Abstract

This article negotiates family therapists´ professional identities in the Family Counselling Services (FCS) in Norway and their experiences when following up parents whose children are placed in public care. A qualitative study following seven family therapists in the FCS, through focus groups and individual interviews, found that they struggle with contradictory positions within their professional identity when following up with these parents. This struggle involves a dichotomy between their personal feelings and their theoretical orientation as systemic therapists. Their dilemma becomes evident when the two systems emphasise different interpretations of the 'truth', and when they react to how the welfare system, in general, treats these parents. This study argues that the systemic family therapy approach seems to be useful both for handling the parents' often fragmented stories, and for reconnecting these parents to society through allowing them to tell their own stories. A particularly demanding challenge for therapists in these situations is that the help they have to offer is inadequate in relation to the complexity and enormity of the needs of these parents. Thus, collaboration with other welfare instances is particularly important in these cases, but this collaboration brings its own complications. Knowledge about each other's service and mandates is therefore particularly important for constructive and non-judgmental collaboration.

Keywords: Family therapy, qualitative research, professional identities, positioning theory, child protection

Background

This study will explore family therapists' negotiation of their professional identities when meeting with parents whose children have been placed in care. In most countries, the Child Protection Services (CPS) have the responsibility of following up with parents after a child has been removed. It is well documented that the follow-up of parents who have lost the care of a child is inadequate, and that in many cases, parents return to court having made no progress (Broadhurst and Mason 2017). Studies show that this situation places the professionals in a demanding dual role. They are the ones who take the children away from their parents, but they also carry the responsibility for following up with the parents and helping them with the adjustments they must make (Schofield, Moldestad, Höjer, Ward, Skilbred, Young and Havik 2010).

In Norway, this demanding situation led to the political decision that the state-run Family Counselling Services (FCS) would offer these parents assistance that is supplementary to that which they receive from the CPS. The CPS still carries a legal responsibility to follow up with the parents, while the FCS offers them a voluntary service. The FCS falls under the Norwegian Act on Family Counselling, and it is thus in a different and more independent position than the CPS, which falls under the Norwegian Act of Child Protection. The aim of the FCS is to assist families who are struggling with their relationships, and they are mandated to help parents whose children are placed in care to deal with the difficult feelings around the placement of a child, how to handle their lives and their new role as visiting-parents (Bufdir 2017). This article will focus on the experiences of family therapists in the FCS as they negotiate their professional identities when faced with parents who have lost the care of their children.

Several studies have suggested that the follow-up of parents should focus on recourses (Boddy, Statham, Danielsen, Geurts, Join-Lambert and Euillet 2014; Hall and Slembrouk 2011). Forrester et al. (2013) describe the 'Hackney model' in which a systemic unit approach was implemented in the children's services for following up parents. Kielty (2008) argues in favour of the narrative approach, where the parents are offered the possibility of telling their own stories as the means of restoring and strengthening their dignity. This approach can increase their willingness to engage with the services (Kemp, Marcenko, Lyons and Kruzich 2014) and can result in more efficient and effective outcomes (Toros, DiNitto and Tiko 2018). This involvement may increase the parents' engagement and motivation (Heatherington, Friedlander, Diamond, Escudero and Pinsof 2015). When working with families in this context, systemic family therapy appear to be promising practices, focusing on context, relationships and resources.

In the systemic family therapy field, there has been a shift in the therapeutic position away from the therapist being the 'expert knower' and towards a position that is more collaborative, also known as the 'not-knowing position' (Anderson and Goolishian 1988). Understanding is understood as something constructed in social interaction, and dialogue as essential to the human meaning-making process (Gergen and Ness 2016). Understanding is seen less as an individualistic cognitive process, but instead as relational, worked out in back-and-forth conversation and effective only when contextualized (Strong 2005). Since holding a non-expert position is something that seems to be dominating in the systemic family therapy field, in this article we have chosen to focus on the different possible positions of the therapist when working with parents whose children are in care. Further, we have chosen to use the term *professional identities* to explore the different positions that therapists both find themselves placed in and also actively adopt during therapeutic conversations (Harré and Langenhove 1991). Professional identities are seen as plural and flexible positions (Jørgensen

and Phillips 2006). Definitions of professional identities do not assume that there is a proper way to be professional (McNamee 2015) but that our identities are constructed through a conversational and negotiating practice. This assumes that meaning and relationships with parents are negotiated simultaneously (Strong 2005). This avoids the binary position of right/wrong thinking, and leads instead into the negotiation of new forms of local, situated understanding (Gergen and Ness, 2016).

In negotiating professional identities that are not linked to a predetermined way of being, the ethical dimension is of particular importance for systemic therapists. Tomm developed 'ethical postures' to help therapists navigate through the ethical dimension (Strong, Sutherland, Couture, Godard and Hope 2008). These ethical postures may help therapists to position themselves in relation to their clients by providing an understanding of the consequences that such a positioning might have for the therapeutic relationship and alliance.

Tomm (Strong et al. 2008) claims that if the client's options are limited and the knowledge is hierarchical, the therapist's position will be more manipulative. This is what he calls a monological practice, and it is seen as an ideological instrument for holding others to a particular interpretation of reality (Strong 2005). The opposite position is where knowledge is shared between the therapist and the client and where there is space for multiple options. In this situation, the therapist focuses on the client's empowerment. This position suggests a different kind of expertise, which is dialogical. Even though Tomm expressed his preference for this empowerment position, he also opened the possibility of there being other positions that serve different purposes (Strong et al. 2008).

Minuchin (1998; 1999) voiced criticism regarding the dialogical approach to family therapy and particularly of the not-knowing position, suggesting that it fails to take the power aspect seriously. According to Foucault (1999), power should not be defined as something negative, it can also be productive. Weingarten (2000) claims that, as helpers, we find

ourselves in the position of a witness. The witness position is influenced by the extent to which we are aware and empowered to do something about what we see while remaining conscious of how our witness affects us. If therapists use their power without being aware, it can have unfortunate consequences. High levels of awareness combined with the ability to act can, however, be constructive. These positions are not something that only therapists are responsible for; as part of a system, they automatically have discursive framing (Weingarten 2016).

Psychotherapy research shows the importance of an alliance between the therapist and the client if there are to be good therapeutic outcomes (Carr 2016). The parent's experience of being supported is crucial if they are to gain an understanding of why their children were placed in care and become motivated to receive help. Weitz (2016) found that parents and professionals have different perspectives on the meaning of change. While the professionals think change is an individual process, the parents look at change in terms of improving their living conditions. This shows the importance of researching professional identities and the pursuit of professional practice if this complex follow-up is to be managed successfully. While previous research has recommended systemic family therapy as being promising for parents who have had a child removed from their care (Boddy et al. 2014; Kielthy 2008), there is lack of research that has explored this approach with this parent group. The purpose of this article is to develop knowledge on how systemic therapists negotiate their professional identities in their encounters with parents who have lost the care of their children. The Norwegian FCS's theoretical platform is inspired by a systemic family therapy approach, suited to handling relational challenges. The following research questions are thus addressed:

1. What dilemmas do family therapists experience in negotiating their professional identities with parents whose children are placed in care?

2. How do they seem to solve these dilemmas in their professional practice?

<center>**Methodology**</center>

Qualitative design

This is a qualitative practice research study, contextualised within a social constructionist epistemology that assumes that human realities are negotiated in language, relationships and culture (McNamee 2010). In an FCS in the western part of Norway, a competence group has been organised to work on developing national guidelines for the follow-up service with parents who have lost the care of their children. From this competence group, we established a research group (not the research informants) for this current study that consisted of two parents, two therapists, two child protection workers and three academic researchers (including the authors of this article). The purpose of this research group was to collaborate throughout the entire research process: from formulating questions for the interview guide, to analysing and interpreting the findings. This group approach permits more voices to be heard in the research process and includes the service users' voices and preferences in the research (Beresford 2003). In this way, it links the research to the practice field.

Recruitment and participants

Seven family therapists from three different FCS were recruited to participate in the study. The therapists engaged in the research group helped us with this recruitment. Two of the therapists in the research group also participated in the focus group with the purpose of assisting the interviewer to structure the focus group discussion. The inclusion criteria for the focus group were that all had met therapeutically with parents whose children were placed in care. This could have been in peer-groups or in individual therapy. The therapists worked in three different family counselling offices in different parts of Norway. Of the seven participants, two were men and five were women. Three were psychologists and four were

social workers with supplementary training systemic family therapy. They were all experienced therapists with backgrounds in related fields. Four had worked in the CPS, two in drug-treatment services and two in mental health services.

Data collection

To collect the data, we conducted multi-stage focus group discussions based on a participatory philosophy (Hummelvoll 2008). The aim was that, over time, experienced family therapists would together construct and develop knowledge about their professional practice. A benefit of focus groups is that discussions arise, reflections are shared and then developed in the group process; this can result in practical ideas that would have been hard to establish through individual interviews (Piercy & Hertlien 2011). The multi-stage focus group design allows ideas developed in the focus group to be tried out in the practice field, and this experience can then to be brought back to the group.

The focus group discussions were supplemented with individual interviews with the same therapists. These individual interviews provided the opportunity to go deeper into themes or phenomena that participants suggested without the interruptions of the group process. An example of the advantage of an individual interview would be one of the therapists explaining in depth why she had become so eager to act together with the parents. However, the focus group served a unique role: the profound discussion between four therapists about what 'truth' means to them in their professional practice could not have taken place in an individual interview. This discussion also showed how values and positions are not something static but expressed in a context. For example, one of the therapists said that, while sitting listening to the others, she realised the extent to which the parent group challenged her, particularly in relation to the divergent stories they often presented. The process showed how the different research methods elicited statements relating to different

contexts. This combination of interview methods might be seen as two voices speaking from different contexts (Smithson 2008).

We used the same interview guide in the two focus group discussions and in the individual interviews, using a 'rolling interview design' (Stewart and Shamdasani 2014). This means that the experiences from the first interview enable new questions to be added to the next interview. One example of this rolling design was a discussion around their feelings of disempowerment in relation to the parents' complex needs and how this led them to become more practical in their orientation than was their custom. This theme was explored further in one of the individual interviews. In the first focus group discussion with the therapists, we invited them to join a conversation about their experiences of meeting the parents, and in what ways they thought it differed from their professional practice as expressed in the CPS context. Four months after the first focus group, we conducted individual interviews with the therapists from the focus group. All seven interviews started with a question about their reflections since the last focus group. Their professional practice and their dilemmas in relation to the parents had both deepened. One of the therapists told in detail how she had chosen to enter into collaboration with the CPS in these cases, based on an idea that had been expressed during the first focus group. In the final focus group discussion, two months later, she was requested to recount this experience to the group. Collaboration with the wider welfare system had become a key theme in the last focus group. The whole interview process lasted for six months.

At the same time as this study, we also ran focus groups with six parents who had lost custody of their children (AUTHORS, under review). These groups met to investigate the parents' needs and their experiences with the FCS. We found it useful to include some of these topics in the interviews with the therapists. For example, the parents raised the topic of not understanding why their children were placed in care, and this theme was later discussed

by the therapists. This subject was also of concern to the therapists, who thought it was one of the biggest challenges they faced in relation to the parents. The first author completed all the interviews. They were all held in the location of the FCS. The individual interviews lasted from 30 minutes to two hours, and both focus groups lasted for two hours. They were all recorded and transcribed verbatim before analysis.

Data analysis

To analyse the transcribed data, we used constructionist thematic analysis, which is a method for organizing and constructing themes within data (Braun and Clarke 2006). To explore how therapists, negotiate their professional identities, we drew on elements from discourse psychology (Jørgensen and Phillips 2006) and positioning theory (Harré and Langenhove 1991). Discourse psychology assumes that the therapists' identities are multiple and are constructed through several contradictory and non-contradictory positions (Jørgensen and Phillips 2006). These positions may lead to a conflict within a therapist's identity, which will raise dilemmas in their professional practice.

According to positioning theory (Harré and Langenhove 1991), the therapists will be positioned and can also actively position themselves in relation to the parents. These different positions are also moral in the sense that they involve 'oughts' (Harré and Langenhove 1999). This dimension was useful in the analysis as different positions highlighted different 'oughts', which in turn raised dilemmas and clarified for the therapists how the outworking of their own positions would result in different options for handling the client (for example, if I am positioned as a non-expert therapist, I ought to let the client manages the agenda). The analysis was conducted in the following two phases:

Phase 1: The analysis started as a process running in parallel with the interview process. After each interview, the first author transcribed the interview and presented both the transcribed material and the preliminary thematic analysis to the research group. In this way,

the material was analysed at every stage. After reading the transcriptions several times, the

research questions were used to formulate the material into preliminary themes. Meaningful

elements such as quotes and descriptions of themes were identified and then sorted into seven

tentative categories: (1) When own values are challenged, (2) Perspectives on supervision, (3)

When parents do not understand, (4) Neutrality, (5) To support versus to challenge, (6) The

non-expert position in a wider system, (7) The FCS as something different. The categories

were then converted into overall themes and the data were examined multiple times. These

themes were validated by the research group and the second author. Through this step-by-step

process of thematic analysis, three positions were identified in relation to the therapists'

professional identities. These positions were: (1) *The therapist's own values and feelings*, (2)

The theoretical backdrop for the systemic therapist, and (3) *Being part of a wider system*.

Thus, we organized their professional identities into the following three positions, as shown in
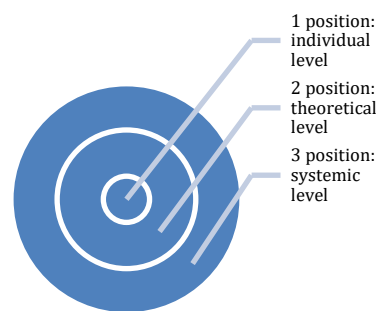
figure 1.

1 position:
individual
level

2 position:
theoretical
level

3 position:
systemic
level

Figure 1. Professional identities: three positions

Phase two: In the second analytical phase, we used the three positions as tools to guide

the further analysis. Aiming to explore the dilemmas relating to how the therapists positioned

themselves and how they perceived their positions (Harré and Langenhove 1991), we posed

the following analytical questions (Søndergaard 2018): (1) Which positions create dilemmas

for the therapist? (2) How do the therapists negotiate these dilemmas? (3) What distinguishes

their position from other positions in the system? (4) Do their dilemmas open new ways in

which to position themselves? These analytical questions led us to three dilemmas that seem to occur in therapists' navigation of their professional identities as they work with parents whose children are placed in care. These three dilemmas seem to occur at the intersection between the following three levels of position:

a) When their own feelings threaten their professional ideals (navigating position 1-2)

b) When the meaning of 'truth' is emphasized differently (navigating position 2-3)

c) When the therapist reacts to the system (navigating position 1-3)

Research ethics

Ethical approval to conduct the study was granted by the Norwegian Centre for Research Data (NSD) (project id: 46249). All participants gave their informed consent. For this, we presented the study to the therapists and obtained written permission from all the participants to take part in the study. Taking part in the study was voluntary, and anyone could resign without explanation. No one did. Anonymity was ensured at every point of the study. To anonymise the participants, everyone is called 'the therapist' (T), and we have consistently used the female designation. The therapists were given numbers to show that all the therapists' voices were included in the article.

Findings

The study focused on how family therapists negotiate their professional identities when working with parents whose children have been placed in public care. The findings are organized as dilemmas occurring between three levels of position in the therapists' professional identity, as shown in figure 1, visualized above. The first finding reflects the distinction between the therapists' own feelings and their professional ideals, the second finding identifies the problem when 'truth' is understood differently by the two systems, and

the last finding concerns what happens when the therapists react to how the parents have been treated by other systems.

When therapists' own feelings threaten their professional ideals (navigating position 1-2)

The therapists described it as challenging to follow their professional ideals when their emotions pulled them in another direction, and also how their emotions put them into different positions from those they wanted to be in due to their theoretical ideals as a family therapist. The ideals they specifically presented as challenging positions to be in were being neutral and a non-expert. Therapist 1 (T-1) spoke in an individual interview about the challenge of being a neutral therapist in relation to the parents:

> They do something to us that create anger and indignation because they fail to take care of their children. Why are they so stupid that they abuse drugs when they have children? This might prevent us from entering into these cases. On the other hand, you see someone who has been pretty dumb and lacks the prerequisites (for parenting). This ambivalence gives rise to uncertainty. Therefore, it is extremely difficult to maintain neutrality because the situation provokes contradictory feelings in us, creating polarization.

Powerlessness was the feeling the therapists most often described when faced with the parents' enormous need for help — a need that they were unable to meet. T-7 reflected that this could be particularly demanding in those cases where the parents frequently requested that they should bring their children back, something they did not have the mandate to do. This gap often led to their being eager to act, for example, by giving advice. This action was something that clashed with their ideal of being a reflective therapist who would let the client control the agenda (T-6). This dilemma was highlighted by T-2, in an individual interview:

I: Are there common practices in the FCS you think might be helpful in meetings with

the parents?

T-2: I think we are good at letting the client define the problem. But what this group

challenges us with, is the helplessness the clients show. Their disempowerment. It

makes it easy for us to suggest things for them, to handle things on their behalf.

I: What do you think this is about?

T-2: The more I feel their powerlessness, the more eager I get to make changes on

their behalf. I would like to help, to do something. We get so emotionally involved. It

feels that there is so little we can do for them

When the systems cope with 'truth' differently (navigating position 2-3)

The therapists highlighted the differences between the CPS and the FCS systems, and

how these differences seemed to affect their perspectives on 'truth'. Some of these differences

related to various mandates, for example, the fact that the CPS was in charge, in the control

position. These different positions seemed to influence how they related to change work. This

was exemplified in the second focus group in a discussion about whether they believed that

the change process was possible with the parents. T-4 said she was not sure whether she

believed in a change process for the parents, since most of them had already received

supervision from the CPS for months before the child was removed. T-3 said that the

supervision they received from the CPS was not what she would define as supervision. Her

impression was that supervision from the CPS was more about finding 'the right way', or how

to be the 'right' parent. In her view, this decreased the parents' readiness to change. In the

individual interviews, several of the therapists presented stories about how the parents'

behaviour was limited. One of these examples came from T-3:

Most of the parents we meet say they try to do what they think we want them to do.

And that they do not understand how the CPS's mind works. A father described how

he was restricted in his behaviour. He said that if he showed temper and his real feelings, he was described as unstable. If he did the opposite, he was described as passive. The situation developed where he became more and more scared of acting for fear of being interpreted negatively.

Another finding of this study emerged from a discussion among four of the therapists at the end of the second focus group discussion. They discussed how their own perspectives on the meaning of 'truth' influenced their practice. The interviewer asked the question whether there was anything about the parents that might challenge their professional identity or practice? The question of 'truth' seemed to be particularly challenging in this situation, because quite often the parents' stories appear unbelievable. The therapists varied as to whether the stories seemed to be 'true' or not, and how important 'knowing' what was 'true' was. T-4 expressed the challenge related to the veracity of these stories: *I want to believe them. But now that we talk about it, I know it is hard for me. I do not "buy" their story. I have been tricked more than once before, to put it bluntly.* The perspective of T-5 on the 'truth' was that the stories the parents present are what they chose to tell, and that their stories are a part of a larger story, with more layers, which they might need help to explore. How the therapists related to 'truth' seemed to affect how they positioned themselves towards the parents. T-2 said that this system easily led her to adopt a 'fighting mode' as she witnessed how the parents, time after time, seemed to be losers in the welfare system. However, T-4 defended the CPS, saying that there was information they did not know, and she personally chose to doubt the parents' stories.

When the therapists react to the system (navigating position 1-3)

The therapists responded emotionally to how the parents were sometimes positioned by the welfare system. When the parents were met with suspicion by the system because their stories appeared unbelievable, it made them further marginalised and even less empowered. In

the discussion about the importance of 'truth' that took place in the second focus group, one of the therapists (T-3) expressed that not knowing the 'truth' was not the hardest aspect of these cases. For her, emotionally, the hardest part was the way in which the parents were treated with a lack of respect by the welfare system. She thought this exemplified an attitude towards this group of people, where their dignity was not upheld. This observation was supported by several of the others who seemed to agree that the hardest part was witnessing how the parents lost out in the system, time after time. That their stories were not believed by the system was, according to the therapists, a sign of the lack of respect with which they were met by society. Therefore, listening to their stories contributed to a rebuilding of their dignity.

In rebuilding their dignity, it was important not to regard the parents as being disempowered. One therapist described this negative attitude as being condescending: *A sacrifice that held them tight in a particular position* (T-1). Another therapist (T-6) thought there was a connection between the disempowered ways in which they behaved and how they had been violated by the system. All the parents she had met had told about the total absence of a positive focus from the CPS towards them as parents. The therapists did not want the parents to become dependent on the professionals, but rather to be empowered to make their own decisions. The therapists held fast to their ideal that the parents were agents in their own lives, despite having lived a hard life. As one of the therapists expressed this concern: *Then you stop believing in them* (T-1). According to the therapists, the parents' position as being disempowered was reinforced by the normativity in the assistant systems they were used to, where someone required them to change. This was explained as a despair that their conception of reality was 'wrong'. One goal expressed by the therapists was to get the parents to move away from this normative position of thinking 'right/wrong'. T-3 expressed this as follows: *If we meet them in their expectation of a right answer, we fail*.

Discussion

The findings in this study present the dilemmas within the therapists' professional identities when they, as systemic family therapists, try to assist parents whose children are placed in care. The therapists struggled to maintain a non-expert position as their theoretical approach emphasises they should. To practice according to a theoretical orientation that is open to multiple truths also poses challenges to both the welfare system with which they collaborate and to the parents. Another challenge is how the therapists witness to the stories about how these parents have been met by the system, and how this has prevented them from becoming empowered. This strengthened the therapists' confidence in the value of using a family- and systemic approach with the parents. These findings show how family therapists negotiate their professional identities in relation to parents whose children have been placed in care, and how their different levels of position are sometimes complementary, but sometimes contradictory, and how this creates dilemmas for them. In the discussion, we will consider these dilemmas and see how the therapists appear to have resolved the dilemmas within their professional practice.

How marginality makes therapists act differently

One of the findings of this study was that when the therapists met with parents who had lost the care of their children, it raised some emotions in them that were about anger and moralism, compassion and sympathy. These feelings often led them to move out of their ideal professional position, where they acted neutrally, by activating more of their personal norms and values. These findings correspond with the results from studies by the CPS that show how feelings such as anger and sadness over the situation that parents have placed their children into can make it difficult for CPS caseworkers to feel empathy with the parents (Moldestad and Skilbred 2010). Weingarten (2000) claims that therapists will always be in a witness position in relation to the stories they hear from clients. To witness trauma, abuse and other serious events, will emotionally affect the therapist and she emphasises the importance of

being aware of this, and the consequences this may have on the therapist's actions (Weingarten 2003) and the therapist-client alliance (Shamoon, Lappan and Blow 2017). In addition to the fact that it can be difficult to maintain neutrality, the therapists described how these feelings of being emotionally overwhelmed also led them out of the 'not-knowing' position (Anderson and Goolishian 1988) and into the position of a practical trader. They explained this positioning as being both an escape from the pain they felt for the parents, and reflecting the difficult emotions they experienced, as they were unable to meet the parents' huge and complex needs for help. This positioning by the therapists could also be explained as something the therapists did to meet other needs that the parents might express which were more immediate, and were brought about by their being in such a marginalised position.

This group of parents are, generally, marginalised due to socioeconomic factors, and many are struggling with finances, drugs and housing problems (Schofield et al. 2010). As Bøe (2015) describes in the 'family-stress-model', these living conditions will often be more important for the parents to talk about than their experience following a child's placement. Weitz (2016) found that parents look at the need for change in their living conditions as the most important factor after their children are placed in public care, while the therapists' regard change as an individual process for the parents to engage in. Thus, a therapist's change of position towards a practical orientation will be in line with the parents' wishes, and will not necessarily be a 'wrong' practice but one that is necessary when faced with people with such complex problems (Syrstad 2011). Relating this to Weingarten's (2000) witness positions, it may mean that the therapist acquires more power or uses his/her power in a productive way to help meet the parents' needs. This is also called the 'contributor position' (Bird, 2004, p. 327). This corresponds to Foucault's perspective of power not as something that is transferred from one to the other, but rather as something that is used to produce or obtain a result (Foucault 1999).

If these complex needs of the parents are to be met, collaboration with the welfare system would seem to be of utmost importance. However, this collaboration can be demanding for the therapists because they are guided by difficult and often contradictory feelings, which can easily lead a therapist into a position of ambivalence, insecurity and polarisation. This highlights the importance of the therapists' awareness in their witness position, particularly regarding the way in which their position can influence their practice and lead to polarised alliances that can complicate collaboration.

How polarisation affects collaboration

Other findings of this study point to a clear connection between the therapist's perspectives on whether the 'truth' or a 'right way' exist, and how this perspective has consequences for their alliances, both with the parents and with the CPS system. For example, if the therapists choose to believe in or even to acknowledge the parents' stories, their alliance with the parents is described as being in 'fight mode'. Whether the parents' stories appeared to be 'true' or not, was secondary to the fact that they had been subjected to repeated system failures, simply by not being believed. These therapists saw that a way of restoring dignity to the parents was to acknowledge their stories. If they chose to doubt the parents' stories, which often appeared to have little credibility, their primary alliance was directed towards the CPS. This shows how easily these positions are polarised, and the consequences this may have for the parents and for the CPS. An alliance with the parents seems to be essential to the parents before they will engage with an individual process in their meaning making (Carr 2016). The danger of such an alliance can be a position of 'opposition' to the CPS and the rest of the welfare system, through a lack of inter-professional respect. This shows the potential for being pulled into polarised positions in these cases, with the consequences that may result for both collaborators and parents, especially when one bears in mind that most positioning are unconscious (Harré and Langenhove 1991).

The fact that the CPS and the FCS relate to the meaning of 'truth' differently can also reflect their different purposes and mandates (Healy 1998). Within the CPS, and particularly in cases where children have been placed in care against the parents will, factors such as control, coercion and power are important aspects of the CPS's professional practice. The discursive framework of the CPS will probably lead towards a professional position that is close to what Tomm describes as 'manipulation' (Strong et al. 2008). It may not be surprising that when such a discursive framework meets a different discursive framework (here, the FCS), where factors such as dialogue, a non-agenda and the non-expert position are emphasised, the collaboration is likely to be challenged.

The social constructionist's approach to therapy has been criticized for not taking the power dimension between the therapist and the client seriously (Minuchin 1998; 1999). This might lead to a paradox in that power is already unequal in these situations (Järvinen and Mik-Meyer 2003), and even if you equalise the power balance, the loss of power will not end for the parents who have had their child removed, but rather increase the diversity (Minuchin 1998, 1999). Thus, a social constructionist approach to therapy with these parents could be criticised for pushing the parents still further away from society's current standards and norms to an even greater extent than they are already. This might dissuade them from pursuing their goal of recovering their children, and thus the therapist's position might be considered a disclaimer position (Mik-Meyer 2012), where they are not aware and are not empowered to do anything (Weingarten 2000). This could constitute a danger for the FCS, due to their lack of authority to decide in these cases.

Connecting parents to the community

The therapists had desisted from helping clients by giving instructions. They were clear in pointing out that they could not change the parents, but rather wanted to help them to pursue their own process. For the parents to become empowered, the therapists said that they

must move to a position where they are no longer victims, but actors in their own lives. To achieve this, the therapist must focus on the parents' resources (Boddy et al. 2014) to help them regain belief in themselves and to meet them with a different approach rather than a normative 'right/wrong' way of thinking. This corresponds with Tomm´s model on ethical postures, which show the links between how a therapist positions him/herself, and the consequences of this positioning for the client (Strong et al., 2008). For example, if a therapist tries to convince the parents that there is a 'correct' answer and that they must learn 'correct' ways to behave, the therapist could appear to possess the 'truth' and therefore instructs the parents and moves into a position of 'manipulation'. In this situation, the parents' own versions of reality are of secondary importance. If the therapist's perspective is that the reality is complex and consists of several versions and truths, he/she will not be preoccupied with the question of whether what the parent presents is 'true', but will rather be curious about what it means that he/she chooses to tell this particular story among their other expressive possibilities (Frank 2012).

This narrative approach is suggested for parents whose children are in public care as being something that will empower them (Hall and Slembrouk 2011; Kielthy 2008) and strengthen their engagement (Kemp et al. 2014). Such a positioning can also make it easier for parents to reach an alliance with the therapist (Carr 2016). In such a dialogical process, the therapists play on the same team as the parents, so the parents do not have to spend energy convincing and winning them over (Anderson & Goolishian1988) as often happen in these cases (Sykes 2011). The ideal is to empower the parents to take control of their own lives. If the follow-up service is able to do this (Memarnia et al. 2015), their dignity will be restored and they will recover faith in themselves and in their own stories. While they are in the position of 'victim' in the system, deprived of authority and control, they will also write off their responsibilities and continue to not understand the position they are placed in

(AUTHORS, in review). They will lack ownership of their lives, of their position and of their history. It is this 'subjectivity' that the therapists must help them to rebuild or to grasp, this link to their own lives, which in turn, will connect them to the community into which they must strive to become more integrated (Biesta 2016).

Concluding remarks

This study has shown several dilemmas experienced by family therapists when they negotiate their professional identities with parents whose children are placed in care, and it has considered how the therapists try to solve these dilemmas in their professional practice. Systemic family therapy approach may be particularly demanding with these parents, as they do not necessarily take hold of the expert position very readily because they have possibly been deprived of control in own lives, and they need more support before they will grab such control. This does not mean that this theoretical approach is less suitable for these parents. Nevertheless, this approach may consist of ideals that the parents are pushed into before they have the capacity to manage within it (Järvinen and Mik-Meyer 2012). This is an important consideration for the family therapist facing this marginalised group.

This study also reveals the dilemmas that can occur in the collaboration between two welfare systems with their different theoretical approaches and different mandates. Nevertheless, this collaboration seems to be essential if the parents' extensive needs for help are to be met. The study shows how important it is to visualise the alliances that can develop, and then try to avoid unfortunate alliances by understanding the context and the rationale behind the professional practices. Nevertheless, one can conclude that both systems (the CPS and the FCS) have something to learn from the other. While the FCS needs to gain knowledge from the CPS about meeting with marginalised groups and interdisciplinary collaboration, the CPS could gain by expanding its perspectives and recognising that dialogue can consist of multiple realities. We suggest the further research on systemic family therapy is needed in the

field of child protection, particularly with parents who need follow-up services after their

children have been placed in care.

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