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Is a 'Both/and' Approach to Integration Possible? A Practice Reflection on Working with Children in Out-of-Home Care and Their Caregivers

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The prevalence and complexity of children's mental health concerns is increasing for children living in out-of-home-care settings in Australia and in other Western countries. Therapists face an amplified challenge of finding innovative ways of working with children and their caregivers, often drawing upon multiple therapeutic approaches to respond to such complexity. This article discusses some tensions of integration in practice. A case example is offered to demonstrate a way of enacting integration with Deanne, a six-year girl, and her foster family. These practice reflections illustrate a certain way of doing a 'both-and' approach to integration, drawing on narrative therapy and attachment therapeutic lenses. The reflections on practice reveal how a nuanced and reflexive approach to integration is needed to ensure theoretical congruence, to avoid contradictory therapeutic stances of 'knowing' and 'not-knowing.'

Keywords: children, discursive and attachment therapies, integration, reflexivity

Key Points

1. The complexity of mental health concerns for children in out-of-home-care settings in Australia is increasing.
2. Integration of varying therapeutic approaches occurs in practice, yet limited research has been done to explore how therapists make decisions as to what approaches they draw upon in their work with children and caregivers and how they employ such concepts.
3. Wile's (1993) practice pictures offer a helpful way to conceptualise how therapists integrate competing therapeutic approaches in a theoretically congruent way.
4. A constructed case study describes how primary narrative therapy practice ideas were given expression in working with a foster carer. The case study demonstrates how attachment practice concepts were modified to inform the work with a six-year-old girl and her caregiver.
5. In order to develop theoretically congruent practice and an ethics of practice, reflexivity is required on the part of the therapist.

Rising global social and economic inequality means families are facing significant challenges to provide for their children. With such competing pressures, caregivers may struggle to respond to their children's developmental, social, and emotional needs. This growing disparity has meant an increase in substantiated child protection notifications in the last decade in Australia (Australian Institute of Health and Welfare, 2017). As a result, a greater number of children are now living in various out-of-home care (OOHC) contexts such as residentials placements, kinship, or foster care (Australian Institute of Health and Welfare, 2017). Research has confirmed that such

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children may experience several placement changes (James, Landsverk, & Slymen, 2004; Sigrid, 2004). This has led to therapists working with an increased number of children in such OOHC settings who have experienced significant disruptions in their relationships with their primary caregivers.

Children are presenting to therapy with a complex range of mental health issues (Hafekost et al., 2012015; Sawyer, Miller-Lewis & Clark, 2007). Therapists face a magnified challenge of finding innovative therapeutic ways of working with children and their caregivers, to respond to the mental health concerns children may be experiencing (Avdi, 2015; Sawyer, 2011). In this contemporary context, one therapeutic approach may be insufficient to respond to such complicated emotional, social, cultural, and mental health concerns which may be impacting on various aspects of a child's life. Consequently, therapists working in various practice settings are often tasked with employing practices drawn from differing therapeutic approaches.

Integration: What Does it Mean in Practice?

While it is generally accepted that therapists draw from a range of therapeutic approaches to respond to diverse challenges children may be facing, it is unclear how therapists go about this. The question remains: What does integration actually mean in practice? How do we, as therapists, make decisions as to what therapeutic practices we employ in our conversations? Once these decisions are made, how do we integrate additional therapeutic ideas into our practice in a coherent way? Larner (2000) asserts that the integration of multiple therapeutic approaches is possible only with a 'both/and' approach as opposed to the therapist assuming a purist 'either/or' stance (p. 62). Each therapeutic approach, however, is informed by markedly different epistemological assumptions about therapy, and the person and/or family seeking therapy (Dickerson, 2010). The child and youth mental health field has a rich theoretical historical backdrop that has been developed over many decades. The historical development of first-, second-, and third-wave therapeutic approaches has led to diverse theoretical understandings influencing therapeutic practice in the therapy field (Bertolino & O'Hanlon, 2002). Each wave, however, is built upon a very different epistemological foundation and associated theoretical assumptions.

Depending on the specific theoretical assumptions, the *issues* children may be experiencing are defined in conflicting ways. Accordingly, each theoretically informed approach constructs a deviating version as to how therapeutic change might be achieved (Dickerson, 2010). Unless the practitioner has a clear sense of the theoretical framework informing therapy, their practice could be characterised by what has been informally coined the *blender approach* to therapy. Such an approach takes specific therapeutic skills drawn from contrasting first-, second-, and third-wave therapeutic approaches and combines them. If this is done without critical reflection, incongruent epistemological stances can cloud the therapeutic interaction and undermine the child's experience of therapy. Furthermore, Dickerson (2010) argues, 'it is impossible to integrate theories across epistemologies' (p. 349) with such a blender approach being 'illogical and existentially impossible' (p. 357).

The question remains: Is it possible to integrate various therapeutic practices in a consistent and theoretically congruent way? For example, a therapist may gravitate to discursive therapeutic approaches from the third wave as informed by social constructionist theory. Discursive therapies is an umbrella term which can include solution-

focused brief (De Shazer, 1985), narrative (White & Epston, 1990), and competency-based therapies (Bertolino & O'Hanlon, 2002). From a post-structuralist, social constructionist perspective, therapeutic practice is represented as a means to working in partnership with children to draw forth their local and unique knowledge (Anderson, 2012; Strong, 2006). The child is recognised as the expert of their own experiences. 'Talk' in discursive therapy is intended to make visible the initiatives children are taking, despite the challenges they face.

These discursive therapeutic approaches define issues in ways that separate the child and other family members from dominant discourses and problematic identity conclusions. Issues are conceptualised in sociopolitical terms (Monk & Gehart, 2003). Therapeutic interaction from this third wave of therapeutic approaches is seen as a means to actively invite the child and their family to co-construct their own knowledge to assist them in their current challenges. By drawing from such theoretical assumptions, the therapist seeks to assume a 'not-knowing' and curious therapeutic stance when working with the child as well as other family members.

From a psychodynamic perspective, however, therapy interaction is seen as a means to establish historical 'truths,' to formulate clinical understandings of key childhood events that undermine the child's and the family members' current relational patterns. Given children living in foster care may have experienced complex relational trauma in their families of origin, therapists working in this area may also be drawn to attachment theory. While some therapists may question how attachment theory sits within the broader psychodynamic theoretical family (Fonagy, 2001), Bowlby's focus is on the development of the inner self within the context of their attachment relationships (Connolly & Harms, 2015). Talk from a psychodynamic theoretical perspective is constructed as a means for resolving childhood trauma or attachment disruptions (Corey, 2017). If the therapist employs these psychodynamic theories informed by first-wave approaches in a pure sense, the therapeutic posture would be one of 'knower' and 'interpreter.' From this approach, the therapist assumes a position of 'expert,' defining the *truth* pertaining to such unconscious issues experienced by the child and their caregivers.

Such therapeutic stances are contradictory, with each therapeutic approach being informed by conflicting epistemological understandings. Consequently, how is it possible to assume a *both/and* approach without competing theoretical frameworks undermining the therapeutic interaction? Larner (2000) discusses such tensions and identifies therapeutic possibilities explaining that in any approach to integration there is a complex relationship between 'knowing and not knowing' (p. 63). Larner (2009) asserts that therapists who are drawing on 'modern' and 'postmodern' epistemological approaches can assume both an 'interventive and noninterventive' stance in their work with children and adolescents from an ethical stance of hospitality (p. 53). Rober (2005) further adds to this discussion by drawing on Bakhtin's dialogical perspective to show how the therapist's position of receptivity and reflection could enhance the meaning-making possibilities. He characterises a not-knowing stance as being receptive to the client's meaning-making, while the therapist also shares their reflections to expand the dialogue. But how we, as therapists, traverse this varied therapeutic terrain remains unclear. How do therapists make such decisions, to know when to step into a position of knowing, and when to refrain from such positions, to actively *not-know*.

With the increase in complexity of children's mental health concerns, the benefits of a range of therapeutic practices with children and their caregivers is well

recognised. Beyebach and Morejón (1999) point out that the messy reality of therapy means that 'integration happens' (p. 25), with or without our reflexive understanding. To avoid a monological discourse constraining the therapeutic interaction it is helpful to draw on multiple theoretical perspectives and associated practices. To ensure our therapeutic approach is theoretically congruent however, it is crucial to consider how we integrate additional therapeutic practices when working with children and their caregivers.

Theoretically Congruent Ways of Doing Integration: A Framework for Understanding

In my previous work with children who live in foster or kinship family contexts, I have found Lowe's (2004) explanation of Wile's practice framework pictures invaluable in making sense of how to incorporate different therapeutic approaches in a way that is theoretically congruent. Wile (1993) formulated three different types of pictures that inform how we make sense of relationships and others. His book focuses on couple counselling, highlighting how therapists bring differing assumptions depending on what theory informs their practice. Wile (1993) offers a particular description of integration explaining that as therapists, we all have varying primary, secondary, and rejected pictures constituting our practice frameworks. Wile (1993) defines primary pictures as 'the theories that you have in your mind most of the time: even before your clients walk into your office, even when there is no immediate evidence -- even perhaps when there is contradictory evidence' (pp. 273–274). Such theories are highly influential in how we make sense of our therapeutic work with children and their caregivers. These theoretical lenses shape the assumptions we bring to the therapy room, the way we talk, act, and interact in therapeutic conversations.

My theoretical primary pictures have been informed by a critical poststructuralism epistemology (Pease & Fook, 2016) and characterised by some of the following interrelated primary pictures:

- Children are active meaning-makers
- Therapy-as-collaborative inquiry
- Stories are highly influential and shape the way we see ourselves and others
- Discourse privileges certain truths, while marginalising others
- Power operates in therapeutic talk, reproducing specific realitiesSuch a critical poststructural framework is informed by an interest in nexus between power, discourse, and identity.

When I began working in the child and youth mental health field with children and young people who had been removed from their families of origin due to complex trauma and abuse, I found myself facing various challenges in my therapeutic practice. I realised my primary pictures were somewhat inadequate to join with children and young people in therapeutic ways, and the multiple people in their lives. At the time, I was exposed to a range of other therapeutic approaches, including attachment and systemic theoretical lenses. However, over these years of practice I found myself questioning how I could draw from these other theoretical frameworks in ways that are not disingenuous to my primary theoretical beliefs.

Wile's (1993) explanation of integration aligned with my own practice experience, particularly in the way he defines how we might engage with secondary pictures.

Wile (1993) defines secondary pictures as ways of thinking that 'are not typically at the forefront of your mind. You do not have them even before the client walks into your office. You have them only when there is immediate evidence. And you can shift easily out of them' (p. 274). Lowe's (2004) description of how therapists borrow elements from secondary pictures resonated with my own practice experience of taking an integrative approach. In revisiting Wile's work, Lowe (2004) has provided a conceptual framework to guide my decision-making process. During these years of practice, I found myself selectively borrowing from these other frameworks, for specific purposes. Lowe (2004) characterised the process of integration as therapists *borrowing* from other frameworks, but not taking the whole approach on board. Lowe (2004) describes how a therapist instead 'adapts' these secondary pictures 'in various ways in order to negotiate obstacles to the use of their primary pictures' (p. 160). I would go further to argue that therapist *modifies* such therapeutic practices from other approaches in ways that ensure that their practice is harmonious with their key theoretical assumptions, therapeutic beliefs, and values.

As a result, I selectively *borrow* practice ideas from other therapeutic approaches by *modifying* these ideas to ensure theoretical integrity. For instance, because my primary pictures are informed by a critical poststructuralism lens (Pease & Fook, 2016), the way I engage with attachment-informed therapeutic practices will be vastly different from other practitioners who might fully subscribe to attachment and psychodynamic theory as their primary pictures. I will draw on some attachment thinking as a meaning-making resource for conversations with caregivers. While at times I may be invited to assume a position of *knowing,* I attempt to avoid positioning myself as the expert, interpreting the caregiver's potential unresolved attachment issues. This means avoiding dispensing unsolicited parenting advice as to how the caregiver should enhance the attachment relationship with the child in their care.

Lowe (2004) illustrates how our therapeutic practice frameworks are also defined by rejected pictures. Wile (1993) indicates that 'rejected pictures are those you do not snap into even if there is immediate suggestive evidence for them' (p. 277). He goes on to explain that our rejected pictures are as influential as other primary pictures in establishing our theoretical practice framework. Wile (1993) defines that these rejected pictures are 'the pictures you go out of your way not to have, and if you find yourself having, you try to shift out it' (p. 277). My rejected pictures are characterised by my unwillingness to subscribe to deficit-focused approaches in which my role is to identify 'family dysfunction,' to deliver therapy in a way that compensates for such diagnosed individual and family system 'pathology.'

Practice Reflection: Enacting a both/and Approach to Integration

The following practice reflection is not offered as the most ideal form of integration in practice, but just as an example that can be used to begin to tease out some of the potential tensions and opportunities in consciously bringing a critical integrative approach to practice. In the following case example, I brought a narrative therapy lens to my primary practice framework, then integrated an attachment and systemic lens to my secondary practice framework pictures. For the purposes of the practice case example, I will only focus on how I integrated attachment ideas to my primary practice framework. This constructed case example has been informed by an amalgam of differing practice experiences and does not relate to a specific child or caregiver.

Deanne and Her Foster Family

At the time of referral, Deanne was six years of age. She had experienced significant abuse and neglect in her early years. Her family lived a transient life, with her parents experiencing chronic drug addiction. Deanne had endured a range of unpredictable and frightening events prior to coming into care. At the time of referral, Deanne would seek out affection from people she did not know. She struggled to contain intense emotional states, physically or emotionally lashing out at previous female caregivers. Deanne found it very difficult to get to sleep due to overwhelming fears during the night. Once in OOHC, she continued to endure unpredictability due to several placement breakdowns and changes in caregivers and consequently home environments. Deanne's escalations were increasing in severity.

Deanne spoke about how 'no one loves me.' Drawing from an attachment lens it is possible to interpret her behaviour as an example of her 'inner working model' (Connolly & Harms, 2015) with Deanne believing she was 'unlovable,' needing to be in control due to believing that adults cannot be trusted and fearing future rejection due to the disrupted attachment experiences in her early years. Such a therapeutic approach could define her current 'behaviours' or 'issues' as evidence of her unresolved childhood traumas, leading to developmental deficits. However, due to my rejected pictures, I considered such deficit-fuelled interpretations of Deanne and her behaviour as unhelpful.

Deanne's caregiver Fiona spoke about the challenges she faced in offering care to Deanne. As a caregiver, she described herself as 'stubborn' and a 'control freak.' When Fiona set firm limits for Deanne she would react negatively. Fiona described how they both would engage in a power struggle, with Deanne expressing intense emotions. When this type of interaction escalated, Deanne would respond by emotionally or physically hurting Fiona. Again, psychodynamic theory could be used to analyse such behaviour as an example of 'projection,' with Deanne projecting on to Fiona the unbearable feelings of pain and rejection. However, I wanted to avoid a positioning of *knowing,* as an expert who defines what the truth is for both Deanne and her foster caregiver Fiona.

Instead, I wanted to engage with both Deanne, her caregiver and foster siblings in *not-knowing* ways that could draw forth their understanding of what was occurring, to make visible their preferred ways of responding to the challenges they faced. There were a variety of ways in which I worked with Deanne and her family. Some of these ways included individual sessions with Deanne, sessions with Deanne and her siblings, dyadic sessions with Deanne and her caregiver, and caregiver-focused sessions with Fiona. Each of these ways of working were for different purposes. Given the scope of this article, my focus will be on how I worked with Fiona, Deanne's caregiver.

Fiona spoke about how she would at times overact to Deanne when she perceived her as being 'non-compliant.' Drawing on psychodynamic theories, I could have assumed a *knowing* stance, interpreting such examples of over-reactions as an 'attachment trigger' stemming from an unresolved attachment issue from Fiona's own early childhood and compromised attachment experiences. As an alternative, I drew on my primary picture to attempt to draw forth Fiona's own understanding of what may have been occurring for her in her attempts to offer care to Deanne. In particular, I used externalising, a narrative practice that is based on the belief that the person or the relationship is not the problem (White & Epston, 1990). Externalising ways of working involves working with the client to find their name of an issue that separates the

problem from the person's identity. I invited Fiona to name what might be getting in the way of her relationship with Deanne. To make visible Fiona's understandings, I wrote her a therapeutic letter to summarise our previous conversations. Below is an excerpt from this therapeutic letter, which shows how I have used externalising to explore the relational challenges Fiona was experiencing:

> In the rest of our chat, you spoke about how "the control" can come onto the scene for you and your parenting especially when "the back-chatting" or other examples of "disrespect to adults" is occurring, especially in public places or other peoples' houses. You spoke about how during these times you can sense some external judgement from others around you. "The control" can get you focusing on "she's not doing what I want her to do!" We spoke about how "the control" and "the expectations" can work together. We explored how these expectations were usually reasonable expectations about ensuring the safety of others.

To assist Fiona to separate herself from the relational challenges she was experiencing with Deanne I asked a range of questions, from a position of *not-knowing* and of genuine curiousity. For example, I asked 'What happens when "the control" appears on the scene?' Another excerpt from the same therapeutic letter demonstrates how I have created a therapeutic summary that characterises the effects of 'the control' in Fiona's life and her parenting:

> When "the control" is around it can get you*:*

- *Feeling edgy, asking yourself 'What is she going to do next?'*
- *Having less patience, being shorter with her, and sometimes overreacting to certain situations.*

> I was curious if there were any other effects of "the control"?
>
> You stated how these effects were not okay for you, because it doesn't make you feel good as her carer and it can escalate her further. You spoke about a hope you have of Deanne being nurtured and loved by those around her.

Instead of seeing my role as the expert therapist, delivering interventions to somehow 'fix' this attachment relationship, I wanted to make visible any unique outcome. Unique outcome is a term from narrative therapy which refers to any events that cannot be explained by the dominant story (White, 2007). I asked questions to unpack any time the issue was less present or completely absent. This unpacking process involved inviting Fiona to reflect on and makes sense of these key events in her relationship with Deanne. These conversations were also informed by re-authoring practices. White (2007) discerns that re-authoring conversations assist people to reflect on the significance and meaning of potentially neglected relational experiences and events in their lives. By recognising these moments in time, the conversation sought to richly describe such events, to explore alternative or subordinate stories that relate to these events. White (2007) underscores the importance of resurrecting such stories of significance, in order for people to move closer to their preferred ways of living, parenting, and doing relationships. The excerpt from another therapeutic letter below shows how I attempted to make visible the initiatives that Fiona was trying to take in offering care to Deanne:

> When we explored what has made these positive changes for Deanne possible, you noted that "I don't give up." You spoke about how "the stubbornness" willed you to

> "prove that I can do it." You found yourself wanting to win for Deanne, to overcome "the push and pull" in her relationship with you. You said this was about not wanting to let her down. I am left wondering who in your life would not be surprised to hear that you have not given up, despite "the emotional roller coaster"? What might they know about you? What other stories would they share about other times you have drawn on "the stubbornness" to "not give up" on something you considered important?
>
> When I asked you, "If these developments were a part of a new chapter in your parenting and family, what you would call this chapter?" you were initially not sure. You said this chapter is about a "don't stress approach to parenting." When we explored what difference this approach has made, you spoke about how it has actually decreased the need to feel "in control." You noted that this had led to lowering of your expectations of Deanne and yourself. You spoke about the importance of appreciating the small steps you are both taking.
>
> I am left curious about why these developments in your family matter. What do these steps reflect about what is important for you and how you prefer to do "family"? Is there a word or a phrase that comes to mind?

Fiona and I met for several weeks to put words to what may be interpreted as her "'attachment triggers' in her relationship. After a period of months, I then invited both Fiona and Deanne to attend dyadic sessions, to invite Deanne to put her words to relational challenges and make visible her preferred ways of being in relationship with her caregiver. Through inviting Fiona to reflect on her ways of responding to Deanne, she became less reactive. Over time Deanne became more open to receive care and comfort from her caregiver and could tolerate some limits being set from her caregiver, with fewer power battles being reported.

Discussion

There are myriad ways of undertaking therapy with children in OOHC settings and their caregivers from contrasting theoretical approaches. The case example I have presented shows a specific way of attempting to enact a *both-and* approach by drawing on both narrative practices and attachment-informed ideas. Attachment theory informed my secondary picture, which offered a way of understanding what might have been occurring in Deanne's relationship with her caregiver, Fiona. Attachment concepts offered one way to understand the relational complexities present for Deanne and Fiona. Due to the critical social constructionist theoretical assumptions that inform my primary pictures in my practice framework, as Lowe (2004) would say, I 'borrowed selectively' attachment ideas from my secondary picture to inform a hypothesis of what may have been occurring (p. 159). I used these ways of knowing to help inform my work with Deanne. However, I used these secondary attachment pictures 'in the same way, to the same degree or for the same purpose as do therapists for whom these are primary pictures' (Lowe, 2004, pp. 159–160). Instead of positioning myself as *knower* or *interpreter* of Fiona's potential attachment triggers, I assumed a curious, *not-knowing* position to draw forth her understandings of what was getting in the way of her relationship and her preferred ways of offering care to Deanne. Therapeutic questions were asked to invite Fiona to explore the relational challenges she was experiencing in her own words.

While providing psychoeducation regarding clinical forms of attachment theoretical knowledge may have supported Fiona to interpret her relationship with Deanne

and supported positive change, I wanted to centre Fiona's meaning-making. I used externalising to invite Fiona to explore her own understandings of her ways of being in relationships. By inquiring with Fiona how 'the control' was operating in her relationship with Deanne, she was able to conceptualise this issue in a sociocultural context. She noted that being a single mum, she was more aware of perceived judgement in public places, which explains why 'the control' was more likely to appear in these settings, when Deanne was not following her direct instructions. By identifying the contextual factors that give strength to this issue, a more sociopolitical conceptualisation of the presenting issue was possible. Instead of this issue being interpreted as evidence of unresolved attachment issues from Fiona's childhood, the politics of experience became more visible. By exploring the effects of this issue, Fiona was in a position to evaluate for herself, her preferred ways of offering care to Deanne. By asking re-authoring questions, the initiatives Fiona was taking to bring a 'don't stress approach to parenting' were rendered visible. This preferred approach to parenting represented Fiona's values, intention, and knowledge. By further characterising this approach, Fiona's local knowledge was resurrected. The more visible Fiona's local knowledge was, the more she could enact her preferred ways of parenting despite the 'emotional roller coaster' and the "'push and pull' in Deanne's relationship with her.

This approach to integration would not have been possible without a position of reflexivity. Reflexivity is beyond reflecting on what may have occurred in the sessions I have had with children in OOHC and their foster family members, and how I might try to refine my therapeutic practices in future sessions. Reflexivity requires the therapist to identify both the theoretical and personal assumptions influencing their therapeutic interactions (Dickerson, 2010). Reflexivity also means we as therapists understand how we personally 'influence what and how knowledge is made, and can therefore shed light on how specific assumptions we make can arise from our own background and experience' (Fook & Gardner, 2013, p. 6). While I have drawn on some attachment thinking, I wanted to remain aware of how these theories of understanding can become assumptions I may impose.

Critical theorists such as Bourdieu (1990) remind us thatan acute analysis of power and a congruent epistemological foundation is required for the production of knowledge. In order to co-construct knowledge with children and their caregivers, I need to remain vigilant as to whose knowledge is being legitimised in therapy interactions. Therefore, it is essential that we as therapists continue to find robust ways to position ourselves in the epistemological territories we traverse, to critically question how key theoretical and personal assumptions are informing the micro-interactions we have with children and their caregivers.

Considerations for Integrative pPractice Approaches in OOHC Settings

I will not be able to do justice to the many considerations for integrative practice approaches in OOHC settings. Some key points that may be worth considering for therapists working with children and their caregivers in OOHC include:

- identifying what key theories inform our primary pictures;
- critically reflecting on how these assumptions influence the way we represent the children's mental health issues and understanding what may support therapeutic change;

- revising how we adapt and modify secondary pictures to achieve specific purposes in therapy with children and their caregivers, in order to maintain theoretical congruence in our practice;
- reflecting on how we may 'shift back' to our primary pictures when possible (Lowe, 2004, p. 171);
- engaging in reflexivity to avoid imposing our assumptions and/or knowledge on to the child and/or caregiver and develop our ethics of practice.

Conclusion

Offering therapy to children and their families is increasingly a complex endeavour. The complicated issues that children living in OOHC settings face means therapists draw on a variety of therapeutic practices from a range of approaches. The case example demonstrated how Wile's conceptualisation of practice frameworks can help us think about how we integrate different theoretical approaches. A specific way of enacting a *both/and* approach was shown, by drawing upon both narrative therapy and attachment concepts. Attachment concepts offered a theory of understanding to make sense of what may have been occurring for Deanne and her caregiver Fiona. By assuming a *not-knowing* stance, these attachment ideas became a conversational resource to explore the caregiver's knowledge. Therefore, instead of assuming a purist approach, these attachment concepts were modified to ensure an epistemologically congruent stance with the primary narrative therapy practice framework pictures.

Given integration happens, further research is required to understand how it occurs in the immediacy of the therapeutic encounter with children and their caregivers. Without further critical investigation, a *blender approach* to therapy with children and their family members will mean ongoing contradictory therapeutic stances are assumed. Consequently, further research is needed to reveal a nuanced understanding of how therapists enact a critical approach to integration, to identify how therapists find ways to navigate the therapeutic terrain to shift between positions of *knowing* and *not-knowing*. Such research findings could provide a key resource to enable therapists to assume a reflexive positioning in their therapeutic interactions. Now, more than ever, such a reflexive positioning is required to enact a critical approach to integration which responds to the diverse and complex challenges children in OOHC face.

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