	*A1: Group A2: Eric(cm) P: Power (structure)*
Alisha(pf):	*/Eric(cm)...Eric(cm).*	Monological (Eric(cm) did not respond)	A: Eric(cm) V: pleading P: powerless (Alisha(pf))

			Powerful (Eric(cm))
Eric(cm) (with his mask on):	*I want to be in the meeting!! and I want to ring the bell. I wanna ring the bell I don't want to go*! (unintelligible).	Interactional and semantic dominance. Dialogical dialogue (responds that he does not want to go)	A1: Alisha(pf) A2: therapists V: demanding P: powerful
Alisha(pf):	*You are going to be late for lunch!*	Interactional and semantic dominance. Dialogical dialogue Indicative language External language	A: Eric(cm) V: factual P: mother
Eric(cm):	*MEETING!!!! BELL!!!!*	Interactional dominance. Monological dialogue	A1: Alisha(pf) A2: therapists V: demanding P: powerful
Judith(T):	*how can we help? It's a lot of us/*	Interactional and semantic dominance. *(not responded to by Alisha(pf), but by Yasar(cm))*	A1: Alisha(pf) A2: group V: collaborative *P: Power (therapist)* P: needing help/powerless/ non-agentic (Alisha(pf))
Yasar(cm):	*/tomorrow, I let you come with this. You play football with me*	Interactional and semantic dominance.	A: Eric(cm)

	and...bring the book or not… if you go home.		V: collaborative-peer. Suggesting ideas to convince Eric(cm) P: peer
Judith(T):	*Carry on! he wants attention!*	Interactional and semantic dominance. Monological (it does not respond to Yasar(cm)- ignores him after asking for help from the group)	A: Alisha(pf) V: carry on! (collaborative). He wants your! attention (powerful) *P: Power (therapist)* P: needing help/powerless/ non-agentic (Alisha(pf))
Eric(cm):	*I don't wanna go home!*	Interactional dominance. Monological dialogue	A: Alisha(pf) A2: therapists V: demanding P: powerful
Yasar(cm):	*If you ring the bell once and then you go?*	Interactional/semantic dominance. Dialogical dialogue	A: Eric(cm) V: collaborative, tentative.

			Suggesting ideas to convince Eric(cm) P: collaborative peer
Eric(cm):	(nods) *I agree.*	Dialogical dialogue	A1: Yasar(cm) A2: group V: accepting P: collaborative with peer
Yasar(cm):	*Ah?*	Dialogical dialogue	A: Eric(cm) V: confirming P: curious
Eric(cm):	*I agree!*	Dialogical dialogue	A1: Yasar(cm) A2: group V: accepting P: collaborative with peer
Yasar(cm):	*OK, cool.*	Dialogical dialogue	A1: Eric(cm) V: happy/proud peer.

			P: collaborative with peer
Judith(T):	*Alisha(pf) is mum*	*Power explicitly acknowledged.*	A: Yasar(cm) and Eric(cm) V: therapist rebalancing structure and affirming mother's control P: power
Yasar(cm):	(says something to the interpreter).		
Interpreter:	*she just wants her son to tell...*	Dialogical dialogue Semantic dominance	A: group V: collaborative
Judith(T):	(nods)	Dialogical dialogue Non-verbal communication	A: Salma(pf) P: therapist
Yasar(cm):	*I already did!*	Dialogical dialogue External language	A: Salma(pf)- his mother V: annoyed P: annoyed child
Alisha(pf):	*Er!... We'll come back here on Monday! Do you wanna be able to play outside?*	External language Dialogical dialogue	A: Eric(cm)

		Semantic dominance	V: Mother, trying to convince him. P: mother, gentle.
Yasar(cm):	*Yeah! On Monday you can come back...and play outside!*	Dialogical dialogue External language	A: Eric(cm) V: collaborative peer P: collaborative peer
Eric(cm):	*Ah?*	Dialogical dialogue	A: Yasar(cm) Alisha(pf) V: curious
Alisha(pf):	*Yeah! Come back and play outside in the break time. Remember?*	Dialogical dialogue External language	A: Eric(cm) V: Mother, trying to convince him. P: mother, gentle.
Eric(cm):	*I wanna ring the bell!*	Dialogical dialogue External language Interactional dominance	A1: Alisha(pf) A2: group V: demanding P: powerful

Yasar(cm):	*Can we just you just ring the bell once?*	Dialogical dialogue External language Interactional dominance	A: therapists V: collaborative peer P: collaborative peer
Eric(cm):	*I agreed, I wanna ring the bell!*	Dialogical dialogue External language	A1: Yasar A2: Therapists A3: Alisha (pm) V: collaborative peer. Demanding P: collaborative peer/ powerful
Alisha(pf):	*Will you come Eric(cm)? PLEASE!*	Dialogical dialogue Semantic dominance	A: Eric(cm) V: Pleading P: powerless/non-agentic
Eric(cm):	*I wanna ring the bell!* (stands up).	Dialogical dialogue External language Interactional dominance	A2: Therapists A3: Alisha (pm) V: Demanding P: Powerful
Alisha(pf):	*You need to ask*	Dialogical language	A: Eric(cm)

		Semantic/interactional dominance	V: *Powerless/non-agentic mother* P: *Powerless/non-agentic mother*
Yasar(cm):	*ask Judith(T)!*	*Knows who is in power* Dialogical dialogue Semantic dominance	A: Eric(cm) V: collaborative peer P: collaborative peer
Judith(T):	(talks quietly to Alisha(pf) - unintelligible): *once*	*Monological language* Interactional dominance	A: Alisha(pf) V: collaborative P: powerful
	(Eric(cm) walks towards his mother. Yasar(cm) follows him. Eric(cm) goes to his mother. Yasar(cm) returns without being prompted)	Non-verbal communication	
Judith(T):	*OK!!!...*	Interactional dominance	A: Group V: therapist P: power
Judith(T):	*So, now is the chance for... people that made their masks*	Interactional dominance.	A: Group

	to... present them and for people who are watching to... let's find out what's behind the mask... which family would like to go first?	Monological dialogue Dialogical dialogue.	V: collaborative P: *Power and collaboration*
	(Bell rings).		

APPENDIX 22.- EXTRACT 2: DETAILED ANALYSIS INFORMATION: TABLE 4

TABLE 4	Session 1- (lines 67-107)	**Response categories**	**Voices, position addressee**
Judith(T)*:*	*Erm Ibrahim(pm), shall I just?... do you want to just explain to everyone? If everyone can just listen to Ibrahim(pm) for a second… Erm, do you just wanna, just, just explain to everyone?*	Interactional dominance Dialogical dialogue	A1: Ibrahim(pm) A2: group V: collaborative P: *Powerful*
Ibrahim(pm):	*Yeah. I asked Ismail(cm) yesterday, how was your school this morning? and then he said it was very bad. I said: 'why?' He said: 'I wasn't happy'. So, I don't know why he wasn't happy... because of the target yesterday.*	Dialogical dialogue Monological dialogue External language	A: group V: confused
Judith(T):	*So, he is going to have to be Ismail's(cm)'s memory.*	Power: Gives him a task Monological dialogue Internal dialogue Interactional dominance	A1: Ibrahim(pm) A2: group V: Therapist in charge/control P: Powerful

Ibrahim(pm):	*Yeah!!*	Dialogical dialogue	A: Judith(T) V: group member listened to P: group member
Judith(T):	*But you would like parents to… help… him with his targets from yesterday, don't you?*	*Dialogical dialogue* *External dialogue* Interactional dominance	A1: Ibrahim A2: group V: collaborative therapists. P: Judith(T): *Power and collaborative-* *Ismail(cm:) in a non-agentic/vulnerable position.* *Ibrahim(pm): Requesting help is powerless/voiceless/non-agentic.*
Ibrahim(pm):	*Yeah!!*	Dialogical dialogue	A: Judith(T) V: group member listened to P: group member
Judith(T):	*Is that OK with people?*	Inviting multiple voices and support	A: Group V: collaborative

		Dialogical dialogue Interactional dominance	P: Collaborative therapist
Alisha(pf):	(nods- making eye contact).	Non-verbal communication Dialogical dialogue	A: Judith(T)
Asir(pm):	*So, this is not the target/homework from yesterday?*	Dialogical dialogue External language Interactional dominance	A: Ibrahim(pm) V: curious group member P: collaborative group member.
Ibrahim(pm):	*Yeah.*	Dialogical dialogue	A: Asir(pm) V: group member listened to P: group member
Asir(pm):	*Oh yes, it is.*	Dialogical dialogue	A: Ibrahim(pm) V: curious group member P: collaborative group member
Ibrahim(pm):	*I just want to tell you the homework from yesterday.*	Monological dialogue External dialogue	A: group V: collaborative group member.

		Interactional dominance	P: collaborative
Judith(T):	*And I guess it has/*	Dialogical dialogue Interrupts	A: Group V: collaborative P: Collaborative therapist
Cathy(pf):	*What about Monday? Did he have a good day on Monday?*	Interactional dominance Dialogical dialogue Interrupts Monological dialogue	A: Ibrahim(pm) V: curious group member P: collaborative group member
Ibrahim(pm):	*Yes.*	Dialogical dialogue	A: Cathy(pf) V: group member listened to P: group member
Ismail(cm):	Yeah!	(First time he speaks). Dialogical dialogue	A: Cathy(pf) V: group member listened to P: group member
Cathy(pf):	*Well done!*	Dialogical dialogue	A: Ismail(cm) V: proud group member. Shared enjoyment

			P: proud group member.
Ismail(cm):	(nodded).	Dialogical dialogue Non-verbal communication	A: Cathy(pf)

APPENDIX 23.- EXTRACT 3: DETAILED ANALYSIS INFORMATION: TABLE 5

TABLE 5	Session 1- (lines 2297- 2322)	**Response categories**	**Voices, position addressee**
Yasar(cm):	*And this is my mask!*	Monological dialogue Semantic dominance	A: group V: proud P: collaborative group member
	(Silence -8 secs)	*It seemed to me that group members did not know how to respond to Yasar's(cm) mask.* Non-verbal communication	
	(Ismail(cm) whispered something to his father in his ear).		P: Non-collaborative group member
Yasar(cm):	*What?*	Dialogical dialogue Semantic dominance	A: Group V: curious P: confused group member
Jonathan(cm):	*It's kind of freaky.*	Internal language Dialogical language?	A: Yasar(cm)

		Semantic dominance	V: judging, criticising
Trudy(pf):	*It looks like... erm... you know, what's that one of those Indian chiefs... with feathers and erm... plus take it off, it's got his name inside there.*	External language Dialogical language?	A: Yasar(cm) V: curious, encouraging group member P: collaborative group member
	(Yasar(cm) takes off his mask and shows it to everyone- interpreter translates).		
Salma(pf):	*Um, um.*	Dialogical language	A: Trudy(pf) V: agreeing
Trudy(pf):	*Yeah!*	Dialogical language	A: Yasar(cm) V: encouraging P: collaborative group member
Rosan(cf):	(talking quietly) *Oh, oh, OH! what is it called? What's the word?*	External language Dialogical language Semantic dominance	A: group V: collaborative, curious group member P: collaborative group member
Trudy(pf):	*It's good isn't it?*	External language	A: group

		Dialogical language Semantic dominance	V: supportive group member P: collaborative group member
Jonathan(cm):	*Native AmEric(cm)ans?*	External language Dialogical language	A: Rosan(cf) V: supportive group member P: collaborative group member
Rosan(cf):	*Yeah, what's… what's wrong with me?... It has a specific name.*	External language Internal language Dialogical language	A: group V: supportive group member P: collaborative group member
Harriet(pf):	(unintelligible) or something?	External language Dialogical language	A: group V: supportive group member P: collaborative group member
Rosan(cf):	No!	External language Dialogical language	A: group V: disagreement P: not understood

Yasar(cm):	*WHAT? what are you talking?*	External language Dialogical language Interactional dominance	A1: Paul(T)? A2: Asir(pm)? A3: group V: curious/ annoyed P: powerless/judged
Judith(T):	*Is that a surprise to you? What did you think?*	External language Internal language Dialogical language Interactional dominance	A: Salma(pf) V: curious/ collaborative P: collaborative therapist
	(Paul(T) laughed quietly. He looked at Asir(pm). Asir(pm) said something and they both laughed quietly for about 20 seconds. Jonathan(cm) and his mother looked at them).	Non-verbal communication	A: Paul(T) and Asir(pm) V: judging P: Paul(T): another group member
Interpreter talks to Judith(T):	(unintelligible).		
Yasar(cm):	*I don't know how to draw stars or hearts.*	External language Dialogical language	A: Rosan(cf) V: vulnerable

		Semantic dominance	P: younger sibling
Rosan(cf):	*It's easy to do it!*	External language Dialogical language	A: Yasar(cm) V: supportive P: older sibling
Judith(T):	*Why is that making you laugh?*	External language Dialogical language Re-positions Paul(T) Interactional dominance	A: Paul(T) V: curious P: Therapist overseeing the group
Yasar(cm):	*Yeah, that's what we did.*	External language Monological language Semantic dominance	A: group
Paul(T):	*I think it is just really colourful and I really like it.*	External language Internal language Dialogical language Semantic dominance	A1: Judith(T) A2: group V: unauthentic?? P: group member

Harriet(pf):	(smiled).	Non-verbal communication	
	(eye contact between Ibrahim(pm) and Ismail(cm)- unintelligible)	Non-verbal communication	
Trudy(pf):	*Did you have fun doing it?*	Internal language Dialogical language Interactional dominance: She distracted him from Paul(T) and Asir(pm)	A: Yasar(cm) V: curious/ supportive member P: collaborative group member. Really caring
Yasar(cm):	*Yeah!*	Internal language Dialogical language	A: Trudy(pf) V: sharing his enjoyment
Trudy(pf):	*Why did you do it like that?*	Internal language Dialogical language Semantic dominance	A: Yasar(cm) V: curious/ supportive member P: collaborative group member. Really caring
Yasar(cm):	*Because, erm I wanted to write my name on it... I like my name on it.... I was gonna do... I was gonna do Yasar(cm)boss (smiling).*	Internal language External language Dialogical language	A: Trudy(pf) V: proud P: collaborative group member

		Non-verbal communication	
Trudy(pf):	*Oh, boss?* (laughs).	External language Dialogical language Non-verbal communication	A: Yasar(cm) V: curious/ supportive member P: collaborative group member. Really caring
Yasar(cm):	*Yeah!* (laughs together).	Non-verbal communication Shared enjoyment	A: Trudy(pf) V: proud
Paul(T):	*Can, can I just check in with (Yasar(cm)'s mother) actually? Salma(pf) you were not here yesterday, but your husband was, who did that mask... Yasar(cm) can you just hold it up?*		A: Salma(pf) V: curious P: He is now repositioned as a therapist

APPENDIX 24.- LIST OF ACTIVITIES TO ENGAGE FAMILIES, PROMOTING GROUP COHESION ACROSS LANGUAGES

- **Pat-pat-name:** Group members sit in a circle and pat on their knees using a rhythm, creating a gap (silence) in their rhythm to allow group members to say their names. They take turns in order. After a few attempts, they can also say other's names in the group. The person whose name has been called is then the next person to say someone else's name.

- **The 'Mexican clap':** group members sit in a circle and pass a clap around between them. The youngest member could start with a clap, which is sent around the whole circle, similar to the Mexican way. Group members could send this clap at different speeds. They could also check how long it takes them to pass it around and encourage group members to beat their timing after a few attempts to improve their timing.

- **Passing a 'hand squeeze':** this activity is similar to the 'mexican wave', but its aim is to pass a 'hand squeeze' from person to person around group members sitting around in a circle. Likewise, the youngest child could start and after they understand and are comfortable with the activity, then they could add a rhythm to pass the 'hand squeeze' and check if the rhythm that starts is the same that finishes.

- **Finding your place (Asen and Scholz, 2010):** Group members find their place in the room regarding a characteristic. For instance, line up according to their height, hair colour, birthday, where their families come from, the languages they speak or the number of languages they speak.

- **'Mirror me':** Group members stand or sit together and copy someone else in the group who takes a leader position and makes certain movements or sounds with their bodies for others to copy. The group leaders could start to give group members some ideas. This activity could also be done in interfamily pairs.

- **'Emotion maps' (Gabb and Singh, 2015): This could be used as an intrafamily activity to share with others. G**roup member draw floor plans of their homes, each family member uses a different colour sticker. Then they are asked to stick an 'emoticon sticker',

representing where and when emotional interactions occur. This visual material could be used to facilitate a dialogue about different scenarios and emotions involved and represented. Emotion maps can be used with a wide range of people, of different ages and also across cultures, as not much language is needed. They explained that it "encourages critical reflection on how events and emotions may be perceived and experienced differently" (p.186). As an assessment tool, it could help to show the process of change within families.

- **Counting to ten (or the number of group members):** group members are encouraged to count to ten, but only one of them is allowed to call out a number at a time, without any specific order. If two people talk simultaneously they need to start again. The aim is to develop a sense of togetherness, listening to each other and watching what they are doing before they speak. Group members could do this in different languages, learning from and tuning in with each other.

- **Marshmallow challenge:** Group members could be divided into smaller inter-families groups, and they use a material (e.g. leaves, pasta, strings) to build a tower strong enough to carry the weight of a marshmallow. The same material should be used by all groups.

For more activities, please refer to Asen and Scholz (2010), Gabb and Singh (2015), Singh and Dutta (2010).