Cogent Psychology

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/oaps20

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To cite this article: Pravin Israel, Cathrine Steffensen & Hege H. Hadland (2023) Experiences of family therapists working with parents after the forced removal of children: What can the contextual model tell us?, Cogent Psychology, 10:1, 2151731, DOI: 10.1080/23311908.2022.2151731

To link to this article: https://doi.org/10.1080/23311908.2022.2151731

Published online: 04 Dec 2022.

Israel et al., *Cogent Psychology* (2023), 10: 2151731
https://doi.org/10.1080/23311908.2022.2151731

cogent psychology

CLINICAL PSYCHOLOGY | RESEARCH ARTICLE

Experiences of family therapists working with parents after the forced removal of children: What can the contextual model tell us?

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Received: 09 February 2022
Accepted: 21 November 2022

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Abstract: Parents whose children have been statutorily removed by child protection services are a vulnerable, hard-to-reach, and under-focused group. Their needs are numerous and complex. The Family Counselling Services in Norway are mandated to prioritize and provide emotional support services to this parent group. The study aimed to explore and understand the experiences and needs of family therapists through the lens of the Contextual Model (Wampold, 2015). A national sample of 21 therapists currently providing services to this parent group participated in the study. Data were collected using focus-group interviews. The main categories of the initial bond, the personal relationship, expectations, and therapy-specific ingredients provided a framework to assess what therapists already know and need in the future to provide services to the parent group. Therapists showed great awareness and strength in building a personal relationship with the client. However, they felt that sharpening their generalist knowledge with therapy-specific models would make them more effective therapists. The contextual model provided new concepts and vocabulary that can enrich research and clinical efforts and lift it to a broader audience.

Subjects: Mental Health Services & Policy; Family Therapy; Parenting; Marriage & Family Counseling
Keywords: birth parents; forced removal of children; common factors model; the contextual model; Family Counselling Services; theory-driven analysis; therapist factors

Parents whose children have been statutorily removed by child protection services (henceforth known as the parent group) are a vulnerable and marginalized group (Broadhurst & Mason, 2020; Kenny, 2018; Memarnia et al., 2015). Removal of the child is often preceded by experiences with Child Protection Services (CPS) and the judicial system, which exposes parents to additional trauma (Bruskas & Tessin, 20132013). After removal, events like termination of reunification or the decision of CPS to place children for adoption continues to add to the existing trauma (Katz, 2019). Recent reviews found high rates of PTSD, particularly complex PTSD (CPTSD), complicated grief, mental health problems, and suicidal risk in the parent group (Suomi et al., 2021; Nixon et al., 2013; McKenna et al., 2021).

There is a conspicuous lack of research on the parent group (Slettebø, 2009, 2013). The limited research literature shows that only a few parents received help from routine mental health services (MHS). A recent literature review evaluated the effectiveness of practice models in CPS based on the following criteria: The model should have i) a clear theoretical basis, ii) a framework

for client practice, and iii) a description of practitioner skills and tools. From an initial 1,360 eligible studies, they found only five studies that met the inclusion criteria. These studies were deemed low-quality studies and had poor outcomes (Isokuortti et al., 2020). Another study used a mixed-method design and interviewed birth relatives (63 parents and 10 grandparents) at two time points 15 months apart (Neil et al., 2010). They found that only a few birth relatives received regular support from adult service providers. Further, the services were scarce for birth relatives. The literature also tells us that parents who were offered help services reported that the services were neither appropriate nor tuned to their particular needs (Bolen et al., 2008). Further, the concrete interventions did not seem to improve their parenting practices. Three-fourths of the participants were still using physical punishment to discipline their children despite allegations of physical abuse that attracted the attention of CPS.

However, some studies reported optimistic results. For example, Morgan et al. (2019) conducted a small sample study to understand "what works" for the parent group. They found that counselling created a strong bond between the parents and their counsellors, parents felt that the healing process had begun, and they felt safe to talk about their children and motherhood. Choosing to listen to and operate out of the client's experience of trauma is an essential feature of trauma-informed care (Katz & Haldar, 2015). A review article showed that trauma-informed care was actively pursued by child welfare stakeholders and successfully implemented in CPS (Bunting et al., 2019). There is also some research on the parent group in the Norwegian context (Falch-Eriksen, 2016; Slettebø, 2009, 2013; Syrstad & Ness, 2019, 2020a; Syrstad & Slettebø, 2020b). Syrstad and Ness (2019) examined how systemic therapists in Family Counselling Services (FCS) negotiated their professional identities in providing services to the parent group. They found that therapists' emotions influenced their professional ideals like neutrality and non-expert position. Therapists also described how the contexts of FCS and CPS promoted differing versions of reality due to differing mandates, work contexts, and previous experience with the parent group. Moreover, therapists' feelings toward CPS were incited by the painful narratives of the parents. Another study by the same authors reported therapists' temptation to move into an expert position as a response to the lack of agency and insight, the magnitude of the need, and overtly simple attributions for the removal of the children (Syrstad & Ness, 2021). They also reported that therapists found exploring the parents' stories helpful instead of being critical of the content.

Overall, the results show that timely contact with a counsellor has great potential to help the parent group. However, the literature regarding intervention and services for the parent group is mainly populated by small qualitative studies. Conversely, there is a vast body of knowledge under the umbrella of psychotherapy process and outcome research (American Psychological Association, n.d.; Barkham & Lambert, 2021; Knobloch-Fedders et al., 2014; Orlinsky et al., 2004). A plethora of evidence-based therapies (EBTs) was developed and disseminated to help parents with parenting problems and skill-building (Forrester et al., 2012; Hundeide & Armstrong, 2011; Katsikitis et al., 2013; Marcenko et al., 2010; Saldana, 2015; Sanders, 1999; Yoo et al., 2020). Some evidence-based methods are implemented in the Norwegian CPS and routinely offered to troubled families (Berg et al., 2020; Mørch, 2012; *Tiltak i Barnevernet*, n.d.). However, these interventions target parents before removing the children and stop after the child's removal. Trauma-informed care made headway into the Norwegian CPS system with training programs and nationwide implementation (*TraumeBevisst › Barnevern*, n.d.). Nonetheless, the therapeutic work is primarily directed toward children and youth and other caregivers like foster parents (Bunting et al., 2019; Sullivan et al., 2016).

Developing and implementing sustainable mental health services requires vision, mandate, and leadership. The Norwegian government commissioned Family Counselling Services (FCS) to provide supplemental services to meet the emotional and support needs of the parent group (Falch-Eriksen, 2016). The FCS is a national, low threshold, voluntary, and free-of-charge service organized under a different management level than CPS. Therapists working in FCS are multidisciplinary, and many identify family theory and systemic practice as their theoretical foundation (Grasaasen & Michaelsen, 2019; NOU, 2019). However, many family therapists also embrace the

common factors model as a relevant source that informs their theory and practice (Davis & Hsieh, 2019). The common factors model proposes that shared factors across various therapy models explain psychotherapy effects. The core factors such as the therapeutic alliance, empathy, goal consensus and collaboration, positive regard and affirmation, mastery, congruence/genuineness, mentalization, and emotional experience explain most therapeutic outcomes (Nahum et al., 2018). Recognizing the need for a theoretical framework to understand and examine the common factors B. Wampold (2001); B. E. Wampold (2015) developed the Contextual Model. According to the contextual model, the therapy process starts with an initial bond phase where the client assesses if the therapist is trustworthy and has the necessary expertise and investment to help. If the therapist is acceptable to the client, therapy moves forward along three pathways. The first pathway is the real or personal relationship. This is psychodynamically defined and "marked by the extent to which each is genuine with the other and perceives/ experiences the other in ways that befit the other" (Gelso, 2014). The second pathway is the client's expectation of therapeutic benefits. It also includes expectations of whether the client will complete therapy's tasks. The third pathway consists of therapy-specific ingredients tailored to meet the client's needs.

From a scientific perspective, building a research base with diverse research designs and empirical vigour is the desired agenda. For instance, studies that provide the opportunity to compare with established theories/models and other related studies can help better locate and position oneself in the broader field of mental health services. In addition, evidence-based treatments (EBTs) benefit standardization, training, and supervision. However, EBTs are theoretically on a different tangent than the systemic family practice that undergirds FCS in Norway. Nevertheless, using multiple perspectives and methods can provide insight and help clarify blind spots that are otherwise not visible (MacFarlane & O'Reilly-De Brún, 2012). The contextual model offers a theoretical framework to assess therapists' strengths and growth potential. This study aimed to understand and evaluate therapists' experiences with the parent group through the lens of the contextual model.

1. Method

The current study used an explorative qualitative design (Hunter et al., 2019). Data were collected using focus group interviews and analyzed through theory-driven procedures. This approach's advantage is combining a focus on theory with rich qualitative descriptions (Murphy et al., 2014). Several qualitative studies developed frameworks by using pre-existing concepts and theories to guide analyses of textual content and expand the scope of the studies (Chew et al., 2019; Colón-Emeric et al., 2010; Morrow et al., 2011; Nguyen et al., 2021; Swaithes et al., 2021; Travis et al., 2014).

1.1. The study context

FCS in Norway consists of 42 family therapy centres spread across the country. There are five regions, and each region has a resource group. Each resource group serves the local FCS centres in their respective region. The Directorate of Child, Youth, and Family Affairs (Bufetat) finances FCS, and all services are provided free of cost. Bufetat commissioned a national competence group (SKM) to provide leadership and implement knowledge-based services in FCS for the parent group (Bufdir, 2020). The authors are employed in various capacities in the FCS and SKM.

1.2. Participants

A purposive sampling method was used to recruit a national sample of 21 therapists. The age of the participant and the number of years of experience was not collected. However, there were 18 family therapists and three clinical psychologists. Family therapists had a bachelor's degree in social work and advanced training in family therapy. Clinical psychologists have family therapy courses embedded into their professional program. Seventy-five per cent of the participants were women, and all the participants were senior therapists with long experience in FCS.

1.3. Recruitment and data collection

Information regarding the study was first sent to the five regional resource groups. Thereafter, the contact persons in the resource group contacted the FCS centres in their respective region and

recruited the participants. The goal was to recruit participants that would mirror the typical workforce in FCS, for instance, interdisciplinary and heterogenous in terms of age and experience. However, direct experience with the parent group in the current position as a therapist was an absolute requirement. Participation in the study required at least two clinical cases with the parent group prior to the focus group interview. There were 3–6 participants in each focus group, and the average time spent on the focus group interviews was 75 minutes. Participants were allowed to interact and respond to each other in the focus-group interview if the discussion deepened the emerging theme. Two representatives from the national competence team were moderators and regulated the focus group discussions. All the focus group interviews were audio-recorded.

1.4. The semi-structured interview

The interview guide was built to elicit responses reflecting the principles of phenomenological-hermeneutic research, and also to capture tacit knowledge in clinical practice (Edwards & Young, 2013; Kvale, 1996; Welsh & Lyons, 2001). The format of the questions was broad and reflected a typical client trajectory in FCS. The questions that guided the focus group interview were as follows: i) What needs did parents present to the therapists? ii) What characterized cases that therapists deemed successful? iii) Challenges that therapists faced with the therapeutic work and/or the context of providing services at FCS, and iv) Needs that therapists' deemed necessary to provide effective services to the parent group. Have these needs changed with time and experience with the parent group?

1.5. Data analyses

All focus-group interviews were transcribed word-for-word, with repetition, pause, laughter, and other filler words like ahhh, um, etc. The data were coded using the software package NVivo 11. In keeping with the deductive analytic strategy, we used four main categories elucidated from Wampold's contextual model: 1) The initial bond 2) The personal relationship 3) Expectations, and 4) Specific ingredients. First, all the authors read the transcripts from the perspective of the contextual model as preparation for the coding. Thereafter, the relevant quotations from the participants were coded into the four main categories of the contextual model. Some quotes fit more than one category and were coded accordingly. Additional subcategories based on the contextual model were added as they emerged from the data (see, Table 1). Finally, all the authors reviewed the categories and arrived at the final coding through discussion and consensus.

1.6. Ethical issues

The study was a quality assurance project and the Regional Ethics Committee did not require an application for the study. No personal and identifiable data was collected including the participant's age and the actual number of years in employment. However, the participants received written information regarding the background for the study, what was expected of them, their voluntary participation, anonymity and confidentiality, and publication plan. The participants gave their consent.

2. Results

2.1. The initial bond

Three subcategories emerged i) the referral context and presenting problem ii) clarification, and iii) therapist preparedness.

i) The referral context and presenting problem: The parent group was unsure of what to expect from FCS and the therapist. They said, "we do not know what we want," and asked the therapist, "what can we get?" CPS told parents to seek help at FCS, which caused the parents to be sceptical and careful. One participant reported, "*the parents are unclear about why they came. They were told by CPS to get in touch with us."* Another reported that a parent asked, "*what is wise and unwise of me to say here?"* The participants wondered if the parents' felt CPS was still calling the shots. One participant said, "*I realized that they (CPS) sent the parents to us, they (parents) are confused*

Table 1. Categories based on the contextual model (**B. E. Wampold, 2015**)

1. The Initial Bond	2. The personal relationship	3. Expecatations	4. Specific ingredients

• Clients determine if the therapist and FCS is trustworthy
• Therapist has the necessary competence and skills to meet the specific needs of the client
• Therapists is prepared to invest in the client
	• Genuine and natural
	• No threat that therapist will terminate relationship
	• Statutory limitations are often not relevant because status is "post-mortem"
	• Human connection
	  ○ Attachment
	  ○ Belongingness
	  ○ The lack of loneliness
	  ○ Social support
	• Psychotherapy provides human connection with
	  ○ an empathic and caring therapist
	  ○ should be health promoting
		• Provide explanation for client's psychological distress and difficulties that is adaptive
		• Client comes to believe that competing therapy task will be helpful
		• Therapist instills hope that clients can finish the tasks
		• Discuss mastery, self-efficacy and response expecations
		• Clients believe that the help will remedy their situation
		• Agreement of goals and tasks (alliance)
			• Every treatment has specific actions
			• Congruence between treatment, theory, explanations, client expectations, and therapist actions
			• Strong collaboration is needed
			• Treatment elicits health actions
			• specific ingredients build expectations

about coming here … wonder what they should do here." Another therapist recalled, "*a couple was sent to us because CPS wanted the father to receive a training course on anger management*." ii) Clarification: Parents wondered if FCS could help them regain custody of their children. Some parents needed help understanding the complicated system, especially parents with minority cultural backgrounds. The participants saw that clarifying the differing roles of FCS and CPS would better prepare the parents to evaluate if they wanted help services from FCS. iii) Therapist preparedness: Participants were prepared to offer the parent group their services. Many saw the initial goal to be available, present and help the clients tell their stories, *"Concerning our (services) … . what we can provide is to be the one that they can talk to and retell their story. To be there for them."* They were prepared to provide a human connection in concrete ways, "*I am quite practical … . I ask quite a bit about practical things to start with. I do not know if I am careful or curious or what it may be, but it begins with that. Will you be going to court? Or something like this is checked."* There was a general belief among the participants that "being available and present" for the clients was the right thing to do in the initial phase of therapy.

2.2. The personal relationship

Participants talked about the personal relationship in two ways: one was based on what they thought the relationship should be- *a global level*, and the second was based on their actual clinical experience with the client group- *the factual level*. A third subcategory was therapists' understanding of the client's context and thus gaining the client's trust. i) The global level: Participants reported system-level content and showed an understanding of the parent's context, *"there is a lot of shame, anger, frustration, and helplessness. There are often intense and painful feelings that come up, for most of them this is an enormous loss that is mixed with shame … that someone has determined that your caregiving is not good enough"; "it is a tabu, (they are a) pariere group and not very popular."* Regarding placement in foster care, one participant recalled a parent saying, "*now my child is placed with two men, and she is calling one of them mamma … what kind of an upbringing will she have?"* ii) The factual level: Participants talked about their emotional reactions to the parents' story and the system that put

them in this situation. Here are some examples: *"I have such a gut feeling … have things (for the parents) really gone right here? Has CPS understood and assessed correctly? When they (parents) have explained time and again, I see there is room for misunderstanding (has CPS?). I get a nagging feeling that this couple has been misunderstood"; "I have read the reports from the kindergarten and meeting after the visitation and such reports . . . .I get uneasy . . . .to come to that position that one is worried and does not know what to do with this uneasy feeling."* Participants saw the parents' dilemmas and system-level challenges and were emotionally moved by their stories. iii) Understanding and trust: Deep, vulnerable, and painful narratives are communicated when there is a certain level of trust. The clients' trust can be explained from what they told the therapists. For example, one participant said, "*she had suicidal thoughts and such, I was worried for her when we talked." I asked her every time how it was for her to sit here and talk about these things. She said it was good to open up a little. I have my children in a coffin, so when I am here, I open up the lid a little and then put it back on again."* Other responses were: *"some come in tears and cry at the office"; "many say they have no one else, this is very painful to talk about . . . "; "I worked with a parent who is a public figure . . . lost custody . . . it was in a way to go to work in shame, come home and draw the curtains and be there."* Although the presenting problem was unclear at the initial bond phase and the clients were unsure of the therapist, the quality of their relationship got better as a personal relationship developed. Clients began to trust the therapist and FCS.

2.3. Expectations

Three subcategories emerged i) client's expectations, ii) therapist provides adaptive explanations, and iii) agreement on goals and tasks.

i) Clients' expectations: After the initial clarification, the client's expectations reflected a social level and a personal level. On the social level, participants reported that parents expected to meet like-minded people and were looking for fellowship. Parents also expected advice and counselling from their peers. On the personal level, they were, among others, terrified of making mistakes because they were afraid of CPS. For example, a mother told one of the participants (the therapist) that her daughter was starting kindergarten. She was afraid of practical tasks like dressing the child, which was used against her. Consequently, the mother wanted concrete advice and supervision from the therapist.

ii) Therapists' adaptive explanations: Therapists provided adaptive explanations to understand the unique situation of the parents. They explained that "*they (the clients) have little experience meeting the human side of professional workers and have been previously mistreated. After a while, this could affect one's social competence too"; "they have a need to be seen, heard and understood"; "some of them are children of parents that lost custody, and they have now become parents, they are now in this situation without help"; "I have come to realize, beyond a shadow of a doubt, that CPS has been unfair."* The parents gained hope for change because of the therapeutic encounter. A participant reported that "*an immigrant mother previously lost custody of two children but got another baby. She came to me when she was pregnant and after she gave birth. She did not say much but said that she would very much like to come here, and it means a lot for her to come here. She hugged me and was very thankful."*

iii) Agreement on goals and tasks: Participants reported that agreement on goals and tasks was a tall order. For example, the parents told their therapists about their experience with, among others, visitation but did not ask concrete questions like, "*what can we do or how can I handle it?"* Another participant countered by saying, "it is *about what we (as therapists) make it to be." If we sense a need for supervision, we could ask parents, "tell me what you did, what did you think, what could you have done differently?"* This participant implied that therapists could be proactive in helping clients define goals and tasks. However, the participants were careful and explained that such moves could backfire if one came in too fast and assumed the role of an advisor or an expert. Nevertheless, the participants had concrete ideas regarding what could be helpful, for example, helping them re-discover relationships, take care of their sense of self, and address their existential needs.

2.4. Specific ingredients

Every treatment has specific ingredients that the theory proposes, the therapist deems essential, and the client finds acceptable. Two subcategories emerged i) therapy-specific actions and ii) limitations and needs of the therapist. i) Therapy-specific actions: The most favourable actions that the participants reported were conducting support peer groups for the parents and providing training courses. They felt that support peer groups allowed the parents to meet others in a similar situation. Further, the peer nature of the group would provide parents feedback in a way that they could accept- "*if a parent says it is all right to flick a child's ear (to discipline the child) so can another in the group say, "I beat my son, and he is destroyed. Violence is not the answer."* Therapists also mentioned emotion-focus, emotional regulation, and counselling/coaching as goals to help parents prepare for meeting with CPS. Therapists felt that their meeting with the client had a significant impact as a therapeutic intervention when it provided a safe relationship, empathic listening, and acknowledgement of their experiences and narratives.

ii) Limitations and needs of the therapist: Participants recognized that the parent group had many needs, and therefore wished for a better theoretical framework to be more effective. One participant talked about the lack of structure in individual sessions and a need for a concrete model—"*Mini-Cos (Circle of Security) is a concrete intervention with a manual. My need for a framework would be met with something like this."* Another participant discussed the need for concrete tools like training in the International Child Development Program (ICDP- Hundeide & Armstrong, 2011). The participant added that a concrete model would serve as a backup plan should there be a lack of parent-initiated topics. Participants reported feeling less confident about handling clients' strong emotions and experiences, implying a need for structured and established EBT-like programs.

3. Discussion

The focus groups' data covered the four categories of the contextual model: the initial bond, personal relationship, expectations, and specific ingredients. The themes that emerged from the focus-group interviews mainly centred around the second category- the personal relationship. Conversely, the least discussed theme was the third category- expectations.

3.1. Building a relational foundation

The current study showed that therapists in FCS knew that providing services would help the parent group. As a result, they were prepared to provide a human connection and invest in building a personal relationship with the client. The content of the second category- a personal relationship, appears to parallel the concept of the therapeutic alliance (Bordin, 1979), particularly the "bond" phase of the therapeutic alliance. Alliance can be measured from multiple perspectives- the client, the therapist, and the observer (Horvath, 1981). From the therapist's perspective, the following statements reflect the bond: i) I believe my client likes me ii) I am confident in my ability to help my client iii) I appreciate my client as a person iv) My client and I have built a mutual trust. Morgan et al. (2019) noted that parents felt a strong commitment and affection toward their therapists. Therapists in this study were actively involved in building the therapeutic alliance, which is linked to therapist initiative and actions (see, Baldwin et al., 2007; Del Re et al., 2012).

3.2. The professional helper: A compassionate fellow human and a competent therapist

Many are drawn to the helping professions by a desire to provide care and better the lives of suffering and needy people (Ybañez-Llorente, n.d.). However, professionals also must abide by a code of ethics to protect the client. One example is the code of ethics drawn by the American Association for Marriage and Family Therapy (AAMFT), which clearly states therapists' responsibility regarding standards of knowledge, maintenance, scope, and acquiring new skills (AAMFT, n.d.). While being a compassionate and motivated fellow being is a good starting point, professionalism requires going beyond and providing services that reflect high-level competency and skill.

The category of "expectations" operates at two levels. First, clients' pre-conceived expectation that seeking therapy will help them is closely related to their health actions, which is associated with subsequent alliance building and outcome (Patterson et al., 2014). The expectation that a particular agency can help is often a consequence of the reputation it has built over time. However, given the recency of FCS as the mandated helping agency for the parent group, it has not yet built a renome'. Nevertheless, with systematic and protracted efforts like marketing the services and outreach, it is possible to create awareness and expectation even with stigmatized and hard-to-reach groups (Joa et al., 2008). Second, the client's expectation of their ability to complete the therapeutic tasks provides them hope and perseverance. Many parents have had prolonged contact with caseworkers in CPS and endured judicial proceedings that render them with a sense of helplessness. However, meeting a neutral, supportive therapist who listens to their narrative with empathy is often a new and positive experience for many (Morgan et al., 2019; Yoo et al., 2020). Such experiences return a sense of dignity and self-confidence to complete the required therapeutic tasks.

Therapists wanted more knowledge about specific models of interventions (category four- specific ingredients). They favoured peer support groups for the parent group and noted specific advantages. Generally, support peer groups provide participants with a sense of community and support network, which helps reduce the effects of being excluded, shamed, and marginalized. Group members can use each other as a sounding board to express themselves and receive feedback, correction, and advice (APA, n.d.). Irrespective of their skill level as group leaders, therapists influence the process and outcome of groups (Roback, 2000). Therefore, training in group therapy would enhance the effectiveness of the intervention. However, a group-based approach may not be feasible due to practical reasons. For instance, a group may not be available at the time of referral, or the parents may have just lost custody for the first time and are in an acute state with a high level of pain and distress.

While broad-based approaches provide some promise, the parent group also have specific challenges and traumas like complex PTSD, complicated grief, and comorbid mental health conditions (McKenna et al., 2021; Nixon et al., 2013; Suomi et al., 2021). Such conditions will benefit from targeted interventions in conjunction with the therapists' desire for structured programs and specific models. Training therapists in interventions like EMDR and Trauma-focused CBT would provide FCS with evidence-based treatments (EBTs) to effectively serve the parent group presenting with trauma like PTSD (Mavranezouli et al., 2020). However, in Norway, most of the conditions mentioned above fall under the purview of specialist mental health care. Nevertheless, as the agency with a mandate to provide specialist-level care for the parent group, FCS would benefit from availing itself of EBTs and implementing them in their centres. Researchers have developed family-based models to address trauma in parents and children. An Australian program called Black Box Parenting (Torres et al., 2015) was designed to repair the parent-child relationship by addressing past trauma. Another evidence-based family program, Attachment-Based Family Therapy (Diamond et al., 2021), was developed to help parents and youth repair traumatic attachment ruptures. These trauma-informed programs would introduce EBTs to the routine practice setting and provide a diversity of methodology and competence while providing the parent group with high-quality services. Family-based trauma-informed programs would also find a meaningful place in the systemic agenda of FCS.

3.3. System-level challenges

There is a political and administrative directive to provide services to the parent group, but beyond that, the field is operating with generalist knowledge and skills. The FCS and CPS are different services organized under the same government department (Bufdir/Bufetat). CPS is closely tied to the judicial system and is normative and prescriptive. The preferred interventions are to provide targeted programs to improve parenting and other caregiving skills. The systemic context of the FCS focuses on understanding, empathizing, empowering, and preventing, and therefore a qualitatively different service. These ideological differences are neither immediately apparent to people working in these systems nor the parent group. Therefore, there is a need for leaders and administrators to build a communications strategy so that referral sources in CPS and the parent group are well informed.

Some therapists have previously worked in CPS and encountered the parent group, albeit in a different role. Their experiences have the potential for a deep understanding of what parents go through in assessments and judicial proceedings. However, the combination of initial training in family therapy in the distal past and recency of experience as case managers in CPS could be barriers. Ongoing peer supervision would help identify dysfunctional practices and streamline effective therapeutic strategies in FCS (Golia & McGovern, 2015).

3.4. Implications for clinical practice

This study provided information that could help strengthen therapists' knowledge and skills in several ways. First, training in building bonds, goals, and tasks, essential to the therapeutic alliance (Bordin, 1979), provides therapists with concrete knowledge and skills. Second, the parent's account and experiences evoked strong emotions in therapy and the therapist. Emotion-focused therapy (Greenberg & Goldman, 2008 & 2019) is a model that directly addresses these issues. Further, it is gaining momentum in FCS in Norway ("EFT-Terapeuter i Norge—IPR," n.d.), and training in this model would strengthen therapy-specific skills. Third, training programs in trauma-focused care are already developed and implemented in Norwegian CPS. Mandatory training for FCS therapists would expose them to the fundamental principles of trauma-informed care. Adapting the principles to the parent group and developing specific models would be a positive next step. Fourth, therapists with previous work experience as caseworkers in CPS and direct contact with the parent group may experience barriers. However, they also have an insider preview of parents' experiences in CPS. Identifying these therapists and providing them with good supervision tools would be a valuable investment. Finally, the contextual model provides concepts and vocabulary from the field of psychotherapy research and clinical psychology. Their use in FCS could expand the therapists' theoretical scope and reflect the workforce's multidisciplinary nature.

4. Limitations and future research

We noted some limitations. This study used the Contextual Model to examine and unpack the experiences and needs of therapists in FCS to provide services to the parent group. Using methodology and borrowing perspectives from other fields may have limited the depth and coverage of all relevant topics in one article. There is a need for more theoretical and empirical work to connect the theory and practice of systemic family therapy with the contextual model. Therapists volunteered to participate in the study, which suggests that participants with high motivation and a particular interest in the parent group participated in the study. Further, specific demographic data of the participants age and experience in FCS was not collected. We acknowledge the limitation this imposes on better understanding, interpretation, and generalization the results to therapists in FCS. Future studies could build on this study, design a questionnaire, and use a quantitative design to gather data from a large representative sample in FCS.

Acknowledgements
We thank the participants for sharing their knowledge and the resource groups that supported and recruited them. As well, we thank Jon Aarsland, who was the director of the Family Counselling Services in South Rogaland County, for his encouragement and support.

Funding
The authors received no direct funding for this research.

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Disclosure statement
No potential conflict of interest was reported by the author(s).

Correction
This article has been republished with minor changes. These changes do not impact the academic content of the article.

Data availability statement
The nature of focus groups does not entirely guarantee anonymity. Concerns that despite the lack of identifying information, members of a focus group can identify statements of a particular individual triggered assurance from the authors that data (transcripts) will not be freely available. However, in conjunction with this publication, data that support the findings are available on request from the corresponding author [KPI].

Citation information
Cite this article as: Experiences of family therapists working with parents after the forced removal of children: What can the contextual model tell us?, Pravin Israel, Cathrine Steffensen & Hege Hadland, *Cogent Psychology* (2023), 10: 2151731.

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Cogent Psychology **(ISSN: 2331-1908) is published by Cogent OA, part of Taylor & Francis Group.**