European Family Therapy Association Series

Roberto Pereira · Juan Luis Linares
Editors

Clinical Interventions in Systemic Couple and Family Therapy

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Family Therapy with Involuntary Clients. The Therapeutic Alliance as a Major Key to Therapy Success

Ana Paula Relvas and Luciana Sotero

"Mother: *We actually thought of asking for help, but now that we were forced to be here we don't want it anymore.*

Therapist: *What made you change your mind?*

Daughter: *I think that the more they want to help us the worse it gets... Too many people interfering with our lives... Here, at school, at CPCJ (Children and Young People Protection Centre), at the Health Centre... I am sick of people intruding in our lives and telling me what to do!*

Mother: *I agree.*

Father: *You can speak all you want, you will hear nothing else from me! Besides, I don't know what else we can do here in therapy.*

Therapist: *Believe me, your point of view and what you really want for you and your lives, individually and as a family, is essential to our work. The work of all of us, indeed. I still don't know how we can help and if we can at all, but I am certain that you, the family, can help us, therapists. How? By telling us with all honesty and no fear what you would like to happen. To all of you as a family and to each of you individually.*"

The Involuntary Family/Clients: Who Are They? Can We Apprehend the Specificity of Involuntary Families?

Although the recognition of an involuntary client would seem intuitive, the truth is that it is not so immediate or uncontentious, both in theory and in practice.

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The first point to consider is the way in which the involuntary clients are seen by the receiving institutions and by specialized literature. Terms such as involuntary, mandated, and non-voluntary are frequently used as synonyms with little conceptual rigour. However, they carry distinct meanings. Involuntary client refers to a wide group of cases where there was clear external pressure by an entity (e.g. School, Child Protection Services, Employer, Health Centre) or a helper to enforce therapy (Sotero & Relvas, 2012). Mandated client refers to cases where there is a legal mandate or court order to enforce the client(s) therapy intervention; they are therefore a subcategory of the involuntary client (Sotero & Relvas, 2012). The non-voluntary client was first described by Rooney (1992) as the "invisible involuntary" client and refers to those clients who are in therapy due to informal pressure by family members, neighbours, work colleagues, etc. Accepting Rooney's categorization, involuntary clients are in therapy because they face legal and judicial consequences (mandated) as well as personal consequences (non-voluntary), if they decide not to participate in the therapeutic process. Within this logic, it is the very fact that leaving the therapy will lead to legal or personal repercussions that create in both scenarios an environment of coercion. This coercion immediately makes it impossible to opt out of the therapeutic process, which leads to a specific framework in the relationship between therapist and client that must be understood (Rooney, 1992).

The second point to consider relates to the way in which the clients see the psychosocial support institutions, the therapy, and the therapists. We consider in this perspective the importance of the motivational factor (Sexton & Alexander, 2003), associated to the desire for change, the engagement in therapy and the recognition of its usefulness. In this regard, the clients can be positioned in a continuum that goes from not wanting to participate in the therapy at all and the opposite pole in which, even though they did not request therapy, they desire it and see it as a good opportunity (Relvas & Sotero, 2014).

In sum, when defining and identifying involuntary clients, one must articulate and match these two aspects: the referral made by a third party and the unwillingness to participate in therapy (the former being a particularly evolving and dynamic aspect, as we will see next). We can therefore suggest a flexible approach to the involuntary client's circumstance subject that will place the clients in a continuum and not in rigid pre-defined positions.

If we look at a family that non-voluntarily (or even voluntarily) arrives at therapy, we can see that the above-mentioned aspects become more complex. Frequently, the degree of motivational and voluntary engagement and participation, as well as the specific demands for each element of the family, are not clear. More than that: these demands are multiple and diverse and, as is known, in most cases there is no consistency amongst the family members' ones, not even an agreement or congruency. Sometimes they can even be antagonistic. On the other hand, when we work in therapy with families, we deal with different levels of development (youngsters, children, adults, elderly, etc.) and different levels of power (which are related, for example, to the roles of each element within the family system or with the gender).

In the case of involuntary families, all this is amplified first at the referral stage, and then during the actual therapeutic process.

Often, it is the deviant behaviour of one element of the family (i.e. the recognition of one or even more than one identified or designated patient) that leads to referring the family and to impose therapy externally. It is therefore expectable that this "designation" brings a degree of internal aggravated blaming of that element, as well as coalitions, which undermines the possibility of the family getting involved as a whole in the therapy (Escudero, 2009). This makes it harder to establish common family goals for the process. When the family is referred for therapy after being referred by a public institution, this means that the social context has rendered it incapable of fulfilling its roles and tasks, for instance with regard to parental role when the referral comes from child protection services. In these cases, there is a kind of extension of the sanction and social control (Cingolani, 1984) of one individual to the whole family group and its capacity to function and respond to the psychosocial demands of society.

When we think about a family in therapy placed in the voluntary pole of the continuum mentioned earlier, it is easy to imagine that the active search for support was probably carried out by one or several of its elements, but not by all. This is why, at our therapy service (Family Therapy Centre, Faculty of Psychology and Educational Sciences of the University of Coimbra—CPSTF/FPCEUC), from the beginning of the process and with the completion of the appointment demand form, the degree of agreement, and knowledge of the family members about the demand is always assessed. Secondly, it can be assumed that the motivation for therapy and the belief in its value and effectiveness is different from individual to individual and, thirdly, there can always be one or more people who are in therapy under some kind of pressure. Regarding the opposite involuntary pole, with the exception of the first aspect, an almost mirrored situation can be observed: even though the active search for support is external to the family, the motivation for the therapy continues to be different from individual to individual. Besides, there can always be one or more members of the family that are in therapy with no feeling of pressure. Therefore, we can conclude that both voluntary and involuntary families are distributed throughout the continuum and very rarely are they positioned, as a group, in one of the extremes (Relvas & Sotero, 2014).

In addition, wanting therapy and considering it useful are dynamic feelings; consequently, during the therapeutic process, this stance varies. In this regard, let us look at the case of a family who came to therapy referred by the Children Protection public services (CPCJ) due to the adolescent daughter's behaviour (missing school, taking psychoactive substances, disobedience). Even though they were referred, the elements stated that they needed help as they did not feel capable of dealing with the problem by themselves. After missing two consecutive sessions, the family reappeared, and the mother indicated it was due to pressures from CPCJ's social worker. The family therefore came to the session with a very distinct attitude, the family members were angry and not collaborative, the mother having stated: "We were coming here because we wanted to. Now we are forced and the therapy no longer makes sense!" However, the opposite also happens.

Therapeutic Challenges. How Do These Families Challenge Their Therapists?

Based on all the aforementioned information, the involuntary families in therapy challenge their family therapists at three main levels: (1) Recognizing the usefulness and kindness of the therapy and the therapeutic environment; (2) Creating a therapy request co-constructed by the family and the therapists within the therapeutic process; (3) Establishing a good therapeutic alliance.

First Challenge: Why Family Therapy?

Concerning the first challenge, frequently these clients define or present themselves as (a) not having any problem; (b) not needing therapy; (c) being in therapy only because they were forced to do it. With such a stance from the clients, some therapists feel they are not qualified in their skill and function, or classify these families as "resistant" or, in a closer approach to the receiving institution or the referencing entity perspective, as "non-cooperative". This posture from the therapists does not seem very useful (e.g., Miller & Rollnick, 2002; Rosenberg, 2000). In many cases, the family reactions described are common and expectable, and the therapists should be able to anticipate these initial attitudes and develop strategies and skills which allow them to deal with them in an efficient manner, as we will see further on. To understand the context that "explains" the "lack of collaboration" is a fundamental first step, even to prevent false interpretations (e.g. "what I know of family therapy cannot help this family"; "families or clients I work with are very disturbed or limited", etc.) (Escudero, 2009; Relvas & Sotero, 2014).

Second Challenge: Co-construct Shared Therapy Goals and a Broader New Request

The most frequently used solution to face this challenge and ultimately reduce or even eliminate the feeling of disqualification and almost therapeutic impotency is to co-create with the family a joint demand that can be transformed into goals shared by the various members of the family as well as by the therapist.

The respect for the dignity and rights of the person, as well as promoting the client's autonomy, are some of the fundamental principles of the psychological intervention that cannot be jeopardized. However, there are cases where the individual autonomy and the interests of society clash, and the professional can easily get triangulated. In effect, the therapist working with involuntary families (particularly mandated families) has probably two clients: the client making a request or mandate—"the referencing entity"—and a client that is the target of

the intervention—"the client-family". One of the two clients often represents the interests of society, the social norm, and the other is a unique system, different from all the others and with its own will that urges to be respected and promoted in the therapy. Thus, the therapist must be very clear and transparent about his/her contacts and the information shared with the referencing entity. It is therefore easy to conclude that in these cases there is a relational triangle constituted by referencing entity/client(s)/therapist(s), in which the client and therapist apexes are subjected to pressure (Relvas & Sotero, 2014). Clarifying the norms regulating the relationship between therapist and referencing entity as well as respecting the ethical and deontological principles are fundamental aspects. In our clinical practice, we establish certain rules, which we reveal to the referencing entity before accepting the process and to the family on the first session. These rules can be summarized as follows: (1) the intervention goals proposed by the referencing party are considered, but their exact definition is carried out with the family within the therapy context; (2) the information sent to this entity can only contain data related to the attendance, conclusion or need to proceed with the process, with no justification regarding the contents of the process; (3) all material related to the contents of the process/sessions is confidential and cannot be passed on to the third party; (4) when the family explicitly requested that additional information be reported, or when the therapist considers this advisable, the matter is discussed in the therapeutic system, where it is also analysed and the content and form of such report is decided.

Thus, at the initial stages of therapy, therapists must create a safe environment in which all members of the family can express what they hope for the future in terms of change, both individually and as a family. Then, always in cooperation with the family, the therapist must articulate the different proposals in order to create a new integrative request. In all this process, the therapist's interventions must work towards getting the client to recognize that the disagreement within the family can be approached without damage and, as such, there will be common goals that can benefit all without having to eliminate individual goals and needs (Ausloos, 2003).

Third Challenge: Building a Forced Alliance. The Role of the Therapist

One of the singularities in involuntary client's intervention is the complexity of co-creating the therapeutic alliance (Friedlander, Escudero & Heatherington, 2006; Honea-Boles & Griffin, 2001; Snyder & Anderson, 2009). In family therapy, the alliances are simultaneously developed at an individual level (family member—therapist; family member/family member) and at a group level (family—therapist), so it is important to consider the alliance established by the family members amongst themselves. The alliance, in terms of the family as a whole, has been alternately conceptualized as allegiance (Symonds & Horvath, 2004), within-family alliance (Pinsof, 1994), and shared sense of purpose (Friedlander et al., 2006), referring not

only to the willingness to collaborate in the therapy but also to the emotional bond between the family members (Friedlander, Escudero, Heatherington, & Diamond, 2011). Keeping this in mind we developed a set of studies that allowed us to define some specific profiles of the problem, as well as note some implications for therapy (Sotero, Cunha, Silva, Escudero, & Relvas, 2017; Sotero, Major, Escudero, & Relvas, 2016; Sotero, Moura-Ramos, Escudero, & Relvas, 2017).

Based on a comparative study between voluntary and involuntary family-clients on building the therapeutic alliance, we conclude that the two groups significantly differ in all dimensions of the therapeutic alliance observed on the first session.

Specifically, and according to the Transtheoretical Model of Therapeutic Alliance (Friedlander et al., 2006) assessed with the System for Observing Family Therapy Alliances (SOFTA) (Friedlander et al., 2006; Portuguese version in Sotero & Relvas, 2014) at the beginning of the therapy (first session), the involuntary clients show: (1) less engagement in the therapeutic process than the voluntary ones [they do not consider treatment as important and do not engage as much in therapy regarding the work carried out with the therapist in defining and negotiating goals and tasks]; (2) less emotional connection with the therapist and less safety within the therapeutic system than the voluntary clients [respectively, they do not see the therapist as such an important person in their lives and they feel the client–therapist relationship is less based in trust, affection, interest, and belonging; they also consider to a lower degree that the therapy context can be seen as a place where risks can be taken, where one can be open and flexible]; (3) as a group, the involuntary families have a lower shared sense of purpose within the family with regard to the therapy [the members of the family, amongst them, are less united and supportive in therapy, and find it difficult to see themselves working together to improve family relations and reach common goals] (Sotero et al., 2016). The other relevant point, shown in the first session, is the fact that only negative therapeutic alliances were observed in the involuntary client group, particularly in safety within the therapeutic system and shared sense of purpose within the family (Sotero et al., 2016). These results sustain the hypothesis advanced by Friedlander et al. (2006) that the safety and sharing goals within the family are two of the most affected alliance's dimensions when working with involuntary families. By comparing the two groups at the fourth session, it was clear that these differences become dissipated, with the only exception being engagement. In terms of the therapy practice, this result confirms the importance of what was said regarding co-constructing a joint demand at the very beginning of the therapy because obtaining the involuntary clients' engagement in therapy is an additional challenge for therapists (Relvas & Sotero, 2014; Sotero et al., 2016). Summing up the main conclusions of this study, it can be stated that, despite the lack of unity within these families with regard to the therapy (shared sense of purpose) and the weak values of the alliance dimensions on the individual side (engagement, emotional connection), the beginning of therapy is crucial to establish the commitment because there is certainly the possibility of positive evolvement of this aspect with time. In fact, the opposite happens with the dimensions particularly related to family therapy (safety and shared sense of purpose),

whose values decrease in the middle stage of therapy (although the differences with the voluntary family-clients disappear: the values decrease in both groups).

Let us now analyse what we know from our studies on the role of the therapist in building the therapeutic alliances while working with involuntary families. Based on the results of the comparison between involuntary groups and voluntary groups, it can be stated that, particularly in the first session, therapists try to build and reinforce the therapeutic alliances, especially with involuntary families. To do so, they foment the engagement and the family unit, as well as the shared goals related to the therapy, through more numerous contributions in these dimensions (Sotero, Cunha, et al., 2017). It therefore seems that the therapists recognize the greatest difficulty areas of the therapeutic alliance with these kind of clients and realize the need to give them an intense and direct response (Sotero, Cunha, et al., 2017). After engagement, the emotional connection dimension was found to have more contributions from therapists in both groups, both on the first and fourth sessions. The therapists participating in this study gave preference to strategies that promoted the therapeutic alliance by endorsing the engagement (explaining how therapy works, encouraging the definition of goals, asking what they want to discuss during the session) and establishing a good emotional connection with the clients (expressing trust in the clients' skills, using sense of humour, using self-disclosure) (Sotero, Cunha, et al., 2017). It can be said that the therapists choose contributions that increase the active participation of clients in the therapy and that leads to a positive affective and emotional connection with them. Surprisingly, therapists' contributions for the safety dimension are almost non-existent in both groups although slightly higher in the voluntary group. This result shows that the management of conflict and intrafamilial hostility seems to be one of the areas that therapists probably find harder (Relvas & Sotero, 2014; Sotero, Cunha, et al., 2017), which is particularly relevant both from a clinical point of view and as regards the therapists' learning and training (Sotero, Cunha, et al., 2017). In sum, and recognizing that on the first therapy session the alliances with the involuntary families are weaker, this study shows that therapists seem skilled enough to recognize the alliance problems and focus on creating strong therapeutic alliances by establishing differentiated behaviour patterns in response.

The Therapeutic Work with Involuntary Families: What Effects Does the Initial Condition of Families Have on Therapeutic Outcomes? How Can Family Therapists Work Hopefully and Successfully with Those Clients?

The success of the therapy with involuntary families is a question that often comes up. In fact, the therapeutic change with these families is seen as hard and difficult to achieve.

In order to assess the effect of the families' involuntary condition on the therapeutic outcomes and considering the lack of consensus noted in literature on the

matter (e.g. Burke & Gregoire, 2007; Snyder & Anderson, 2009), we designed a study to compare the therapeutic outcomes of voluntary and involuntary clients, trying to understand as well the influence of the alliance in these results (Sotero, Moura-Ramos, et al., 2017). The results obtained led to the following conclusions: (1) there is no statistically significant difference in therapeutic outcomes; (2) only safety and shared sense of purpose at the fourth session have a significant effect on the final therapy outcomes, and (3) there is no differential effect in the relation between safety and the outcomes and between the shared sense of purpose and the outcomes, considering the two groups of voluntary or involuntary families. So we came to a conclusion that, despite the initial difficulty in establishing the therapeutic alliance, involuntary families can (or cannot) change as much as the voluntary ones. Thus, it seems that the clients' safety in the therapeutic process and the shared sense of purpose within the family in an intermediate stage of therapy (fourth session) are more relevant to the final therapeutic outcomes than the voluntary or involuntary condition. In other words, a reliable therapeutic environment, in which the family-clients feel they can take risks, may lead to better therapeutic results. Additionally, with such conclusions, it can be stated that the first four sessions, and particularly the process of alliance co-constructing during this period, are valuable because they can determine the extent of therapy success (Sotero, Moura-Ramos, et al., 2017). These results somewhat support the importance of what Flaskas (1989) designated as "de-centred" alliance in conjoint therapy. This means that, contrary to what happens in individual therapy in which the alliance is centred on the client–therapist relationship, in family therapy the alliance is de-centred because the alliance amongst the family members is equally or more relevant than the alliance between client and therapist.

Although prior engagement and client motivation are essential to therapeutic change, what therapists do (or not do) during therapy has an important impact on the way in which clients get engaged in process. So, therapists are responsible and must be capable of adjusting their intervention models and strategies to the characteristics of the clients they work with.

Following the conclusions of the previously presented studies, in the case of involuntary families, a first aspect worth highlighting is that therapists need to define, as a central goal of their interventions, helping the clients to see their problems in a less personal and more interpersonal way. This transformation involves challenging the points of view of each client regarding the problem, offering a new unifying perspective of that issue so that each member relates to the problem (Sluzki, 1992). This change therefore implies transforming individual goals into family goals (Rait, 2000). From this new point of view, clients start to recognize that everyone needs to contribute to a solution. To do this, therapists can use strategies such as: incentive family dialogue; deliberately involve the quieter or less participative clients with questions or showing empathy; validate the different points of view; promote the establishment of agreements amongst the clients; encourage the clients to question each other on their points of view; point out what is common in the various perspectives on the problem or on the solution (Friedlander et al., 2006). As a way to help clients recognize each other as a family unit, therapists can draw

attention to what is shared between the various elements in terms of values, experiences, needs, or feelings, for example.

A second aspect implies the need to accept the clients' initial negative stance, but also find strategies to reframe and redefine it. The lack of involvement or the refusal in accepting the therapeutic process can arise from the very intrafamilial conflict or the lack of trust in the services (and the professionals), sometimes originating from previous experiences (Friedlander et al., 2006; Imber-Black, 1988). Listening to each family member separately at an initial stage can be a good alternative when significant conflict is noted. When the lack of trust in the services and professionals is evident, therapists must genuinely try to understand where that lack of trust comes from. In fact, when a family has a tense relationship with the referring entity, clients frequently see therapists as an extension of that entity. As a priority, therapists must then try to understand the different points of view of the family members regarding the value and the goals of therapy, and explore their previous experience with other services and institutions. From our experience, clients usually respond positively when therapists show that they understand the reasons for the clients' lack of trust. In this sense, there is a number of simple but effective measures that the family therapist can adopt (Sotero, Cunha, et al., 2017): (1) avoid interventions that can increase pressure in the family that feels forced against their will to be in the therapy, for example, moving too fast into defining goals or trying to convince clients of the need or advantages of therapy; (2) show kindness towards the negative emotions regarding therapy or the professionals, accepting these as part of the job; (3) avoid blaming the clients for their lack of collaboration or making hasty interpretations of the case; (4) show interest and curiosity regarding what originated the request for therapy, exploring the different points of view of the family members on the request and referral, trying to clarify what each member thinks and feels about the current situation; (5) understand with the family the factors that may be influencing their initial negative attitude.

A third aspect is related to the model adopted by the therapist. With regard to involuntary clients, literature points to a very consensual way in which therapists can adjust some therapy models. In individual psychotherapy, the awareness of the need to adapt intervention strategies in terms of client motivation led to the development of several intervention models, namely the Transtheoretical Model of Change (Prochaska & DiClemente, 1984) and Motivational Interviewing (Miller & Rollnick, 2002). Literature on family therapy with involuntary clients often describes as "good practice" the collaborative approaches, especially Solution-Focused Therapy (TCS; De Jong & Berg, 2001; Osborn, 1999; Rosenberg, 2000; Tohn & Oshlag, 1996), Multisystemic Therapy (TMS; Tuerk, McCart, & Henggeler, 2012; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009) and Functional Family Therapy (TFF; Sexton & Alexander, 2003; Sprenkle, Davis, & Lebow, 2009). In our clinical practice, we use the model we developed at the Family Therapy Centre in FPCEUC, where we work, entitled Curiosity Therapy (Relvas, 2003), an approach which also has collaborative characteristics.

This model was not designed specifically with involuntary family therapy in mind. It is a brief therapy model, usually with seven sessions and two follow-ups

[or brief-long therapy, according to Ausloos, 2003, as the spacing between sessions is normally 3 weeks to 1 month]. In formulating the therapy demand (completing a phone form), one investigates the reason for the appointment and obtains a preliminary description of the problem, trying to understand the precedents and consequences, as well as the involvement of each family member and other significant elements (e.g. teacher, extended family, doctor or the individual or institution that referred the family). The degree of knowledge and acceptance of the different family members concerning the therapy request will also be verified. Even in the case of families referenced by a third party, the therapy team always asks for one of the family members to complete the phone form as indicated before, which will give a preliminary overview of the points of view of the family on the problem and on the referral.

The therapy process involves joint interpersonal sessions in a classical family therapy setting: two adjoining rooms separated by a unidirectional mirror, equipped with an audio and video system. An important aspect is the establishment of a therapeutic contract. Normally, after one or two sessions, the therapeutic contract is established with the clients. This is an agreement in which the therapeutic goals, co-created in therapy, are established, as well as the number of sessions considered necessary to reach them (between 7 and 10), and the spacing between sessions. The contract is conceptualized as having both therapeutic and pragmatic value in itself, redefining therapy as co-participative and co-liable, creating a positive expectation that the problem has a solution. It must always include the possibility of renegotiation or the establishment of a second contract with new goals.

Conceptually, this is a meta-model, framed in a systemic perspective and using a post-modern integrative therapy approach: it articulates core ideas of different family therapy schools and proposes a new epistemological view. In therapeutic terms, the focus is on the meaning (and not on the pathology) and on the dialogue or conversation (and not on the technique). It is intended to approach therapy as a process of construction and deconstruction of the problem by means of client–therapist recursivity. The therapist places his/her clinical stance on "curiosity" (Cecchin, 1987) and never believes he/she "already knows!" managing the therapeutic dialogue in a way that will articulate multiple points of view (dialogic), generating new descriptions of the problem and the solution. The therapist accepts and is interested in all possible descriptions of reality. These principles, jointly with the model structure, make it particularly adapted to work with involuntary clients. Actually, the work of therapists is fundamentally based on creating hypotheses and adjusting and transforming them in a collaborative way with the clients, encouraging the change of the system (Relvas, 1996, 2003). These hypotheses must be systemic, promoting a wider understanding of the problem, from the personal to the interpersonal level, as well as to increasingly vaster contexts (Relvas, 2003). It is through the co-construction of systemic hypotheses between therapists and family that data gets transformed into information and a new "story", "narrative", "map" or "perspective" emerges which relieves the family's discomfort. When working with involuntary families it is fundamental to keep an epistemological positioning allowing the respect for the ecology of the system as well as for the client–therapist relationship,

conferring to the client an active role as responsible for the possibility and meaning of change, from the definition to the attainment of goals.

About the learning, training, and supervision of family therapists, it seems important to highlight two points. Firstly, we believe that the specificities of therapy with involuntary families should be approached throughout the family therapists' learning and training (Sotero, 2016). As far as we know, this does not form part of most of the family therapists' educational curricula; the development of clinical skills and knowledge based on the research findings of the therapeutic process with these families is extremely important, considering the frequency with which family therapists work in such circumstances. Secondly, apart from covering several theoretical models, the family therapists' training and supervision should also cover the complex process of building therapeutic alliances in family therapy (Sotero, 2016).

Conclusions

A 25-year-old mother with four minor children arrived in therapy referred by the court and very much against her will. The need to supervise the reintegration process of the family's minors after institutionalization, the mother's unemployment and the recent divorce after the mother's complaint of domestic violence were some of the reasons worrying the court and were the basis of the family therapy referral. During the first two sessions, work had to be done on helping the family to formulate its own request for therapy. According to the mother, the psychiatric support that she had been receiving for almost 3 years was enough to feel supported, so she could not understand why the court insisted on family therapy. After this initial work, however, both the mother and the remaining family discovered sense and usefulness in family therapy, which allowed them to engage and continue the process. This had a successful outcome in the opinion of all persons and institutions involved.

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