Individual experiences in family therapy: a comparison of perspectives

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<u>**Acknowledgements**</u>

Contents

Abstract

There has been relatively little robust research investigating the experience of family therapy from a client's perspective. Much of the literature fails to make clear their methods for analysing the data, and takes an 'either or' approach to family and individual perspectives. Thus, either whole family perspectives, or the perspectives of a particular group are sought, making it difficult to understand the impact of the family context on individual perspectives or vice versa. The present research seeks to understand the family therapy experiences of individuals within their familial context.

Two families of three were interviewed using a semi-structured interview guide and interviews were analysed using Interpretative Phenomenological Analysis. Results are presented as two family case studies. One over-arching theme of 'the safety of the therapeutic relationship' emerged from the accounts of both families.

The therapeutic relationship provided the safety to talk and explore problems and relationships. This was described as cathartic and helped family members to see themselves and each other differently. Varying degrees of exploration of individuals was associated with differing levels of engagement with therapy. Being able to explore relationships for both families allowed them to develop new understandings of each other. Gender also emerged as an important theme and this is discussed in relation to issues of power and gender.

Some key methodological limitations of the research including the small number of participants and the impact of an overly detailed interview schedule on the data are discussed. As this study involves two case studies of three family members each, it is not easily transferable, but points to some key themes and processes which have implications for practice and future research.

Key words: Systemic Family Therapy, IPA, therapeutic alliance, working alliance, therapeutic relationship, CAMHS

__Prologue__

The research presented in the following thesis has been inspired by personal experiences and to some degree represents the author's attempts to integrate personal experience with professional knowledge. It is likely that these experiences will have impacted upon the author's interpretation of the literature and the present research findings. In qualitative research, the researcher may be seen as the main tool for analysis. A major criticism of qualitative research is that it is 'subjective', and therefore may be heavily 'biased' by the researcher's own perspective. An understanding of the author's perspective on the subject researched may contextualise and perhaps also challenge the notion that the findings have been unduly influenced. This may also facilitate a better understanding of the researcher's interpretation of the data. I therefore provide the following prologue in order to enhance the reader's understanding of my work.

My memory of attending family therapy sessions nearly 20 years ago, aged 11, forms part of my narrative of how I became a therapist. My family also has a number of myths about the therapy and its context, which are intertwined with my own memory of therapy. My memory is largely emotional and sensory: I remember experiencing the therapy on an emotional level, rather than by the 'events' that occurred within it. There are some things I remember having happened, things that were said, but for the most part I don't actually remember the events themselves. Often these are things that have since been talked about in my family.

My memory of the experience is that there was a good deal of uncontained conflict, and that I found it rather intrusive and exposing. My memory of what the experience was like (albeit embedded within the narrative of my early family life) influences my approach to people as a therapist, and as a human being. This research has been driven by a need to make sense of my own experience then, and my practice now.

For me, having stood on the edge of the conflicts in my family for many years, being brought into therapy and being expected to engage with them was intensely threatening. I was ambivalent about family therapy: wanting a change, yet also fearing being drawn into conflicts which might not be resolvable and afraid of what might be expected of me. I felt very much 'on the spot' when asked questions directly, and, not feeling that I could refuse to answer, I found this experience very intrusive. In our case, I felt that, after all this, family therapy had not really helped: the therapy seemed to have consolidated rather than resolved family conflicts.

Learning about working with families subsequently, presented a personal and professional challenge, in that it would mean crossing a divide from being a service user to a service provider. It would involve asking others to take risks, which I myself had not felt able to. In some senses this research is therefore an attempt to form a bridge between my experience as a service user and as a therapist, as well as to make explicit experiential concerns of service users for other family therapists.

Introduction

1 Overview

In this section I will outline the background and aims of the research project. I will also define the parameters of the research in terms of the settings and therapies discussed. I will then review the literature on experiences of family therapy. Individual perspectives on family therapy experiences are likely to vary within the family, and will be dependent on individual characteristics and family dynamics as well as broader social and cultural factors, such as race, gender and age. These factors will be explored particularly in relation to power and how this may impact on the therapeutic alliance.

1.1 Background

According to a survey conducted by the Department of Health (Green, McGinnity, Meltzer, Ford, & Goodman, 2005), approximately one in ten children aged 5 - 15 years was found to be suffering from a clinically diagnosable mental health problem, which was associated with distress and interfered with functioning, for example in the social and family arenas. In addition to the impact mental health problems have on the family, the family environment is also seen as having an influence on children's mental health (Carr, 2006). Family therapy is therefore seen as an important element of many Child and Adolescent Mental Health Services, and is a recommended treatment for several mental health problems in children, including depression and eating disorders (NICE, 2004, 2005). Moreover, the National CAMHS Review (Davidson, 2008) recommended that CAMHS services should aim to be more family focused than child focused in recognition of the importance of the family environment.

In recent years service user perspectives on mental health services have been given greater credence in the NHS and this has been reflected by policy (DoH, 1999). The National Institute of Health and Clinical Excellence (NICE) also acknowledges service user views as an important part of the evidence base for mental health treatments

(NICE, 2009). However, there is a dearth of research into service user experiences of therapy in general, but in particular with children and families. Research which has been published to date in this area tends to draw on interviews with whole families (Campbell, 2004; Howe, 1989; Knott & Espie, 1997; Locke & McCollum, 2001; Reimers, Treacher, & White, 1995; Stanbridge, Burbach, Lucas, & Carter, 2003) or with particular groups such as children or adolescents (Bird et al., 2010; Gregory & Leslie, 1996; Gustafsson, Engquist, & Karlsson, 1995; Lobatto, 2002; Sheridan, Peterson, & Rosen, 2010; Stith, Rosen, McCollum, Coleman, & Herman, 1996; Strickland-Clark, Campbell, & Dallos, 2000).

Research investigating whole family views does not attend to individual variation within the family, and in many studies only some members of the family choose to take part (Howe, 1989; Reimers et al., 1995). Research on the views of particular groups investigates the impact of social and cultural factors on these groups, but discounts individual variation within these groups, and the impact of family factors on how an individual may be affected by social and cultural factors. The family context and the social and cultural context are likely to interact with each other in complex ways to impact on the experience of the individual and the family.

The present research will investigate the experiences of two families in therapy, from an individual perspective, using a case study approach. As such this research aims to investigate the impact of both individual and family characteristics as well as broader social and cultural factors on individual experiences of family therapy. It is hoped that a greater understanding of the experience of family members in family therapy will improve family therapists' knowledge and understanding of their clients' experience. This may help family therapists to build stronger therapeutic alliances with families. It is hoped the research will also inform our understanding of the process of change in family therapy.

1.2   Definitions

For the sake of clarity I will begin by defining the parameters of this research. The research focuses on the experiences of **families** who have attended **family therapy** sessions at a local **CAMHS** clinic.

1.2.1   The Family

The Oxford English Dictionary defines the family as:

> *"The group of persons consisting of the parents and their children, whether actually living together or not; in wider sense, the unity formed by those who are nearly connected by blood or affinity". Oxford English Dictionary (OED, 2012)*

This broad definition of the family fails to capture the rich diversity of family life in the UK today (Dallos & Draper, 2005). For example, families may be headed by married or unmarried couples, heterosexual or homosexual couples, single parents, step-parents and adopted parents.   Following divorce, children may reside with one parent full time, with or without contact with their other parent or may spend varying amounts of time living with each parent. They may also live with step-families following divorce. This research will investigate the experiences of families including at least one parent and one child in therapy. Different families may choose to include different family members in therapy, and this research will concern itself with the experiences of those who attended therapy only. This research will not investigate the experience of couple or marital therapy.

1.2.2   Child and Adolescent Mental Health Services (CAMHS)

Child and Adolescent Mental Health Services (CAMHS) is often used as a very broad term referring to any services provided to improve the mental health of children and young people. Statutory CAMHS services have been conceptualised in the UK using a four tiered model where Tier 1 is provided by 'universal' services such as GPs and teachers, Tier 2 is provided by specialist clinicians working within these settings (e.g. Primary care, schools) to provide consultation, assessment and training, Tier 3 is provided by multi-disciplinary teams working in a community mental health clinic

and Tier 4 are highly specialist teams such as inpatient units (DoH, 2004). This research will focus on Tier 3 services, offering specialist services for children and young people with more severe, complex and persistent disorders. According to the National Service Framework (NSF) for children and young people (DoH, 2004) CAMHS teams can be staffed by a broad range of professionals including Child Psychiatrists, Clinical Child Psychologists, Social Workers, Child Psychotherapists and Family Therapists. However, the NSF states that team development should be driven by the need for a variety of therapeutic skills, including Systemic approaches.

1.2.3   Systemic Family Therapy

The term "Family Therapy" covers a vast array of therapeutic interventions used specifically to work with families. This research will investigate experiences of Family Therapy as delivered by Family Therapists trained in Systemic Family Therapy. Systemic therapy can be used to work with a variety of groups including families, couples and organisations (Stratton, 2011). However, this research will focus on Systemic Family Therapy with parent(s) and their children in CAMHS settings. Typically, families are seen for an average of 7 sessions over 6 months (Stratton, 2011). Stratton (2011) defines "Systemic Family Therapy" as follows:

> *"Systemic family therapy is an approach to helping people with psychological difficulties which is radically different from other therapies. It does not see its work as being to cure mental illnesses that reside within individuals, but to help people to mobilise the strengths of their relationships so as to make disturbing symptoms unnecessary or less problematic." Stratton, 2011, p. 5*

Systemic family therapy draws on a number of theories and models of practice (Dallos & Draper, 2005). While some systemic family therapists adhere to specific models of therapy, others work integratively (Dallos & Draper, 2005). Models of systemic family therapy found to be effective include Multi Dimensional Family Therapy, Multi Systemic Therapy, Functional Family Therapy and Brief Strategic Family Therapy (Stratton, 2011). The key defining feature of family therapy as used in this research is that it works within the context of 'immediate' family relationships

of parents and their children. Systemic family therapists draw on a number of common skills and methods including knowledge of family processes, being able to understand and work with the influence of family traditions, helping families to explore new ways of relating to each other and exploring the existing resources within the family to support each other (Stratton, 2011).

2   The family in therapy

As the experience of therapy is predominantly concerned with the relationships within the family system, I will review the literature on family therapy in relation to different aspects of the therapeutic alliance. Friedlander et al.'s (2006) dimensions from the System for Observing Family Therapy Alliances (SOFTA) provides a useful structure for examining diverse research into the family's experience in therapy.

2.1   Therapeutic alliances in family therapy

Much has been written about the nature of the relationship between client and therapist, and indeed between family and therapist (Flaskas, Mason, & Perlesz, 2005; Flaskas & Perlesz, 1996). Many different terms are used to describe this relationship including: therapeutic alliance, working alliance, therapeutic working alliance, therapeutic relationship. Different authors use such terms interchangeably, although often different meanings are ascribed to them (Horvath & Symonds, 1991). There has been a great deal of debate over the role of 'common factors' (as opposed to model specific factors) in the outcome of psychotherapy (Blow, Sprenkle, & Davis, 2007; Lambert & Barley, 2001). The majority of the research in this area focuses on individual psychotherapy, although there has been a small amount of research into the role of the alliance in Systemic Family Therapy (Escudero, Friedlander, Varela, & Abascal, 2008; Karver, Handelsman, Fields, & Bickman, 2006; Robbins, Turner, Alexander, & Perez, 2003).

Bordin (1979) described a trans-theoretical model of the 'working alliance', comprising the emotional bond between therapist and client, collaboration over the tasks of therapy and collaboration over the goals of therapy. More recently, in the

realm of Systemic Family Therapy, the System for Observing Family Therapy Alliances (SOFTA) has been developed. This system includes similar concepts to Bordin's model, as well as new concepts which are particular to the family therapy context (Friedlander et al., 2006). As such, SOFTA includes two 'individual' dimensions: emotional connection with therapist (emotional bonds), and engagement with the therapeutic process (tasks and goals of therapy). They also describe two dimensions relating to the family group: 'shared sense of purpose within the family' and 'safety within the therapeutic system', which reflect the peculiar nature of the alliance in family therapy.

Another layer of complexity in forming alliances in SFT is the different levels at which this can done. Pinsof and Catherall (1986) describe 3 levels of alliance in family therapy: the individual level (individual family members), subsystem (e.g. sibling groups), and whole system (the whole family). As such, the family therapist must negotiate the alliance at all levels in order to maintain the therapy. Minuchin (1991) wrote about the process of 'joining' with the family system, where the therapist becomes almost a part of the system. As such, the therapist forms alliances with the whole system as well as with individual family members.

Robbins et al., (2003) investigated the impact of individual alliance ratings on drop out from family therapy. They found that the balance of therapeutic alliances between therapist and individual family members – that is, the correlation between family members' ratings - was more predictive of therapy completion than the average level of strength of individual alliances. As such, they concluded that having a balanced therapeutic alliance with the whole family (even if the alliance was weak) was more important than having a strong positive alliance with at least some family members. However, it should be noted that their study was conducted using student therapists, who may have still been developing the skills to effectively work with a family with a split alliance. The study also focused on the alliance between individual family members and the therapist, which perhaps overlooks the complexity of the alliance in family therapy, as highlighted by SOFTA's (Friedlander et al., 2006) family

dimensions of a <u>shared</u> purpose in therapy and the sense of safety within the family therapy system. However, as demonstrated by Robbins et al. (2003), the consequences of a problematic alliance at this individual level, may be that the family drops out of therapy. This aspect of the alliance can perhaps be fostered by the emotional connection with the therapist.

2.2 <u>Emotional connection with the therapist</u>

Within SOFTA (Friedlander et al., 2006), 'emotional connection with the therapist' is described as the therapist being viewed as an important person by family members, and having a trusting, caring relationship with the family members. In addition, the therapist should be seen as genuine, supportive and knowledgeable by family members. It is likely that the different elements of the alliance in family therapy will impact upon each other. As such, the existence of a strong emotional bond will allow the family to take greater personal risks in therapy, leading to greater therapeutic change. A number of studies have reported findings that highlight the importance of the emotional bond with the therapist for families in therapy.

Although there has been little research investigating the specific attributes of successful family therapists, preliminary studies investigating families' experiences of therapy have nonetheless offered some useful findings in this area. For example, it is possible to find evidence of the importance of the Rogerian "client centred triad" of empathy, warmth and genuineness in clients' accounts of therapy. Stanbridge (2003) reported on a study of families' satisfaction with family interventions for the families of clients with psychosis. Among the findings were that families appreciated therapists who were able to listen, be genuine and non judgemental, showed an interest and were helpful, worked well together, and who created a calm and quiet atmosphere during sessions. Campbell et al. (2004) report on families interviewed after accessing Behavioural Family Therapy (BFT) within an Early Intervention in Psychosis service. Again, families were generally very positive about the service, and this was related to the calm, friendly, understanding attitudes of therapists, although there were some negative comments about 'pedantic' or 'patronizing' styles.

In an early study of family therapy practice, Howe (1989) reported on the views of families being seen for therapy within a UK Social Services department and compared the reports of those who had engaged well with therapy or not. He found that a warm, non-judgemental and empathic attitude of the therapist improved engagement of families and furthermore he reported that families identified the absence of these qualities as a negative. Some families in this study reported that their social worker (whom they had usually found to be kind and helpful outside of family therapy), behaved in a somewhat 'robotic' way in the context of family therapy sessions. This may have been due to a lack of training and the inexperience of the therapists involved, although the level of training of the therapists is not made clear in Howe's book.

In addition to a therapist's warmth, empathy and genuineness, some research has found that the 'personality' of the therapist may be important. Stith et al. (1996) investigated the experience of children (ages 8-13) in family therapy, by interviewing both the children and their parents. Parents frequently cited the 'personality' of the therapist as important in engaging their children. Unfortunately, such aspects of the therapist are very difficult to quantify although some research suggests that therapists personality styles may 'fit' with certain clients better than others leading to differential outcomes (Herman, 1998). In family therapy however, a therapist's personality and style may be more or less acceptable to different family members. Moreover, the family therapist must also possess the necessary skill of forming alliances with complex families who are likely to present to therapy in conflict.

The emotional connection that family members have with the family therapist may be fundamental to the family therapy alliance. Previous research has reported that families value their therapist's warmth, empathy and genuineness, which made them feel comfortable to explore their relationships. In addition, the personality of the therapist has been cited as particularly important in working with children, which may reflect particular qualities which assist them in engaging children. These factors may help the family to engage further with the process of therapy.

2.3   Engagement with the process of therapy

Friedlander et al. (2006) describe engagement with the process of therapy as the client's view of therapy as a meaningful process that they are actively involved in. As such, the client who is engaged with the process of therapy feels able to negotiate the tasks and goals of therapy. Several studies investigating the experiences of families in therapy highlight the importance of discussing expectations of therapy. The expectations of families may not be compatible with the expectations of the therapist and several studies have suggested how differing expectations can be managed within family therapy.

In a study of a family therapy clinic in Hong Kong, Ma (2000) investigated the impact of the hierarchical culture on expectations and practice of family therapy. They found that (as they expected), parents from a Chinese background expected their therapist to be very directive. However, rather than adjusting their practice to fit expectations, Ma and colleagues instead ensured they discussed any differences in expectations with their client families prior to therapy. They suggest that differing expectations are not a problem when explained and discussed with client families.

One aspect of therapy which has often been highlighted as surprising by families is the use of a one-way mirror either for the purposes of 'live supervision' or a reflecting team (Howe, 1989; Lever & Gmeiner, 2000; Reimers et al., 1995). The one way mirror can be used for 'live' supervision of trainee therapists; supervising teams are able to observe the session and call the trainee therapist to offer guidance. The one way mirror can also be used by reflecting teams (Anderson, 1987) in order that the team enters the therapy room only to have a reflective discussion in the presence of the family, although some therapists choose to have the reflecting team in the room throughout the session (Dallos & Draper, 2005). The reflecting team approach involves the supervision team having a reflective discussion with the therapist in front of the family. This is designed to invite the family to consider alternative stories and explanations about their family relationships (Dallos & Draper, 2005). Several studies have specifically investigated service user views about the use

of the one way mirror, 'live' supervision, and the reflecting team (Locke & McCollum, 2001; Piercy, Sprenkle, & Constantine, 1986).

Howe (1989) and Reimers (1995) reported that families interviewed about their experiences of family therapy felt more comfortable when equipment had been thoroughly explained and discussed with them at the start of therapy. Locke and McCollum (2001) repeated a study originally completed by Piercy and colleagues (1986), investigating family views of 'live' supervision and the use of the one way mirror and how this impacted on therapy. Satisfaction ratings were high, ratings of the intrusiveness of the supervision were low, and participants rated the supervision as helpful in the process of therapy. They also report a range of qualitative comments. On the one hand participants commented that it was good to have more people thinking about the problem, while some participants commented that the screen made them feel uncomfortable, and could be disruptive of the process. These comments are at odds with the quantitative findings of the study. A key problem with this study is that participants were asked to complete forms within sessions at a family therapy training clinic and – despite measures taken to ensure anonymity – clients may have been reluctant to be honest at least in their ratings of satisfaction.

Lever and Gmeiner (2000) interviewed families who dropped out of therapy after one or two sessions, as well as their therapy teams. For the families in this study, expectations of therapy were not addressed and they were surprised by the set up of therapy (for example, the use of a one way mirror and reflecting team). Families also reported that they felt unable to question the method or focus of the session. Thus, families did not feel powerful enough to raise the conflict of expectations, and this powerlessness was reinforced by the lack of discussion and negotiation around expectations. This sense of powerlessness appeared to have had a detrimental effect on the therapeutic alliance which they suggest was responsible, at least in part, for the families' dropout from therapy. This study highlights the importance of discussions around the process of therapy. Moreover, the findings suggest that these discussions should be raised by the therapist, as the family may be reluctant to

raise such issues at the start of therapy, due to perceived power imbalances. One of the aspects of therapy families reported made them feel uncomfortable, was the use of a one way mirror for observation of the family and the disruption of the session caused by the reflecting team.

The use of a one-way mirror in therapy can make client families feel uncomfortable, and the reflecting team can sometimes be disruptive to sessions (Lever & Gmeiner, 2000). This may be particularly so when care is not taken to introduce the equipment and team to the family and explain their purpose. However, there is also evidence that families value the input of the reflecting team in therapy and that it can enhance the therapeutic process as intended. Families' discomfort may be reduced by having the opportunity to discuss any concerns and the reasons for the use of such techniques (Lever & Gmeiner, 2000).

2.4 Shared sense of purpose within the family

Friedlander et al., (2006) propose that a sense of unity within the family is an important aspect of the therapeutic alliance in family therapy. As such, the family sees themselves as working together in therapy towards common family goals. However, families - and in particular parents - may come to family therapy with varying expectations about therapy which may be rooted in social and cultural discourses about therapy (Ma, 2000). Individual expectations will also be a function of the knowledge and experience of individual family members. For example, parents often report very clear reasons for coming to therapy (Reimers et al., 1995; Sheridan et al., 2010), while children often report being unclear of the reasons for attending therapy (Lobatto, 2002; Stith et al., 1996). Hawley and Weisz (2003) investigated the level of agreement on target problems among children, their parents and therapists in Los Angeles community clinics and found very low levels of agreement between parents and their children. They suggest that the first task of the therapist may be to bring together parents and children in finding common goals.

Systemic family therapists understand problems within the context of the family system, rather than located in the individual (Stratton, 2011). However, this is likely to be a new way of looking at things for families presenting at CAMHS, who may frequently view the problem as located within the child. Within the CAMHS setting, even the service name places the problem within the child or adolescent's mental health. Some CAMHS clinics instead use the name Child and Family Clinic, although clearly these services are set up to receive referrals regarding children's behaviour and emotional wellbeing, rather than to routinely provide family services for parents with mental health problems. As such it is unsurprising that within these settings, children tend to see themselves as 'problem carriers', despite the best efforts of family therapists to engender a systemic understanding of the problem (Lobatto, 2002). Stith et al. (1996) found that pre-adolescent children were often confused about the goals of therapy, and did not know why they were coming, despite their parents' reports of explaining the purpose of the appointments to them. In contrast, Lobatto (2002) found that children tended to view themselves as 'problem carriers', taking responsibility for the problems which brought the family to therapy. It may be that children in Stith et al.'s (1996) study and Lobatto's (2002) study did not have the opportunity to discuss their expectations or the goals of therapy and therefore continued to be either confused or to see themselves as 'problem carriers'.

2.5   Safety within the therapeutic system

Finally, Friedlander et al., (2006) describe safety within the therapeutic system as family members feeling that therapy is a place where they feel comfortable and able to take risks and be open with each other. Importantly, they state that family members should have an expectation that generally good will come from being in therapy and that conflict will be handled without harm. Several studies investigating the experiences of families within therapy have described the experiences of different family members of talking and beginning to take risks in therapy. This aspect of the experience of family members is likely to be strongly impacted by issues relating to power such as family roles and hierarchies, and in a broader sense

by diversity issues such as race and gender. I will now explore additional factors possibly influencing family members' sense of safety within therapy.

2.5.1 <u>Family Roles</u>

It has been argued that in any therapy, the therapist is in a position of power in therapy (Anderson & Goolishian, 1992) This may vary depending on the context of the therapy (e.g. Private practice as compared with an NHS service) and the nature of the therapeutic intervention (e.g. Structural family therapy, as compared with third wave therapies). As such, models of family therapy where the therapist is seen as an 'expert' place the therapist in a more powerful position than the client family (Anderson & Goolishian, 1992). It should be noted that some families may feel a therapist who takes an expert role is reassuring, while others may favour a more equitable power balance. The existing dynamics of power within the family may also have an impact on power within the therapy (Escudero et al., 2008). For example, children may not want to challenge their parents and may be more or less able to navigate the therapy situation (Lobatto, 2002).

Sheridan, Peterson and Rosen (2010) investigated the experiences of parents in family therapy within a private practice setting. They report that a key theme was that parents reported a feeling of connection with their adolescent child, facilitated by the therapist through a strong therapeutic alliance with all family members. Parents tended to come into therapy feeling that they were 'running out of time' (p.150), possibly reflecting the developmental stage of young people on the verge of adulthood (Carter & McGoldrick, 1980). Change was associated with gaining the confidence to take risks in therapy and in their parenting, rather than avoiding difficulties. Thus, having come into therapy in a state of panic about their child, they felt contained, understood and safe enough to take the necessary risks to move safely forward, as suggested by Friedlander's concept of safety within the therapeutic system (Friedlander et al., 2006).

It should be noted that participants in Sheridan's study were accessing therapy privately, and therefore the problems for which help was sought and the context of the help given within a CAMHS setting may lead to potential differences in experience. The present research is concerned with families attending therapy within an NHS CAMHS clinic. This is quite a particular context, which will have different meanings for different families. Howe (1989) found that some parents invited to family therapy by social services felt that they had to 'play along' with therapy in order to prevent their children being removed from the home. Such expectations may impact upon the power relationships within family therapy.

Although the setting of the modern CAMHS clinic is not based within social services, CAMHS continue to have an important role in referring child protection cases to Children, Schools and Families services (DCSF, 2010). However, there has been little research investigating the impact of this context on parents bringing their children to CAMHS. Studies investigating parents experiences of private family therapy indicate that they value feeling safe enough to take risks and talk openly about problems (Sheridan et al., 2010). However, this may be more challenging within a CAMHS setting, due to parental fears around safeguarding and being judged on their ability to parent their children.

Children and young people report a range of feelings about attending therapy. One consistent theme among children of all ages is that of protecting others in the family and in particular parents (Lobatto, 2002; Stith et al., 1996; Strickland-Clark et al., 2000). Strickland-Clark et al. (2000) found that adolescents attending CAMHS family sessions sometimes felt overwhelmed and therefore withdrew from sessions, choosing to stay silent in order to cope with the emotion. However, staying silent left adolescents feeling excluded from the session in their silence, perhaps through a belief that they should protect their parents from their true feelings. This highlights the importance for adolescents of feeling safe in exploring difficult emotions. Lobatto (2002) also found that children were very reluctant to say anything negative about their parents or therapy in front of their parents.

Lobatto (2002) described primary school aged children's experience of being part of a 'therapeutic circle' during family sessions (Lobatto, 2002), where different family members and the therapist move in and out of the centre of attention. The children she interviewed described withdrawing from the therapeutic circle if they felt criticized or worried about others in the circle, for example by playing with toys, or going quiet. At other times children reported feeling excluded from the therapeutic circle by adults, and attempted to rejoin the circle by trying to attract the adults' attention, often through play or behaviour. They report varying levels of ability to perform these navigations among the children interviewed. Thus the therapist, as the most powerful in the therapeutic circle may need to offer opportunities for children who are less able to navigate the circle to join in, for example through the use of games and activities. This perhaps reflects the importance of children being able to choose when they enter and leave the 'therapeutic circle'. All the children seemed reluctant to offer their views in therapy, except when asked a question, because of a worry about breaking social rules as reinforced by their parents (Lobatto, 2002).

Talking openly in family therapy involves a risk to family relationships for all family members, which is not present within individual therapy, where everything said is confidential between the therapist and client (Escudero et al., 2008). Some participants of family therapy will feel safer in talking openly than others, and this may be in part due to family roles, gender expectations and the relationships families bring to therapy. In particular, there is some evidence that children and adolescents tend to feel protective of others in the family therapy.

2.5.2   Diversity and safety within the family therapy system

The issue of social and cultural narratives is likely to impact on therapy in many ways, (Anderson & Goolishian, 1992). Issues such as race and gender may impact on therapy due to assumptions made by the client or the therapist based on cultural narratives (Gregory & Leslie, 1996). It should be noted that race and gender are not the only issues of diversity which might be encountered in family therapy. However,

race and gender may demonstrate some of the key issues relating to power and minority groups, which may impact on family members' experiences of therapy. Much has been written in the family therapy literature about the importance of addressing issues of diversity such as race and gender from a therapist's perspective (Blow et al., 2007). However, families are likely to bring with them their own assumptions about the therapist, and this may further impact upon family perceptions of power within the therapeutic relationship (Gregory & Leslie, 1996).

Gregory and Leslie (1996) found that black female clients who were allocated a white therapist reported being less comfortable initially than those allocated a black therapist, although they report that there was no difference in alliance by the time of the fourth session. Black females, in the oppressed position historically, may initially have felt disempowered by the fact that their therapist was white, due to the context of wider social and political discourses and their own experiences of prejudice and discrimination. However, the fact that the difference had 'disappeared by the fourth session suggests that they may have been able to address these issues with their therapist and develop a good alliance despite their assumptions. Interestingly, there was no difference between the reports of black male clients, who were overall more positive about their therapists than their female partners, suggesting that being male may have placed them in a more powerful position to negotiate difference. This study was conducted in the USA and therefore the dynamics around race and gender are not likely to be directly transferable to the UK context. However, while the specific impact of race and gender on power relationships in therapy may present differently in the UK, this study suggests that such factors may have an initial impact on the therapeutic relationship, although this can perhaps be overcome within the first few sessions with sensitive and culturally competent interactions.

Although it is useful to consider how clients' race and gender may impact on their experiences of therapy, it is important to remember that within these groups there will also be much variation. Chang and Berk (2009) compared the experiences of cross-racial therapy of satisfied and dissatisfied clients, and unsurprisingly found

diverse preferences within and across ethnic groups. They found that having a racially dissimilar therapist was not always seen as a disadvantage, and was in some cases seen as an advantage, as it made it easier to talk about issues such as sexuality which were culturally taboo. Moreover, they reported that cultural incompetence was associated with dissatisfaction of clients with their therapist rather than the race of the therapist. This included very subtle displays of prejudice or dismissal of the importance of race. In contrast, basic therapeutic skills such as warmth, empathy and genuineness, including self-disclosure of thematically similar experiences (e.g. of discrimination) and active negotiation of the parameters of the relationship were seen as helpful by clients.

It is well documented that men are frequently reluctant to engage in psychotherapy (Good & Robertson, 2010) and some research has been carried out around fathers attendance at family therapy in CAMHS (Walters, Tasker, & Bichard, 2001). Walters et al. (2001) noted that mothers often take on the bulk of the responsibility for CAMHS appointments, and suggest this may reflect men's reluctance and/or their increased work commitments. Walters et al., (2001) found that fathers who attended CAMHS family therapy sessions more frequently were more likely to report positive relationships with their own fathers. Conversely, poor attenders were more likely to report insecure attachment styles, and worse relationships with their partners. This may reflect a difficulty in forming secure attachments which may result in feeling insecure in therapy initially (Walters et al., 2001). This may present a challenge for therapists attempting to engage men and particularly fathers in therapy. Walters et al. (2001) also found that men who had been poor attenders in fact began to attend more frequently following the research interviews, which they hypothesise may have been due to being more pro-actively engaged and being given the opportunity to explore themselves more extensively. They also note that poor attenders often had worse relationships with their child's mother, which may have presented a practical barrier if appointments were arranged through the child's mother. This may be related to the idea of a shared sense of purpose within the family and a sense of safety within the family therapy system. As such, where there

are problems within the relationship between parents, it may be difficult for them to work towards common goals and feel safe within the therapeutic system.

Issues relating to diversity may present numerous challenges to the Systemic Family Therapist in making the therapeutic space feel 'safe' to all family members. Issues such as race and gender may have an additional impact on the family's view of the problem as well as their view of the therapist. Therapists may need to discuss difference in order to communicate and verify their understanding of the clients' perspective explicitly. Some client groups such as fathers may present practical as well as psychological obstacles to engagement, which therapists may need to overcome.

3   Summary

A relatively small amount of systematic research investigating client experiences of therapy, and in particular family therapy has been carried out to date. Existing research suggests that the therapeutic relationship plays an important role in family therapy. Individual experiences of therapy may vary and are likely to be impacted upon by the individual's position in the family and other individual characteristics, the dynamics of the family and wider social and cultural contexts.

4   Aims of the research

The present research aims to explore the experience of families in family therapy in a CAMH Service from the perspective of individual family members. By interviewing all the members of a family who attended therapy, it is hoped that a more in depth understanding of the impact and interaction of intra and interpersonal factors in the family on the experience of family therapy. This understanding will not provide widely applicable understandings of how families experience therapy, or how therapy works, but rather will aid our understanding of the processes which may be at work in family therapy. As such the research questions are as follows:

1. How do individual family members make sense of their experiences of family therapy?
2. How do individual family members differ in their experiences?
3. To what extent are individual experiences shared by family members?

Methodology

Previous research in this area has used predominantly qualitative methods in order to document the views of families. However, most studies have been unclear about the method of analysis used. Broadly speaking, qualitative research aims to understand how participants make sense of their experience (Smith, Flowers, & Larkin, 2009). The exploratory nature of qualitative research also allows for the emergence of new knowledge from participants, which may add to or contradict existing theory. The present study aims to provide a detailed account of individual experiences of family therapy within the context of their family.

1   Design

1.1   A Case Study Approach

Previous research has taken an 'either-or' approach to family and individual experiences of family therapy. As such, results are presented either as 'family views' or as 'children's views'. A family case study approach instead takes a 'both/and' approach so that both family and individual experiences of family therapy can be explored. A case study design allows the researcher to reach an in depth understanding of a phenomenon and the processes involved for each family studied. It is not readily transferable to the whole population, but may tell us something about the factors possibly impacting on how an individual responds to experiences of family therapy. In this way, a case study approach supports an understanding of the individual and their family which is 'true' for them, and which can usefully inform us about some possible experiences of other families.

Dallos and Smith (2008) argue that a case study design is ideally suited to clinical research, as it allows an in depth understanding of the process. Case studies in fact have a long tradition of being used by therapists to develop theory (e.g. Freud) and illustrate practice (e.g. in CBT). There are also many examples of case studies being used to develop practice and demonstrate theory in family therapy (Minuchin, 1991). In the field of neuropsychology it is common for cases to be observed following

localised brain damage and written up as formal research since specific neuropsychological phenomena are seen as providing a useful insight into how the 'normal' brain functions, and how cognitive processes may be localised and/or related (Sacks, 1986).

The current study will present two 'case studies' of the experiences of two families in therapy. The method of Interpretative Phenomenological Analysis (IPA) will be used to analyse the data. IPA values the idiographic nature of qualitative research, seeking to understand the experience of the individual, in order to advance understanding of universal processes (Smith et al., 2009). IPA therefore lends itself to a case study approach to research. Previous IPA studies have used alternative perspectives as a way of increasing internal validity by triangulating carers' and participants' responses (Clare, 2002). An alternative way of presenting the data in this study would have been to analyse all 6 interviews as one group. One problem with such a design would have been that the group would not be sufficiently homogenous as required by IPA, as the two families recruited had quite different experiences of therapy, although they were both seen for therapy as families. Moreover, the current study design fits well with the idea of the hermeneutic circle (Smith et al., 2009). As such, the meaning of the individual's experience of family therapy cannot be understood without understanding the context of the family and the meaning of the family's experience of family therapy cannot be understood without understanding the experience of the individuals therein.

1.2   Interpretative Phenomenological Analysis

IPA was chosen as the most appropriate research method to investigate meaning making in cross-sectional and retrospective experiencing which is integral to the study design and research questions. IPA was developed within the field of Health Psychology, but has also been used more recently in studies investigating experiences of psychological distress (Alexander & Clare, 2004), and experiences of using physical and mental health services (Pitt, Kilbride, Nothard, Welford, & Morrison, 2007). IPA aims to give a detailed account of an experience, which

acknowledges differences between experiences, as well as aiming to find commonalities between individual participants, which may inform theory and practice.   This includes the ways in which different participants may ascribe meaning to their experiences within their personal and social context. In the case of experiences of family therapy, the social context of the family can be seen as integral to how an individual may experience family therapy, as well as the wider social contexts individuals inhabit. This study was designed to value the individuality of each participant, while also acknowledging the impact of their family context in how they experience family therapy. IPA is principally concerned with coming to an understanding of how individual participants make sense of their life experiences. This is achieved through the detailed exploration of the personal and social meaning participants appear to give to their experiences (Smith, 2003) through the way that they talk about those experiences. This represents the role of Phenomenology in IPA. However, a key acknowledgement in IPA is that the analysis of the data is the researchers' interpretation, and as such subjective, hence the interpretative aspect of IPA.

Smith (2009) has written in depth about the theoretical underpinnings of IPA in the fields of phenomenology, hermeneutics and idiography and the method of designing, conducting and analysing an IPA study. The depth, detail and rigour with which IPA is conducted allow a much better understanding of the process of constructing experiences rather than outcome, which makes it ideal for exploring therapeutic experiences. IPA emphasizes the active role of the researcher in making sense of the participants' understandings. In other words, the researcher does not have direct access to the participants' understanding of their world, but rather can only interpret the responses of participants. Smith (2009) refers to this as a 'double hermeneutic': the idea that the researcher is "trying to make sense of the participant trying to make sense of what is happening to them" (Smith, 2009, p. 3). In doing so, the researcher brings his or her own personal and professional meanings to the interpretation. It is therefore vital for the researcher to maintain a good awareness of their own assumptions in relation to the research topic through the process of

reflection. The researcher should then attempt to 'bracket' these during the conduct of the research, as much as is possible. Moreover, as it is unlikely to be possible to 'bracket' one's assumptions completely, and the findings will inevitably be influenced by the researcher's position, it is important for the researcher to be transparent about their own assumptions within the research. This reflective aspect of IPA was seen as particularly useful and important in this project, where the researcher has a personal connection to the experiences in question.

1.3   Other possible methodologies

IPA was chosen as the most appropriate methodology to answer the current research questions. However, there are a variety of different qualitative methods that may potentially have been suitable for this study, including narrative and discursive analysis (NA and DA respectively).

Narrative analysis could have provided a useful way to compare the different ways in which family members constructed stories around their individual experiences of therapy within the context of their family. For example, this could have investigated how social discourses about gender and parenting might influence mothers' and fathers' narratives about therapy. It would perhaps have fitted with much of the theory on attachment narratives and family scripts. However, the primary focus of this project was on how participants *experienced* family therapy, within the context of their family. Thus, while the experiences discussed will be looked at within context, the experience itself rather than the emerging stories over time was the primary research focus.

Discourse analysis could have looked at the ways in which families *talked about* their experiences. This may perhaps have been better suited to a design where families discussed their experiences together. However, such a design would not have provided the opportunity to look at each individual family member's experience in depth and may have constrained individuals' expression of their own experience. In addition, the focus of such an analysis would have been to understand the ways in

which families or individuals *talk about* their experiences, rather than understanding the meaning of the experience itself.

2   Participants

2.1   Recruitment

A number of CAMHS family therapists were approached to assist in recruiting families who were about to finish family therapy. The research was explained to families by the family therapist, and information sheets were given (see Appendix 2-5).   If families gave consent to be contacted, the researcher contacted them to answer any questions they had about the research and confirm whether they would be happy to take part. Information was discussed again at the time of interview, and written consent and/or assent was taken (see Appendix 6-9). It was initially planned to recruit one family of 4-6 people for the research. However, recruitment was more difficult than expected, with family therapists only identifying a small number of families who were coming to the end of their therapy, several of whom declined to participate for various reasons when approached.

Eventually, two families of three were approached by their therapists at around the same time, and both agreed to participate, and therefore it was decided to include both families as two smaller case studies. It may have been easier to recruit if I had been part of the therapy team, or part of the wider CAMHS team, but not involved with the therapy. However, a number of potential problems were identified with this method of recruiting. Firstly, potential participants might have found it difficult to talk honestly with me about their experiences if they associated me with the therapy team. In particular they may have been reluctant to discuss experiences they found painful or more difficult or were critical of the therapy received. Secondly, I would have a personal connection to their experience of therapy through my involvement within the team. As such I would have been coming to the data with my own service influenced perspective on their particular experience. It was thought that this would make it more difficult to listen for participants' perspectives on this experience.

2.2   Inclusion and exclusion criteria

It was possible to have very broad inclusion criteria as each family's shared experience of their therapy allowed homogeneity amongst each family.   Thus, inclusion criteria were that all participants were members of a family who were completing or had recently completed family therapy in CAMHS. As will be discussed later, the two families recruited had quite different experiences of therapy, and therefore homogeneity across the two families was met only to the extent that they were both seen as families. Exclusion criteria were any family where not all family members who had participated in therapy were willing or able (for example due to language barriers) to participate in the research. Family members not involved in the therapy were not interviewed as this would have required a different interview schedule and would have moved away from the research questions about the experience of being in therapy. Families including children under 7 were excluded as it was felt that children under 7 years would be less able to reflect upon their experiences in family therapy to the extent required for an IPA project. The process of IPA research relies heavily on the participants' use of language to communicate their experience of the phenomenon in question in their own words (Smith et al., 2009). Younger children tend not to have the vocabulary to communicate their experiences in this way and may need more prompting during interviews. It is also not considered good practice to interview young children without a known adult, such as a parent (Smith, 2003). Both prompting and the presence of a parent would have a negative impact on the validity of the data. It was therefore considered reasonable to limit the scope of this study to families with children older than 7.

2.3   Description of the families:

Two families were recruited to take part in the research. Pseudonyms have been used in order to preserve their anonymity. Both families were of white British ethnicity, living in small towns in South East England.

Family 1 (the 'Smiths') consisted of mother (Joan), father (Paul), daughter (Julie, aged 18) and son (Jack, aged 20). Jack had not taken part in therapy and no longer lived full time in the family home and was therefore not interviewed.
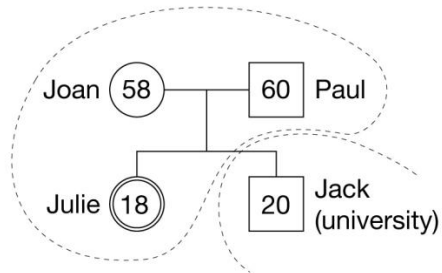
Figure 1. Genogram for the Smith family

The Smiths had attended Systemic Family Therapy sessions as part of the care package offered by CAMHS for Julie, who had received a diagnosis of Anorexia Nervosa, and were in the process of her being transferred to Adult Mental Health Services aged 18 for continued monitoring of her progress. The family was of White British ethnicity. Occupations have been classified according to the Standard Occupational Classification 2010 (Office of National Statistics, 2001) in order to preserve the anonymity of the families concerned. Paul works in a 'professional occupation', and Joan works in a 'caring, leisure and other service occupation', Julie had recently completed her A-levels and was hoping to go to University the following September.

The main therapist was female, aged 50-60, of White British ethnicity and trained in Systemic Family Therapy. The therapy team was all female, ages ranging from 30-60, all White British except one member of the reflecting team who was Asian British. The family attended 11 sessions and were seen by one therapist with a reflecting team of two, which varied from session to session.

Family 2 (the 'Jones' family) consisted of mother (Jill), daughter (Steph, aged 13) and son (Tom, aged 15), with the main involvement in therapy being by Jill and Steph. Jill was still married to the children's father, Phil, although they had separated five years previously. The children had regular and frequent contact with their father, but he was not involved in the therapy at the time of the interview, and was not therefore interviewed.
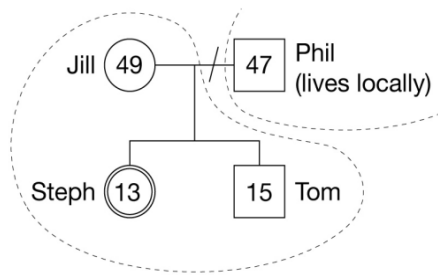
Figure 2. Genogram for the Jones family

The Jones' had attended family therapy at Jill's request due to the escalation of arguments between Jill and Steph, and at the time of recruitment had been due to end therapy, although they were considering further sessions including Tom to a greater extent and also inviting Phil to therapy sessions by the time of interviews. Jill works in an 'associate professional occupation' and both children are in full time education.

The family were seen by one Systemic Family Therapist for six sessions, prior to her retirement. They were then seen for a further 12 sessions by a younger (aged 30-40years). Both therapists were White British females and trained in Family and Systemic Psychotherapy.

3   Ethical Issues

Ethical approval for the research was given by the Riverside NHS ethics committee (see Appendix 1), as participants were to be recruited through NHS CAMHS services. Local R&D approval was sought for each CAMHS site used to recruit.

3.1 <u>Informed consent</u>

Information sheets were given to all participants to read before deciding whether to take part in the research or not. Four different versions of the information sheet were produced for different age groups: age 7-10 years, age 11-16 years, age 17+ (not parents) and parents (see Appendix 2-5). This ensured that participants from different age groups were provided with a developmentally appropriate balance of sufficient information to make an informed decision about taking part, without overloading them with too much information. Thus the 7-10 year old information sheet makes use of pictures to illustrate the points, and contains very brief information about key aspects of the research as detailed by IRAS (NHS, 2007). It is impossible to know exactly what will happen in qualitative research interviews, and so the main possibilities were discussed on the information sheet. Parents were asked to consent on behalf of children under 16 years of age, although children were also asked to give their assent to taking part, and it was made clear that they could decline to take part if they wished.

3.2 <u>Confidentiality</u>

Confidentiality was a key ethical issue in this research, for two reasons. Firstly, as with any qualitative research it is more difficult to completely anonymise data. Secondly, within the family units, it would not be possible to anonymise the data, as each family would know what the mother of the family had said in the interview, for example. Moreover, each member of the family would know that the others had participated in the research, and would also know where to find the thesis if they wished to know what other family members had said during the interviews. Thus, confidentiality within the family could by no means be guaranteed. An embargo on publication of the thesis was considered, but this was deemed by the University to be too restrictive of the usefulness of the research, in itself an ethical issue. Dissemination of the research was detailed on information sheets and participants were reminded at interview where the information would be published and that other family members would be able to see quotes from their interviews. Thus,

participants agreed to participate on the understanding that the information would be available to their families. This may have to some extent influenced or curtailed the nature of revealed experiences.

3.3 Affiliation of the study

Although recruitment was initially through the family therapy team providing the family therapy, it was made clear that the researcher was not part of the CAMHS team, but affiliated to the University of Hertfordshire. However, it is possible that participants might have had concerns that the services they might receive would be affected, although it was stipulated on the information sheets that this was not the case.

3.4 Distress

As with any research of this nature, it was possible that participants would experience emotional distress when talking about their experiences. The exploratory nature of qualitative research and particularly IPA means that I could not predict with certainty the emotional impact of discussed areas. Moreover, it was impossible to know how upsetting the interview process will be for a particular individual. In order to manage the risk of distress to participants, they were informed that this was a possibility within the information sheets and when consent/assent was taken, and that they did not have to continue immediately (if at all), if they became distressed. Some participants did experience some distress in the course of the interviews, although they did not wish to stop the interview. As a trainee Clinical Psychologist, the researcher was skilled in dealing with this and was able to manage and contain distress.

4   Data collection

4.1   Semi Structured interview schedule

Based on the literature reviewed above and the research question, a semi-structured interview schedule was devised (see Appendix 10). A semi structured interview schedule is flexible, allowing for some deviation from the schedule whilst ensuring that key areas are covered. The interview schedule was reviewed by two family therapists working in CAMHS, one of whom was experienced in conducting and supervising IPA research. In order to check the usefulness of the interview schedule and to provide an opportunity for the researcher to practice the technique of semi-structured interviewing, a pilot interview was conducted. It was possible to conduct a pilot interview with a mother whose children had declined to take part in the study. The pilot interview provided an opportunity to try out the questions and prompts and adjust them where necessary. This was also an opportunity to take note of any areas of potential importance but which were not included in the original schedule, such as the inclusion of questions about gender and about the ending of therapy. Finally the pilot interview allowed the researcher to practice her interview techniques and review them in order to improve her interview style. Listening back to the interview recording served as an opportunity to notice interesting comments I did not explore further, and the ways in which I probed other experiences to a greater extent. For example, I noticed that on some occasions, I asked for confirmation of my own interpretation of a situation, where a better question would have been more open, such as "what was that like for you?" or "how did you feel about that?".

The initial part of the interview aimed to get some background on participants' family, and their place within the family. Kinetic Family Drawings (Burns & Kaufmann, 1970), where participants are asked to draw a picture of everyone in their family doing some kind of action were used to facilitate getting to know the family in perhaps a less threatening manner. Participants were then asked to talk about their picture. Visual art may allow communication of ideas and beliefs which are not yet

'fully formed', and may represent 'preverbal construing' (Harter, 2007). It was therefore hoped that reflecting on this may help participants to access a deeper level of knowledge about themselves within their family. The family drawings also provide a visual representation of the family as each participant sees it. However, it was not formally scored as a 'projective' test as adequate norms, reliability and validity remains a concern for the KFD (Handler & Habenicht, 1994). This did, however, provide a useful context for facilitating an understanding of participants' experiences in therapy. Further questions focussed on aspects of family therapy experiences and the interview concluded with some reflections on the interview itself.

5   **Data analysis**

IPA analysis has been described as an 'iterative and inductive process' (Smith et al., 2009). It comprises a number of stages of analysis of different levels of meaning, from the unit of individual phrases to the unit of individual interviews, and overall themes that emerge across interviews. Smith (2009) refers to this as the 'hermeneutic circle', where the researcher must look to the whole to understand the part and the part to understand the whole. Thus, for example, in order to understand a meaning within an individual transcript, one must also look to the set of transcripts. Throughout the process of analysis the researcher is therefore required to go back and forth between the different levels of analysis: from sections of transcripts to the level of themes and back again.

Interviews were initially analysed as individual transcripts, and themes common to participants in each family were analysed as two case studies. In my discussion chapter, I will draw out the key themes emergent from both families, as well as some of the points of difference between the families. I began the process of analysing each individual interview by familiarising myself with the transcript by reading through with the recording and reflecting on the broad themes which appeared to emerge from the transcript. I then began a process of detailed annotation of the transcript with descriptive, linguistic and conceptual comments. Descriptive

comments note aspects of the experience that the participant talks about which appear significant, for example particular events and the emotions they evoked.

Linguistic comments pay attention to the language used by the participant: for example words or phrases repeated in the text. Finally, conceptual comments begin to examine the transcript at a conceptual level, relating particular comments made by participants to theoretical concepts, such as the 'therapeutic relationship' or concepts which may be emerging from the transcript as a whole.

Once I had annotated the transcript I used the comments to identify emergent themes: that is, themes appearing to be the most important within the transcript. These were themes re-occurring within the transcript, or aspects of the experience which the participant talks about with greater emphasis. Once emergent themes were identified, I searched for ways in which the themes may be connected. Quotes which exemplified the themes were identified at this stage. This process of identifying quotes also helped to re-verify that the themes were rooted in the data. I then grouped the emergent themes into 4-5 super-ordinate themes, aimed to summarise the key themes of each interview.

Once analysis of individual interviews was completed, I began to search for connections across individual family members themes for each family. This involved identifying common and contrasting themes across family members and attempting to understand what this might tell me about the experience of family therapy in the context of each family. As such, the data was approached as two distinct case studies at this stage. Analysis of the data as two case studies allowed the researcher to pay greater attention to the individual experiences and differing family contexts.

6   Self Reflexivity

Over the course of developing this research I have spent much time reflecting on my own experience of family therapy as a child, and the assumptions I make as a result. This took three main forms: a reflective journal, a reflective interview conducted by a fellow Trainee Clinical Psychologist (Bolam, Gleeson, & Murphy, 2003) conducted

prior to interviewing participants, and audio journal recordings made immediately before and after each interview. The aim of these reflections was to explore my own thoughts and feelings in relation to the context of the research. The reasons for this were two fold. Firstly, the process of reflection assisted me in 'bracketing' my own experience and fore-understandings when thinking about the experiences of my participants (Smith et al., 2009). Secondly, as it is impossible to completely 'bracket' one's own understandings when conducting research of this nature; I was keen to document the key points in order to increase the level of transparency of the research. I will explore some of the themes arising from my reflections here.

In examining an excerpt of the transcript of my reflective interview, a number of themes emerged.   Firstly, my own expectations of therapy came through as characterised by ambivalence: desperately wanting therapy to bring a resolution, but feeling nervous about being part of this process.

This ambivalence is also reflected in the way that I talk about therapy and my family during the interview. In particular, the notion that we all must attend or none meant that I did not feel that I had my own choice about participation in therapy, which impacted greatly on my own experience. The failure to explore my own ambivalence or that of my family left me feeling exposed in therapy, to a degree that was unhelpful to me as an individual. In addition, the lack of discussion and negotiation around therapy meant that my family struggled to make use of the therapy. A further theme was the 'awful truth' which reflected my difficulty in remembering the therapy itself.

One of the drivers for the design of the research was my own experiences of talking about family therapy with my family. I noticed that different family members remembered aspects of therapy quite differently. Moreover, my family (including myself) talked of mixed thoughts and feelings about therapy. In talking more about it, I became aware that the family script about therapy was not reflective of the totality of our experience.

7   Quality and Validity

Qualitative research is often criticised for being 'too subjective' but the flexible and interpretative nature of many qualitative research methods has resulted in the development of differing indicators of quality to quantitative research.   Yardley (2000) and Elliot, Fischer and Rennie (1999) have set out some key areas which should be attended to in designing and carrying out qualitative research in order to ensure quality of research and validity of the findings.

7.1   Sensitivity to context

Qualitative research should pay attention to the context in which it is conducted. This research was designed with attention to the existing literature and gaps therein. The design of the research places individual experiences of family therapy within the context of the family. Moreover, the interview guide includes questions designed to probe participants about their experience in the wider context of their lives, for example asking about who they have spoken with about family therapy outside of the family. Finally, the reflective aspect – and particularly the reflexive interview (Bolam et al., 2003)– of IPA place my interpretations of the data in the context of my own experience.

7.2   Commitment and rigour

Good qualitative research should be carried out with commitment and rigour in the process of interviewing and the process of analysing the data. Clinical training has provided me with the necessary skills to put participants at ease and to follow participants into new territories. I reviewed a pilot interview in order to improve my interview technique for the purposes of research, such as when I needed to probe more, as well as reflecting on why I did not take up certain aspects. The use of a reflective journal as well as a reflective interview (Bolam et al., 2003) shows rigour and personal commitment to understanding my own position and being transparent about it. The data was analysed thoroughly according to IPA and a section of analysis was checked at each stage by a supervisor and a colleague to ensure that the themes

coming from the data were credible. An audit trail was kept (Smith et al., 2009)to ensure rigour throughout the process from design to completion of analysis.

7.3   Transparency and coherence

Previous studies (Howe, 1989; Reimers et al., 1995; Sheridan et al., 2010; Stith et al., 1996; Strickland-Clark et al., 2000) in the area have not been transparent in terms of the methods used to analyse the data. The method of IPA is well documented and the researcher has been transparent about the research methodology.   The researcher has been transparent about her own position and experiences and this has been integral throughout the research.

7.4   Impact and importance

I hope that this research will form an important part of the qualitative evidence base for family therapy and inform practice by providing an insight into the experiences of families in therapy.   My own experience on training has been that although as Clinical Psychologists we take pride in listening to our clients and empathising with them, there is nevertheless a dearth of systematic research investigating how our clients experience us. Moreover, the nature of the research as exploring individual's experiences in therapy in depth may provide some insights into the process of therapy and change.

Results

The interview data was analysed at the individual and familial level and is presented here as two family case studies. First I will describe an over-arching theme of the safety of the therapeutic relationship emerged for *both* families. I will then present the two family case studies, which attempt to capture each family's descriptions of this relationship. For each family there were 3 superordinate themes, each representing phenomena that family members talked about in their individual interviews. Each superordinate theme encompassed 2-3 subordinate themes illustrating the different aspects and perspectives on these phenomena. Each superordinate theme and its associated subordinate themes will be presented with supporting extracts from participants' accounts. Extracts have been edited to increase readability such that minor hesitations and repeated words have been deleted. Any missing material is indicated with ellipses (...). Pseudonyms have been used to protect participants' anonymity.

1   Overarching theme: The safety of the therapeutic relationship

From both families' accounts of therapy, one over-arching theme emerged as encompassing both the super-ordinate and subordinate themes. 'The safety of the therapeutic relationship' reflects the overarching theme of the participants' experience of feeling safe enough in therapy to explore each other and, in turn, to be explored by each other. Family members talked about this as a new experience not perhaps possible outside of the therapeutic milieu, as summarised here by Paul:

> *"I think the process of discovery around our perspectives on the illness and the journey out of it. I think it was good to share that and I think we wouldn't have spent an hour sitting together in one block talking our way through it, every fortnight. It would have been much more ad hoc and haphazard and driven by events." Paul, p. 19*

As such, Paul identifies that sitting together in a structured environment helped them to explore their perspectives on his daughter's illness. Therapy allowed them

to spend an hour talking together without being disturbed or 'driven' by outside events. This safe space thus allowed them the freedom to explore their perspectives on the illness and reflect on their experiences.

The Jones family had had two different therapists, and had felt particularly positive towards their second therapist. Both Jill (mother) and Steph (daughter) noted that although the first therapist had been helpful, friendly and understanding, they had 'naturally warmed' to their current therapist and experienced her as more engaged with them. The 'natural' warmth described by Jill perhaps reflects the warmth and genuineness facilitating the building of a particularly strong therapeutic relationship, in which Jill felt safe and able to trust their therapist:

> *"I warmed to her more…I've really warmed to [therapist], whereas I didn't warm to this other lady particularly." Jill, p.20*

Jill couldn't recall the name of the first therapist, whereas there was a sense that the family 'clicked' with the second therapist. An important element in their relationship with their second therapist appeared to be her personality being a particularly good fit. Steph struggled to put this into words:

> *"Cause she's just really sweet [giggles]". Steph, p.18*

Indeed, everyone in the family referred to feeling that the therapist understood them, and felt that they could relate to the therapist. In addition to her personality, this may have reflected her use of 'self' in therapy:

> *"…cause she's got a daughter... and I just think ... she knows so much about like teenagers. She's always like, "Oh yeah, that's just teenagers and stuff." And like she always sees your point of view... and mum's." Steph, p. 18*

For Steph, the therapist's gender and her knowledge that the therapist had a teenage daughter helped her to feel understood, illustrating how the self of the therapist was important in building a particularly strong therapeutic relationship with this family.

Finally, Joan (mother, Smith family) described the importance for her of the positivity of the therapists in building a trusting relationship. She described being praised for the care she provided for her daughter as an entirely new experience, where previously she had worried that she was 'getting it all wrong'. This may reflect the 'unconditional positive regard' of her therapists.

> *"They were always <u>incredibly</u> positive. Whatever we said we were doing. They always put a very positive slant on it" Joan, p.5*

In this quote Joan notes how the therapists were always positive, regardless of what they were doing. She uses the word 'incredible' to emphasise the extent to which they were positive such that it was almost not credible.

The safety of the therapeutic relationship was a universal theme that emerged from the transcripts and encompasses all the other themes that emerged from the data. As such the safety of the space provided a basis for exploration, and the superordinate and subordinate themes relate to various aspects of the experience of exploring family relationships in therapy.

2   Case Study One: The Smiths
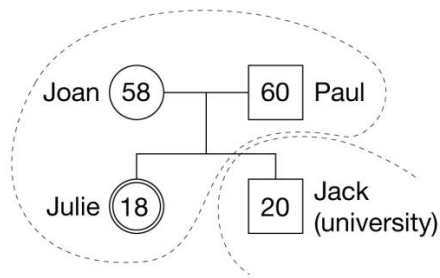
Figure 3. Genogram for the Smith family
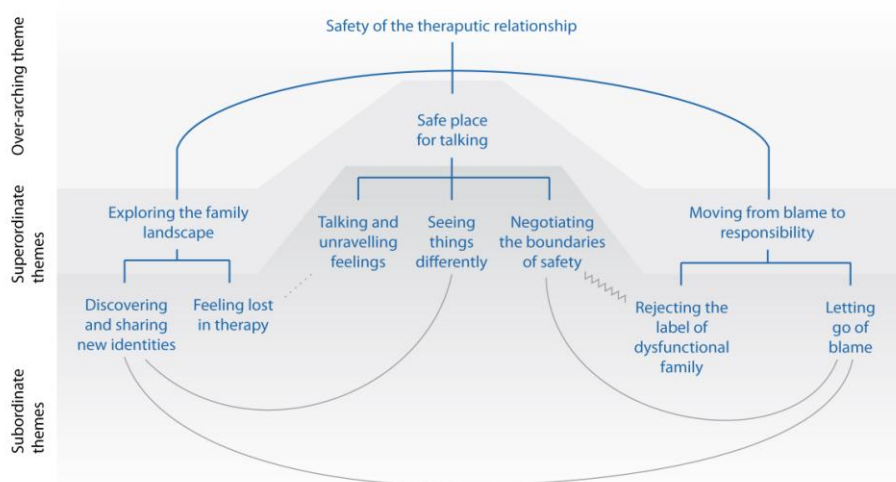
Figure 4. Thematic Map for the Smith Family

Three superordinate themes emerged from the Smith family's interviews: 'a safe place for talking', 'moving from blame to responsibility' and 'exploring the family landscape'.   The themes were not distinct from each other but sometimes overlapped or were related to each other in different ways as shown on the map. As such, double lines indicate themes that reflect complimentary processes, while zig-zags represent a conflict where one process perhaps restricts the effectiveness of another.

2.1   Superordinate Theme 1: A safe space for talking
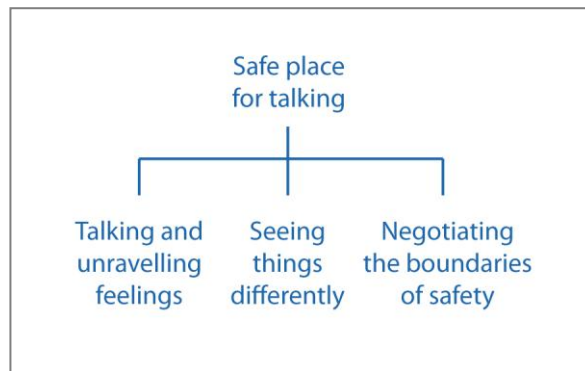
Figure 5. Thematic Map for Superordinate theme 1

The family described how the safety of the environment and the therapeutic relationship allowed them to find new ways to communicate, manage the balance of the conversation and to be able to share their perspectives.

Everyone in the family talked about family therapy providing a safe space to talk, something they felt they couldn't have done at home.

> "...cos there...I could talk quite openly, while at home sometimes it's hard just to sit down and talk about things...You can tell it's sort of slightly controlled as well..." Julie, p.8

This quote from Julie, shows how she felt contained in talking openly in therapy. Paradoxically, the fact that the conversation felt controlled did not restrict Julie, but rather allowed her the freedom to speak openly.

Joan reported that she did not have any worries about attending sessions because the environment of the CAMHS clinic itself was familiar, and she had always experienced it as calm and positive. As such her familiarity with the clinic and the calm atmosphere she had experienced before helped Joan to feel safe in therapy.

> "Well I suppose in the early days, I'd sat in with [Julie]'s therapy sessions. And I'd met a couple of the people who worked there and I suppose I assumed that

they'd be like that... kind, calm, you know there was always a very calm atmosphere," Joan, p. 6

In addition to the calmness of the atmosphere, family members felt that there were too many distractions at home to have the same kind of conversations as were had in therapy. In the following quote Joan talks about things being too busy at home to talk in the same way, and that the conversations had in therapy would not have been possible outside of therapy.

"you can't really do it at home. There's always something else going on and we're not all here so I looked on it very much as a way of us having to be together..not that not that we find it difficult being together, but you know, when we're together, it would have been very unusual for us to sort of done a self family therapy help session," Joan, p. 6

In summary, the family felt a sense of safety in therapy they defined as the calmness of atmosphere, freedom from distractions and the therapists 'control' of the situation. The safety of both the environment and the relationship with the therapist and reflecting team allowed an exploratory style of 'talking and unravelling of feelings' which allowed the family to 'see things differently' in therapy. There were variations in the limits of exploration different family members were willing to undergo. This 'negotiation of the boundaries of safety' will be explored in the third subordinate theme below.

2.1.1   Subordinate Theme 1.1. Talking and unravelling feelings

Paul talked about the change in the quality of the conversation over the course of therapy, moving from a more interrogative style at the beginning of therapy to a more conversational style towards the end of therapy. This seemed to reflect a shift in the family's communication style as they became more comfortable with therapy.

"...perhaps the last two or three sessions felt a bit more like a conversation rather than a series of um, more like conversation than tennis you know..." Paul, p.12

Paul's description of earlier conversations as tennis conjures up a number of ideas: firstly, in earlier sessions that the conversation was more linear, between therapists and individual family members. Thus, in earlier sessions, the conversation had to go back over the net to the therapist before anyone else could speak. As such, as therapy progressed the conversations became more fluid and able to go in different directions, not just back and forth. Thus as the therapeutic space became more comfortable and felt safer, conversations were able to 'unravel' more freely, rather than being structured by therapist questioning. Furthermore, they were perhaps eventually seen as coming from the 'same side of the net' such that the competitive metaphor had shifted to a co-operative one.

The growing sense of safety in therapy seemed to allow a new freedom of thought for Joan, which allowed her thoughts and feelings to be 'untangled' in therapy:

> *"Family therapy didn't actually work like you came out and you felt that you'd actually changed anything. It was more of an unravelling of feelings so that everybody could feel how you felt...it was weird like that." Joan, p.16*

Joan refers to the experience as 'weird' suggesting that she also found the experience of feeling safe to talk openly strange and new. The word weird is derived from the Old English 'weordan' from the German 'werden', meaning 'to become', implying that there may be a sense of development and change in the experience (Harper, 2010). The modern sense of the word 'weird' has its roots in the 'Weird sisters', the three Goddesses who controlled human destiny in Germanic mythology (Harper, 2010). Joan's choice of the word 'weird' in particular, rather than, for example, 'strange', may also reflect a feeling of being guided through the process of exploration by the therapists. She perhaps felt that the therapists were in control of the exploration, while allowing the family to feel it was their exploration, much like the Weird sisters controlled human destiny while maintaining the illusion of free will.

2.1.2   Subordinate Theme 1.2: Seeing things differently in therapy

The exploratory nature of conversations in therapy allowed the family to explore their relationships in new ways. Paul spoke about Julie telling him about a problem of which he hadn't been aware.

> *"...there were some good moments in terms for me in that there were moments when [Julie] showed that there was something that she hadn't appreciated about something I had said or done. Which I hadn't appreciated was a problem. So you know it provided a safe space in which to talk some of these things through..." Paul, p.11*

Thus, the safety of the space allowed Paul and Julie to voice their perspectives for the first time. Although Paul describes the episode as helpful to talk through, he was sceptical about the extent to which this would lead to lasting changes in his behaviour.

> *"two years later most people are hardly different to what they were before the intervention. So it maybe that um, some of (...) my better listening behaviour say or less making assumptions will um, wane as time progresses." Paul, p.20*

However, Julie seemed prepared for this, and perhaps having shared her discomfort with her father in therapy, would be able to let him know in future.

> *"I guess it was... rather than him just learning that he'd done everything wrong, it was about me learning that I've got to be patient with people, because not everyone understands." Julie, p.21*

In addition to getting new perspectives from each other, Julie talked about being shown a new perspective by the reflecting team, which she found helpful. She describes the reflecting team's comments as "judgements" (p.8), which appears to be in conflict with the goal of building a therapeutic relationship that is non-judgemental. However, Julie describes having a new perspective as helpful and implies that keeping this outside of the main therapeutic relationship protected the safety of the exploration for Julie.

"It felt bizarre sort of being talked about right in front of you...But I guess it was quite helpful....cause it felt like an outsider's judgement..." Julie, p.8

Distance seems important to Julie's ability to listen to the team's reflections here: because they are placed outside of the therapeutic milieu, she is able to see their challenges as helpful. She distinguished this from the role of the therapist of exploring and asking questions, which perhaps protected the non-judgemental nature of the therapeutic relationship.

"cause the therapist wasn't making judgements. She was asking questions...and exploring the ideas." Julie, p.11

In summary, through exploratory conversations within the family, as well as perspectives put forward by the reflecting team in therapy, family members were able to see new perspectives on old problems. This allowed family members an opportunity to talk about things which they had never talked about before and through these conversations, they were able to better understand each other. Some challenges came from the reflecting team, which Julie described as judgements that she was able to see as helpful, because they were separated from the relationship with the therapist.

2.1.3   Subordinate theme 1.3: Negotiating the boundaries of safety

The importance of the therapeutic space was highlighted by the ways the limits of safety were spoken about by family members. As such this theme reflects the boundaries of the exploration some members of the family were able to tolerate and the ways these boundaries were navigated and negotiated. Family members talked about moments which were less comfortable, as well as feeling they had 'gone as far as they could go' by the end of therapy. Family members described varied limits for themselves.

Julie in particular talked about feeling over-exposed at times in therapy. Here, Julie talks about feeling embarrassed by sharing letters about the future with her parents:

"I didn't really know where to look I felt a bit kind of...you know you sort of don't wanna catch someone's eye. I don't know. I felt a bit embarrassed really." Julie, p.13

Julie clearly communicates her discomfort with the level of intimacy and exposure when she says: 'you don't wanna catch someone's eye'. This may reflect aspects of Julie's anorexia: that she is uncomfortable being exposed to others, and particularly her parents. Julie's embarrassment may have limited her ability to make use of the space at these times as her avoidance of eye contact will have put up a barrier to communication at these times. As such, Julie was able to keep herself safe at the limits of what she was willing to share by withdrawing, although this felt uncomfortable.

Joan in contrast, had found the letters reassuring and therapeutic, showing the difference in experience arising from differing limits to safety for Joan and Julie:

"having heard them all read out, it was (...) like a (...) little bit of a healing process, you know, cos I suppose, even talking, is not quite the same as writing down, and you often write things down differently to how you speak them" Joan, p.12

The difference in experience of the letters demonstrates the impact of the different levels of exposure that family members were able to tolerate. Thus, because Joan felt safe enough (perhaps due to her position in the family as well as her relationship with the therapists), she was able to tolerate a greater level of beneficially felt exposure. This brought with it a greater sense of benefit from such exercises for Joan personally.

Julie and Paul both talked about the end of therapy being signalled by reaching what seemed to be the limits of the exploration they were willing to do. Paul describes the ending as follows:

"Well I thought they had come to a natural closure." Paul, p.2

So Paul described that the ending felt right. Julie, however, seemed to acknowledge that there could be further exploration or change in their language, but that they were not able to do this at the time.

> *"I guess nearer the end, when we (...) felt like we'd already done everything we could, I perhaps felt like you were talking about things that...looking a bit too much into things..." Julie, p.10*

Julie's feeling that things had come to a natural end may reflect her feeling that she became too much of a focus towards the end of therapy. Here she talks about looking into things 'too much'. She talks about having done everything they 'could' rather than having completed the work. This may reflect that Julie could not bear to expose herself further, as well as the idea of family life as an on-going process of relating which is never 'complete' as such.

2.2 Superordinate Theme 2: Moving from blame to responsibility
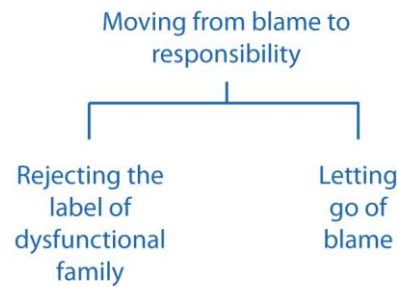
Figure 6. Thematic map for Superordinate theme 2

The second superordinate theme, "moving from blame to responsibility" encompasses the various ways in which the themes of blame and responsibility were talked about by family members in relation to therapy and how this impacted on their experience of therapy. The theme of blame and responsibility emerged from all three transcripts in different ways and appeared to be an influential aspect of the experience, for example impacting on the levels of safety. The perception that the family was labelled as 'dysfunctional' appeared to be associated with an assumption that the family was to blame for Julie's anorexia. A key aspect reflecting the importance of the theme of 'blame', was the family's identity as a 'perfect family'.

> *"Because, I don't know, everyone's got this idea we are the quite perfect family really. And I tend to think we get on very well together the four of us and we have a very nice balance" Julie, p. 16*

The idea of being 'dysfunctional' therefore represented a threat to the family's identity as 'perfect'. Joan described her own and Paul's upbringings as rigid, and feeling that they were expected to parent their children in the same way. However, Joan acknowledged that the family did have some role in the problem, and - unlike Paul - acknowledged that the therapy was for everyone in the family, while also feeling that Julie's needs were the main point of the therapy:

> *"I thought well it's for her, it's not our(...)- well, I suppose it is for everybody, but,*
>
> *I just felt that if (...) she felt she wasn't getting much more from it, then there's*
>
> *no point" Joan, p.29*

In contrast, letting go of blame was associated with the idea of taking responsibility for problems. As such, Joan, acknowledging some degree of familial 'culpability', was able to let go of blame to a much greater extent and therefore perhaps felt safer to explore her own role in the family.

2.2.1 Subordinate theme 2.1: Rejecting the label of a 'dysfunctional family'

Julie and Paul both felt there was an implication that they were 'dysfunctional' as a family and this appeared to leave them feeling a little distanced from the therapeutic process. This reflects their initial response to being invited for family therapy that it would not have much to offer a family like theirs, who 'did not have a problem'.

> *"I was probably holding two or three different not necessarily quite compatible*
>
> *thoughts. Slightly sceptical as to whether we had a problem if you see what I*
>
> *mean as a family but very happy to help [Julie]..." Paul, p.3*

In this quote, Paul struggles to make sense of his position on the family's role in the 'problem', preferring to emphasise his wish to help his daughter. This captures his ambivalence about attending therapy: wanting to help, but not wishing to be labelled as a 'problem family'. The rejection of the idea that there might be a problem at the level of the family recurred throughout the interview. Here he talks about telling some closer colleagues about attending family therapy:

> *" [saying]nice things about it being supportive but I thought probably we of*
>
> *course as a family did not have a problem and that really it was about*
>
> *supporting Julie" Paul, p. 13*

The theme of labelling therapy as about helping Julie with 'her problem' recurred throughout the interview. The focus on helping Julie with her problem was interpreted as partly driven by needing to protect against this threat to the family identity as 'perfect', or even normal. Both Julie and Paul talked about feeling that

their family got on together very well, and rejected the idea that they had a problem as a family, because they did not argue.

"I mean I think people outside probably perceive that we are fairly together. You know families are quite good at that anyway aren't they." Paul, p. 21

Julie's own beliefs about the family may have left her feeling more responsible for her problems and the impact this had on her family. Julie clearly worried about being seen by others as selfish or spoilt and referred to this several times in our interview. Here she talks about feeling dependent on her parents:

"very dependent upon my parents for a lot of things. Not in the sort of money aspect or kind of, you know... Sort of like wasn't a spoilt way. It was more kind of like they were my carers." Julie, p.6

Julie and Paul also talked about feeling that family therapy was not right for them, because of an expectation that it was meant for 'dysfunctional families'.

"I probably thought, we didn't fit into the- into a model of a dysfunctional family." Paul, p. 3

[It was meant for] "Like families from Eastenders or something because our family's never been like that." Julie, p.4

Interestingly, family therapy was indeed portrayed on Eastenders in 1990, when Pat and Frank Butcher went to family therapy with their daughter Janine (Reimers et al., 1995). Although this would have been broadcast before Julie was born, one wonders whether this episode has seeped into the national psyche, or at least the Smith family psyche somehow.

2.2.2   Letting go of blame

Joan did not talk about 'dysfunctional families' or a sense that her family identity had been threatened. Joan did talk about moving on from ideas of blame about Julie's anorexia as a parent. She spoke about being given lots of positive feedback by the

therapists and letting go of blame and this was associated with being more able to explore herself in therapy.

"with something like mental illness you- immediately assume it's your fault. I suppose over the years with CAMHS and family therapy, you realise that actually, that's not what it's about, it's not putting blame anywhere" Joan, p.20

Joan talked about learning not to blame herself for her daughter's problems and a growing sense of confidence in her ability to help her daughter as a result of positive feedback in therapy. This enabled her to become much freer in her thinking and engage with the process of therapy, without being concerned with being blamed or criticised.

"You think well actually, I'm the one having to cope 24 hours with this, um, and actually, here's some really nice people in a room who are giving me attention and actually praising what I do, and making me feel well ok, maybe what I did wasn't too bad after all, so, yes, I think from that point of view, I think it's really really important..." Joan, p.30

Joan talks about needing attention and praise for caring, in order to allow herself to let go of the idea that she is doing it all wrong. She talked about feeling validated by this, which brought a sense of calm to her and which was noticeable in her voice when I listened to the interview.

In addition to feeling less guilty about Julie's anorexia, this also fed into her relationship with both her children, whereby she was more able to allow them to be responsible for themselves as adults. She linked her anxiety about letting go of her children as related to the expectations of her within her family of origin:

"there's still very much a part of me, like my mother would expect me to do things and in a way, I've had to learn myself to relax a bit more, (...)unless somethings life threatening, to sort of be more flexible" Joan, p.18

Julie also talked about feeling that people had not been blamed within the therapy, which she appreciated. This appeared to be associated with her feeling more able to talk in therapy without fear of being blamed for the distress of the family.

> *"I thought perhaps there might be attempt to put blame somewhere...and there wasn't and I thought it was quite good. Cause there was no one blamed." Julie, p.6*

Julie's talk seems to reflect a worry that blame would be placed in the family by those outside of it, and relief that this didn't happen. As such, Julie came with an expectation of being blamed but the fact that this wasn't fulfilled facilitated a greater sense of safety for Julie.

2.3   Superordinate Theme 3: Exploring the family landscape
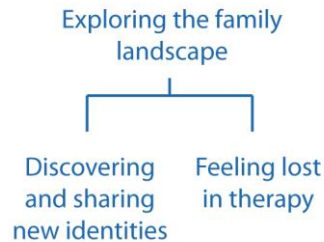
Figure 7. Thematic map for Superordinate theme 3

The third superordinate theme is exploring the family landscape, and encompasses two subordinate themes: feeling lost in therapy and discovering and sharing new identities. Exploring the family landscape illustrates the importance of the family's use of language relating to 'journeys' and place in their talk about their experience of exploration in therapy.

> *"I think having family therapy has been a place to explore that [Julie's progress]. And a place where we could talk out some of the phenomena …that we encountered in that journey" Paul, p.17*

Discovering and sharing new identities in therapy was a particularly powerful theme in Joan and Julie's transcripts. Both described the development of new identities within the family, as an adult daughter and a mother of adult children. This theme was strongly related to the processes of letting go of blame, unravelling of feelings and seeing things differently. In contrast, Paul did not talk about his own identity in therapy, and in fact expressed disappointment that he and his family history were not explored in therapy. Feeling lost in therapy encompasses his attempts to understand the process of exploration in therapy, as well as Julie's experience of feeling lost or stranded at some points in therapy. This experience of feeling lost was related to the theme 'rejection of the label of dysfunctional family'. As such, their

rejection of the idea of a problem in the family made it difficult for Paul and Julie to understand their roles in therapy or to feel grounded in the process.

2.3.1   Subordinate Theme 3.1 Discovering and sharing new identities in therapy

Julie talked about developing herself and her confidence as a positive experience in therapy. Everyone in the family talked about Julie's 'recovery journey' and there was a sense from everyone in the family that this entailed Julie becoming more confident and independent.

> "...wasn't too sure if I'd be able to cope on my own with my problems, but I'm starting to feel a bit more independent..." Julie, p. 15

This seemed to be related to the family managing to make the transition from a family with children to a family with adult children and the change in roles that this brought:

> "I don't think I was very...you know my own person now and this was...Yeah, I guess it's sort of like [...] letting me go really..." Julie, p.26

These extracts show how her developing independence is a product not only of change within herself, but also of her parents allowing her the space to develop. In both extracts, through her use of tense, she locates being dependent on her parents in the past, while her developing independence is located in the present, suggesting it is on-going and incomplete. This perhaps reflects the family's experience of family therapy as part of the on-going journey of family life. Joan also talked about the idea of 'taking the cotton wool off' and allowing Julie more independence:

> "I think Julie wants to kind of um, become more, independent, and make her own decisions" Joan, p.23

Joan described family therapy as providing an opportunity to develop her sense of self and to share this with her daughter.

> "I suppose I feel that... family therapy has unveiled me not just as a mother, but as a person..." Joan, p.17

Again, this was related to Julie's transition to adulthood, and the development of Joan's role in the family beyond that of a mother of young children.

> *"you suddenly find your children are 20 and 18 and you realise they're not little anymore, then you can actually talk to them in a more, grown up way, and you know (...) they perhaps can give you advice and help you, which is really nice."*
> *Joan, p.19*

Joan talks about changing the way that she thinks, as well as the way that others see her. As such, she has been 'unveiled' both to herself and to her daughter, in particular. Like Julie, she talked about this as an on-going process, neither perfect nor complete:

> *"I've got a long way to go, but I think, family therapy, has kind of enabled me to think a little bit more, as a person rather than a mother,"* *Joan, p.18*

In addition to discovering new territory, Julie and Paul described feeling lost in the process of exploration that therapy involved. While Joan felt comfortable with this, perhaps due to not fearing being blamed any longer, Julie and Paul struggled to ground themselves in the process.

2.3.2   Feeling lost in therapy

Everyone in the family talked about wanting to help and support Julie in her recovery and this was clearly the focus of the therapy in the family's eyes. However, whereas Joan felt that part of meeting Julie's needs was to meet her own needs as a carer, Paul felt that attention to his wants and needs would detract attention from this.

> *"I also remember being very conscious that it wasn't supposed to be a place where I spent my afternoon enjoying myself talking about the things I was interested in."* *Paul, p. 12*

Paul also talked about finding it hard to follow the process of therapy when there was a lot to think about while trying also to listen to others.

> *"Sometimes I got a bit lost I mean because as you listen you start thinking and then some people said other things and you start thinking about that and then you get asked a question about the first question and you think what was I thinking..."* Paul, p.9

This extract highlights how Paul spent a lot of time reflecting on conversations, but found that this sometimes got in the way of voicing his own thoughts. As such, he got lost in his own internal conversation and when an attempt was made to draw him into the conversation, he had to find his way back. In part he reported that this was due to a lack of familiarity with such processes. Paul referred to various ways in which the therapy process was at odds with his usual experiences as a man and a biologist. Paul talked about feeling he would not be good at the open conversation required by the therapeutic process:

> *"I think that probably I have a pre judgement that women are good at open conversation(...)that very open style it seems slightly un-unmale [laughs] just a prejudice I think"* Paul, p. 7

Here, Paul describes the therapy process as un-male, in contrast to Joan's description of therapy and the CAMHS environment as familiar. In addition to his assertion that women, not men, are 'good' at the open conversations required for therapy, Paul also explained that he didn't really understand the basis of the therapy, leaving him feeling a little unsettled.

> *"...because I am a biologist by background I just feel slightly unsettled that I don't quite understand the theoretical basis for what one is going through."* Paul, p. 23

Finally, Paul spoke about not knowing where they were on the journey of therapy, which added to his sense of being lost:

> *"I didn't have a very strong sense of what the beginning and the middle and the end of the process was"* Paul, p. 23

Julie also seemed to experience feeling lost towards the end of therapy when she described feeling that she was left to do all the talking in therapy by her parents. Interestingly, Joan told me that near the end of the therapy, their main therapist had left for another job, and I wondered whether this had left the therapeutic space feeling 'knocked off balance' for Julie or perhaps this had just disturbed the team and the family's roles enough to leave her feeling stranded.

> *"...the therapist would ask stuff and often I was left to answer quite alot of stuff...nearer the end. Felt like my parents didn't really say much, they just sort of sat and listened to me and I guess I didn't really like that." Julie, p.14*

There is a sense in this quote that Julie felt the space needed to be filled and that it had become her responsibility to fill it. This loss of balance seemed to leave Julie feeling over-exposed towards the end of therapy.

2.4 <u>Summary</u>

For the Smith family, therapy was described very much as part of their journey. Therapy involved exploration and personal risk taking, which they felt would not have been possible without a level of safety and security in the therapeutic relationship. Different members of the family described differing levels of safety and this was associated with the risks they were willing to take in therapy. The theme of blame and responsibility had an impact on safety, and diminishing the sense of blame in therapy was associated with an increased sense of safety. Paul was least familiar with the CAMHS setting, and described feeling somewhat lost as a result of not really understanding the process or the theoretical underpinnings. Joan on the other hand valued the opportunity to explore her relationships, while Julie did so too, although at times towards the end, she seemed to feel 'over-exposed' to the process, which may partly have arisen due to a change in therapist.

3   Case Study Two: The Jones'
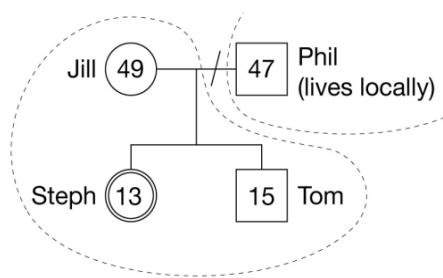
Figure 8. Genogram for the Jones family
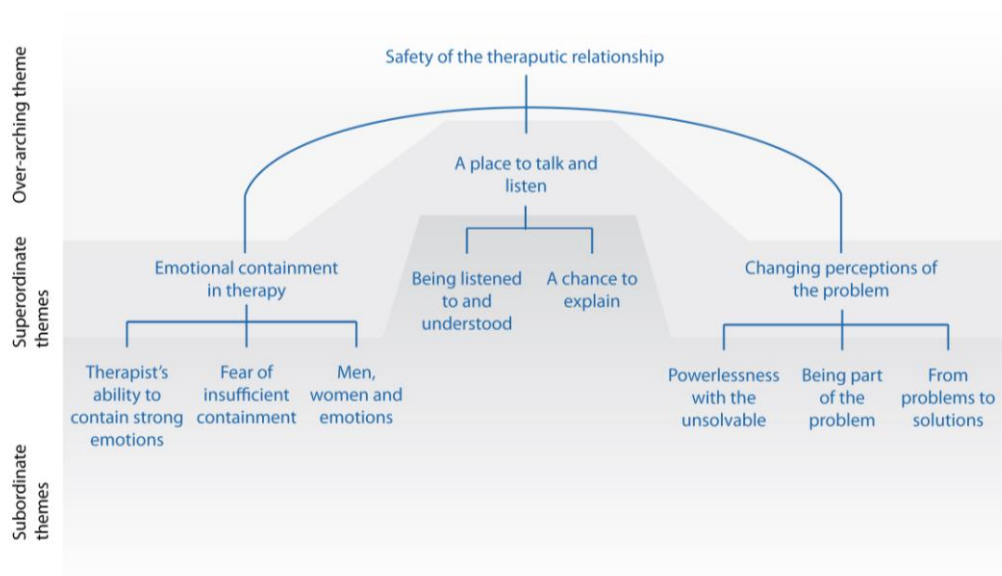
Figure 9. Thematic map for the Jones family

Three superordinate themes emerged from the Jones family's interviews: emotional containment in therapy, a place to talk and listen, and changing perceptions of the problem. The superordinate and subordinate themes describe different aspects of therapy made possible by the strength of the therapeutic relationship. Thus, the emotional containment provided by the therapist was key to allowing the family to talk and listen to each other and therefore to explore the problems they were having. The family's worry that there would not be sufficient emotional containment highlights the importance of this in being able to talk, listen and explore in therapy.

3.1 Superordinate theme 1. Emotional containment in therapy
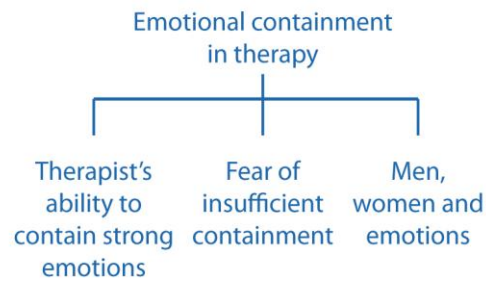
Figure 10. Thematic map for Superordinate theme 1

The Jones family all spoke about therapy as being a place where people are able to talk calmly, without getting angry or shouting at each other. This may be related to the presenting issue: that Jill and Steph had been having a lot of arguments.

> *"Cause like there I wouldn't argue because like I wouldn't shout, because I wouldn't wanna embarrass myself." Steph, p.28*

Jill makes a helpful distinction between being emotional in 'a controlled fashion' and shouting at each other, as they may previously have done:

> *"we've cried, we haven't shouted but we've got very emotional, be it anger, be it frustration, be it whatever, and you know it has been, but in a controlled fashion," Jill, p.23*

Steph sheds further light on this, when she describes how she, her mother and her brother respond to expressing emotions at home:

> *"normally [...] we do get a chance to talk, but if we're like talking about it and we get like, not into an argument, but we're like sort of trying to... express ourselves and then [brother]'ll be like, 'Oh don't argue.'" Steph, p.14*

As such, while Jill and Steph want to express themselves, Tom cannot bear this and tells them to stop. This perhaps reflects the strong gender divide in the family, particularly in the ways in which they manage and express their emotions.

Jill also spoke about feeling she needed emotional support from the therapist, in the context of being a single parent, and therefore not being able to get any emotional support (although he maintained regular contact with the children) from her ex-partner.

> *"I feel like a single mother... And emotionally I have no support emotionally from [father] so I just kind of really felt like oh I want, I need some emotional support here." Jill, p. 6*

Jill repeatedly refers to the emotional in this quote, perhaps demonstrating how the emotion was too overwhelming for her alone (a 'single mother') at that time, and needed to be shared with someone – in this case the family therapist. So Jill came to therapy wanting help in containing her own and her daughter's emotions.

The importance of the therapist's ability to contain the emotional content of sessions was highlighted by the family's description of initial worries about whether she would be able to do this. In particular, the family worried particularly that the therapist would not be able to offer enough - or perhaps the right kind of - containment for Tom and Phil. Consequently they worried that the men in the family wouldn't be able to talk and explore their emotions in therapy.

3.1.1 Subordinate theme 1.1. Therapist's ability to contain strong emotions

Jill and Steph both talked about their hopes to improve their relationship, with the support of an outsider to contain their emotions in doing so. The therapist's calm air was an important element of helping them to be calm.

> *But [therapist] just has this real air of, that you could, literally trust her with your life, sort of thing. She's so calm as well, I'd love to know if she's like that at home [laughs] probably isn't at all. But she's a really calming influence." Jill, p.20*

Jill initially hoped that therapy would help her to understand Steph's behaviour and feelings, and that it would give her the opportunity to talk with her about the break up of her marriage safely.

The Jones family were able to talk about positives as well as negatives about each other in therapy. Conversations in therapy therefore gave rise to strong emotions, from warmth, love and happiness to anger, anxiety and shame, particularly for Jill and Steph. Jill clearly worried a great deal about whether she was a 'good enough' mother to her children, and any sort of feedback about this elicited strong emotions, both positive and negative.

"…we were able in certain sessions to sort of tell each other that we appreciate each other and that we do love each other and you know my, both of my children have actually said to me in those sessions, you know we wouldn't want to change you for the world mum, sort of thing." Jill, p.39

Tom highlights the importance of the therapist containing the emotion in the family through being a quiet, calming influence and the way she spoke to the family.

"She was like really calming and she was like quiet. And really clear with what she was saying...Like nothing was ever really like, didn't really make any of it... like upset anyone, because the way she'd say it, she'd put it in a really calming way." Tom, p.11

In this quote Tom describes how the therapist's manner allowed her to contain their emotions and not upset anyone.

3.1.2 Subordinate theme 1.2. Fear of insufficient emotional containment

The Jones family expressed a number of worries about whether they would be able to benefit from therapy. Steph talked about worries that therapy would feel awkward, and that they would not benefit from it.

"I was thinking that it was gonna be really awkward just like letting my feelings out like to a complete stranger," Steph, p.17

In this quote, she talks about her uncertainty in talking about her feelings with a stranger. The origins of the word 'awkward' are meaning in the 'wrong direction' and Steph's use of this word to describe her expectations may suggest that she

worried the encounter would go the wrong way. Perhaps, for example, she worried that the therapist would not be able to contain her emotions in the way she hoped, preventing the therapy from being successful.

Tom worried about the impact that expressing his feelings would have on his father if he were to come to therapy. Although Tom talked in his interview about the therapist being able to communicate difficult things calmly, so that people don't feel upset by them, he still worried that his father will be upset by what he and his sister had to say.

> *"I think it would be quite awkward. Cause I'd permanently be thinking, he's thinking, oh why are they saying it like... blah blah blah... [missing text]... whenever I'm in a situation like that I feel like all the blame's gonna go to me."*
> *Tom, p.19*

Like Steph, Tom starts by describing the encounter as potentially 'awkward'. He refers throughout this quote to what he will think or feel about what his father is thinking. He doesn't refer to actual things said or done to make him feel this way, suggesting that he may - at least partly - be attributing the blame and feelings to himself. Moreover, he doesn't suggest that others in the family overtly blame him for things, but rather that the blame will 'go to me', almost as if the blame acts of its own accord rather than being directed by anyone. Indeed, Tom does seem to be accepting responsibility for problems in his father's communication with the children, possibly as a result of the gender split in the family. His discomfort may also reflect a sense of being disloyal to his father, in the context of clear gender-based sub-groups in the family. Thus, although Jill acknowledged that it would be helpful for both children if their father was able to attend therapy, his attendance is hinged on "the boys'" problem.

3.1.3   Superordinate theme 1.3. Men, women, and emotions

The family spoke about gender differences in talking about and managing emotions. As such, the dominant narrative for the women in the family was that women talk

and manage emotions and men don't talk and don't manage their emotions, instead becoming depressed.

> *"I'm glad I'm not a boy [laughs], [...] with a dad that's exactly like that because they can't express their feelings at all and I think that must be so hard." Jill, p.25*

In particular, it was expected that the men in the Jones family would not be able to talk about their emotions and therefore would not be able to make use of therapy.

> *"I'm worried [father] will sit there and say, say nothing on an emotional level and [son] will sit there and say nothing. I don't know how she's [therapist] going to tap into their emotions," Jill, p.34*

Jill and Steph were so convinced that Tom would not be able to manage his own emotions that they worried when he wanted to spend time alone that he was not coping because he was not talking. Tom on the other hand, saw this as a normal behaviour and placed it in context – that he liked to spend some time alone after school. However, it was only when this was validated by the therapist that Jill and Steph accepted this behaviour. As such, the therapist could be seen as acting either as a translator or advocate for Tom in the family.

Tom's perspective seemed to be that women talk and don't manage their emotions, while men manage their emotions and don't talk!

> *"It's like almost like I don't have a choice. Like I wouldn't go round there if I had a choice. But it's not like that. I mean like [sister]... cause [sister] wants to see him as often as she can, but to me I... I'd much... I'd rather see him once a week or once every other... like every other week than three times a week[...]" Tom, p.16-17*

> *"Like they think... like I feel like if I... if I didn't go round there so often we'd have more to talk about." Tom, p.17*

The Jones family also had a strong expectation that their therapist would be a woman, and all found it hard to imagine what a male therapist would be like. Tom's

assertion that he expected the therapist to be a woman was the strongest example of this:

"I thought it would be a woman. I knew it would be a woman." Tom, p.5

There was also a strong belief that it would be more difficult to talk to a male therapist about emotions, as is clear in the following quote from Jill:

"in a way I feel the more sort of maternal influence possibly is, is easier for people to open up to, and I would say possibly for children or teenagers maybe that would be applicable, I don't know." Jill, p.21

The importance of gender may relate to the extent to which experience is shared across genders. As such, Steph describes how she believes a female therapist would know more about women, and therefore be easier to relate to.

"No, I don't know, I dunno, I wouldn't like it. I don't know, I just knew women knew more about women than men did. And I don't know, I can just relate more to a female therapist than a male therapist. We were saying like that he must feel really like separated and like cornered out, because he's like the only male." Steph, p.19

She also notes how it must be difficult for her brother to relate to a female therapist, suggesting that the key issue is one of difference between therapist and client, rather than whether men or women are better at talking about emotions.

3.2 Superordinate theme 2. A place to talk and listen
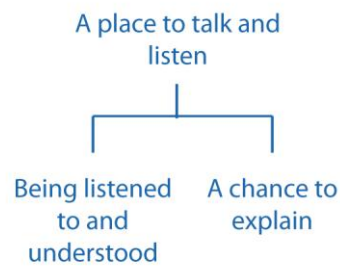
Figure 11. Thematic map for Superordinate theme 2

This theme covers the Jones family's experience of therapy as a place to talk and listen. The emotional containment provided by the therapist allowed them to talk and listen in a way that was different to the usual communication at home. A key element of this was being able to talk about things without 'flying off the handle':

> *"what I find is just it's brilliant because you have a really proper conversation and, and you listen to each other and you make time for each other and nobody flies off the handle and you know." Jill, p.8*

The family described taking the time out to talk as a new experience, which they struggled to find time for in their daily lives. Here, Steph emphasizes not just talking but also listening, which emerged as two sides of the same coin in this experience for the family. As such, being able to talk calmly was one aspect of the therapeutic conversation that was new, but listening and being listened to was another.

> *"I think it's more like you take - it makes you take time... like take an hour out of your day to actually talk about it. And actually like listen." Steph, p.28*

Tom also emphasized the importance of the therapist's presence in doing this. The presence of an outsider seems to allow him to give his opinion for the first time:

> *"I don't really know, like we've never actually sat down and spoke to anyone about what was going on before... That was like when you got a chance to*

> *actually give your opinion... on what was going wrong and what you could do to*
>
> *make it better" Tom, p.13*

Feeling that they were listened to and understood helped the family to take up the opportunity to explain their own points of view to each other and listen to these.

3.2.1 Subordinate theme 2.1. Being listened to and understood

The family all felt that they had been listened to and understood by the therapist and - as a result - by each other. Jill described part of the therapist's role as being a witness for what was said in therapy, so that it was 'like everything you say is in writing' (Jill, p.40).

> *"…you have a witness for everything that's said. So I think you have to be more*
>
> *accountable for everything you're saying, which makes it all that much more*
>
> *meaningful." Jill, p.40*

Here, Jill talks about the ways in which this 'witnessing' was helpful to the family in therapy. The therapist's presence kept everyone calm during sessions, so that no one 'flew off the handle' and therefore things said in therapy were seen as carrying more weight and felt more meaningful. Secondly, the family were able to explore the meanings of what was said more fully in the therapy room.

Tom talked about the relief he felt when Jill and Steph were able to listen to his voice in therapy on this and other issues:

> *"…the only way... like the only way of me getting [sister] and mum to listen to*
>
> *something that I've gotta say is if [therapist] tells them what I've said, because*
>
> *they don't listen to what I have to say." Tom, p.10*

Tom shows in this quote, that although he has things to say, he is either unable to say them, or they don't get heard by Steph and Jill across the gender divide. In therapy, the expectation that Tom's reluctance to talk about emotions with his family was challenged and Tom's behaviour was normalised, enabling new understandings to be developed.

Steph again highlights the importance of explaining things to someone outside the family, who was listening and taking in what she was saying:

It was nice just to sort of explain to someone else who like wouldn't take sides,....[...] And that's because they like actually listened... Like actually took in what you were saying." Steph p.13

The ability to talk and be listened to helped the family to explore their relationships in greater depth than they had done in the past.

3.2.2   Subordinate theme 2.2. A chance to explain

The Jones family all felt that therapy had given them a chance to explain things to one another, which they hadn't been able to before. Tom notes that the therapist's neutral stance was important in allowing them to talk as a family:

 "…it's easier to sort of talk about it there than it is around each other, cause there's someone in the middle [...]like a mutual person, that isn't biased to either person" Tom, p.15

Tom's experience of the therapist as unbiased shows how everyone's views were given equal weight by the therapist, allowing everyone a chance to be heard by each other.   Steph also spoke about the neutrality of the therapist as a facilitative condition for talking about family relationships:

"they don't know anything about like your past, so they don't take sides." Steph, p.18

The neutrality of the therapist allowed the family to talk about their relationships and events in the family's history in a new way. Jill also spoke about being able to talk about family events for the first time in the context of therapy:

 "I was really pleased that it came up because I was able to say to my son, you know you weren't to blame for that...I was able to give him an explanation that actually I had never given him." Jill, p. 16

This chance to explain was described as a cathartic experience, as well as helping the family to understand each other better. Steph described a clear sense of catharsis when she spoke about how talking in therapy allowed her to 'let everything out':

"I think talking about it helped.... Talking about it let it all out." Steph, p.28

Tom experienced therapy as validating his point of view so that his voice was stronger in the family. It was almost as though the therapist was needed to translate his message. As such, therapy allowed him to explain and for the explanation to be understood by his mother and sister.

"But when I can talk... when I can actually give my point across cause someone's listening to it that helps." Tom, p.10

Tom highlights here the importance of having somebody who is actively listening to him in order to get his voice heard. This may be one reason for his not talking at home: it is only helpful to talk as long as someone is listening, and perhaps the gender divide in the family stops this from happening.

3.3   Superordinate theme 3. Changing perceptions of the problem
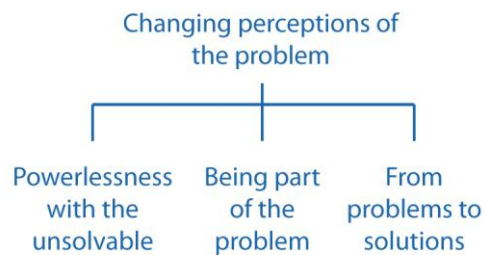
Figure 12. Thematic map for Superordinate theme 3

This theme aims to capture the varied ways the Jones family related to the problem as they explored it. There was a sense from all family members that exploring and understanding the 'problem' was an important part of therapy. The family initially attended therapy due to escalating arguments between Jill and Steph, which left Jill feeling she was 'out of control' of her daughter. At one level, Jill simply wanted to know if there was a significant problem, or whether her children were just displaying 'normal teenage behaviour'. At times, she became quite distressed talking about her worries about the children's futures. The reassurance she gained from therapy was in itself one part of the solution.

> *"You know it's not like we're all… I think we're actually quite a normal family,*
> *but I just needed to know that... You know I needed someone to tell me that."*
> *Jill, p.7*

Steph also talks about the therapist as knowledgeable of teenagers and therefore being able to normalise teenaged behaviour:

> *"... and I just think she like... she knows so much about like teenagers. She's*
> *always like, 'Oh yeah, that's... that's just teenagers and stuff.' " Steph, p.18*

This need for reassurance seemed to lead to a close examination of family life for significance, meaning and problems, which initially had helped to understand the 'problems' the family brought to therapy. Jill talks about the process of searching for

significance and meaning in therapy, which reflects the importance of coming to an understanding of the problem that had brought the family to therapy.

"…sometimes it's a little bit frustrating cause you have to sort of flounder around, touching on things that didn't, that don't really matter, and then every now and again you, you sort of hit a real significant one." Jill, p.22

Jill described feelings of frustration in the floundering, but reported that she was able to bear this in order to find the significant issues and understand them.

3.3.1   Subordinate theme 3.1. Powerlessness with the unsolvable

There was a theme of powerlessness about certain aspects of family life that could not be changed. This theme may reflect an underlying issue of adjusting to life as a family with separated parents. Jill in particular worried that there might be 'unsolvable' problems and described thinking about the impact this could have on her children as very distressing.

"…if there's things that are making my children unhappy that I can change, I am all pre, more than prepared to do that, but some of them I can't." Jill, p.37

This quote comes from a passage where Jill was discussing things about herself that her children would like her to change (for example being disorganised), but which she didn't feel she had the ability to change.

Later on in the interview, she discussed Tom's relationship with his father as another issue she felt powerless to facilitate change. The children's father brought up a theme of powerlessness for everyone, as the family felt he wouldn't want to come to therapy, and wouldn't change. Here, Tom talks about what would happen if he came to therapy and describes his belief that his Dad would either respond well or just carry on as before, although there is a sense that there would be more negative consequences if he didn't respond well.

"he'd either be like when he'd pick us up, he'd permanently be in a good mood, cause he knows it'll make everyone else in a good mood, or he'd feel like, well if

that's what you think that's your problem and then he'd just carry on how it

was." Tom, p.18

Steph remembered becoming emotional in sessions when she heard her mum's side of the story and came to understand more about how her mum was feeling. Again, there is a worry about that which cannot be changed: although Steph resolved to change for the future, there was a sense that she couldn't take back the hurt that had already been caused to her mum.

"…when she said, "Oh, luh luh, luh," and then I feel bad and like I'd hate to make

her feel like that and I didn't know I had." Steph, p. 16

Here, she uses the conditional tense when says she <u>would</u> hate to make her mum feel like that, implying that this was a possible future action, but then switches into the past tense, acknowledging that this is something which has in fact already happened.

3.3.2 <u>Subordinate theme 3.2. Being part of the problem</u>

The second subordinate theme relates to the family's experience of understanding their own role in the problem. Jill described this experience as painful to admit that she wasn't perfect, but wanted to know about things she could do for her children, so that she could try to change.

"But as a mother you know I do my, I just try so hard and when they criticise me

it's horrible." Jill, p.13

Jill and Steph talked about a process of discovering and understanding their own role in the problem. Jill found it hard to hear that her children saw her as having a role in the problem, and described feeling defensive about this. This seemed to be related to her fears of being a bad mother, particularly when she worried that she wouldn't be able to change.

"...and [son] said, oh this is what we were talking to the counsellor about, it's always chaos around here. So immediately I felt really upset and defensive about that" Jill, p.11

Steph talked about the impact of listening to her mother's side of the story in therapy. It was this different kind of listening where she was able to take it in which made an impression on her.

"it was really good, because like it um... it made you listen to each other. And it like instead of just hearing it you actually like listened. That makes no sense [laughs]. Like you heard it...... obviously, but you actually like took it in. And it... like it made an impact." Steph, p.21

Tom, in contrast felt that the family didn't need any help, and that they should be able to simply leave things alone. His solution, quite at odds with the solution of attending therapy, was to not talk about things. In this quote Tom makes clear that he had found his own solution by not 'bringing up conversations':

"I didn't feel the need to change like myself... Cause I sort of keep myself to myself and I don't go round...bringing up conversations or anything..." Tom, p.20-21

Here, Tom suggests that the problems have been created by talking, perhaps alluding to the idea that Jill and Steph have constructed a problem in his relationship with his father during therapy. As such, Jill and Steph defined Tom as part of the problem, in part worrying that there was a problem because he *wasn't* talking. Tom rejected this idea, feeling that he just didn't have anything he wanted to say. Therapy therefore presented him with an opportunity to challenge the idea that he had a problem, which seemed a relief.

3.3.3   Subordinate theme 3.3. From problems to solutions

An important shift for the family was to realise that they could be part of a solution, even if the solution was to agree that there wasn't a problem (in Tom's case). Tom

spoke about getting a chance to give his opinion and finding out that he and his sister shared some of the same opinions, strengthening their voices in the family.

> *"me and [sister] agreed with our opinions and what could be done to make it better like. more than I realised. <u>I don't know</u>. Cause I don't really know, because we never actually speak about it to each other away from..." Tom, p.13-14*

Steph also spoke about how her understanding of how her behaviour made her mum feel made her stop and think. This in itself seemed to give her the power to control her own behaviour towards her mother:

> *" if I was arguing with her... or with mum [...], it'd stop and I'd think like this is making her feel like however she said it was making her feel." Steph, p.22*

Jill talked about how her understanding of the problem (that Steph was trying to bring the family together), helped her to realise that there were things she could do to improve the situation. At times, she felt that it was an impossible task, which would have to be sorted out by someone else, but at other times, her talk was more confident.

> *"But now I feel like there's a whole other side to it, you know we are a family at the end of the day and I think I forget that, we are still a family even though [father] and I don't live together, you know there probably should be a bit more communication going on around the kids and stuff. " Jill, p.29*

In this quote, she says she forgets that they are still a family including her estranged husband, and this possibly reflects the way that she often forgets that she has the strength to affect things that happen in the family. Tom had a strong feeling that the family should be able to sort problems out themselves, rather than having to go to a counsellor again in the future.

> *For us, it's like it's not... we sort of need to actually sort it out ourselves. We can't keep going back every time something goes wrong, you can't keep going back to [therapist] to sort it out. <u>We need to sort of take note of what</u>*

> *everyone's saying and sort it out ourselves.* Like take some initiative and
> actually sort it out between us. We don't need someone... we don't necessarily
> need someone to sort out every single problem we've got. *Tom, p. 25*

Tom clearly identifies the task of therapy of listening to everyone and then 'sorting it out' and feels that they should be able to do this without the containment of a therapist in future.

3.4   Summary

The Jones family described a mixture of expectations about therapy, including hopes about what it could achieve and fears about things that could potentially obstruct the process, such as gender expectations. They formed a particularly strong therapeutic alliance with their second therapist, which allowed them the safety to talk about strong emotions, and difficult events calmly and thoughtfully. They found it helpful to come to a greater understanding of each other and their relationships, which allowed them to feel that they could make changes to help each other as well. Therapy also served an emotional need for the family to have their emotions contained and there was a sense of catharsis associated with being able to explain their points of view, and to be listened to without the conversation escalating into an argument. Therapy therefore provided a somewhat different space to home where things could be talked about safely, and everyone could listen to each other without flying off the handle. Perhaps one reason Jill was anxious to keep the contact going was that therapy was the only place where such things could be talked about safely.

Discussion

In this section I will review the main findings of the research in the context of the existing literature. Firstly, I will present the findings relating to Friedlander's (2006) model of the therapeutic alliance in family therapy and the factors which may impact on individual experiences of this. I will also consider how the results of this research and previous research can inform our understanding of the relationship between the therapeutic alliance, the stated 'content' of therapy, and outcomes. In the latter half of this discussion, I will offer some reflections upon the strengths and limitations of the study and discuss the clinical and research implications of the study.

1   Main findings

This research found further evidence for the importance of the therapeutic alliance, from the perspective of families in therapy. The themes identified fit well within Friedlander's (2006) model of therapeutic alliances in family therapy, and reflect the unique nature of the alliance in family therapy as opposed to individual therapy. As such the alliance reflects not only individual relationships with the therapist, but also the family context and the family's relationship with the therapist. Family members described all the dimensions of the alliance proposed by Friedlander et al. (2006) as beneficial. Family members also cited these as factors which impacted upon their experience of exploring their relationships in therapy. In particular, the dimensions of 'emotional connection with therapist' and 'sense of safety within the family therapy system' appeared to be fundamental to engagement with therapy. As such, rather than all four dimensions being equally important, as suggested by Friedlander et al (2006) the findings of this research suggest that the dimensions of 'engagement in the process of therapy' and 'shared sense of purpose within the family' may be possible only when the fundamental dimensions are in place. Experiences of these dimensions appeared to vary within the families interviewed, according to the position in the family (e.g. children as compared with parents) and gender. As such, existing knowledge and experience that family members brought into therapy impacted upon their subsequent experiences of therapy. The variation in these

aspects appeared to be related to individual reports of outcome of therapy. The relationship between the different dimensions is presented in Figure 13 below. In this discussion, I will first explore the nature and importance of emotional bonds and emotional safety in the therapeutic alliance, then the impact of gender on individuals' experiences. Finally I will discuss the relationship between the alliance, the 'tasks' of therapy, and the variation in outcome.
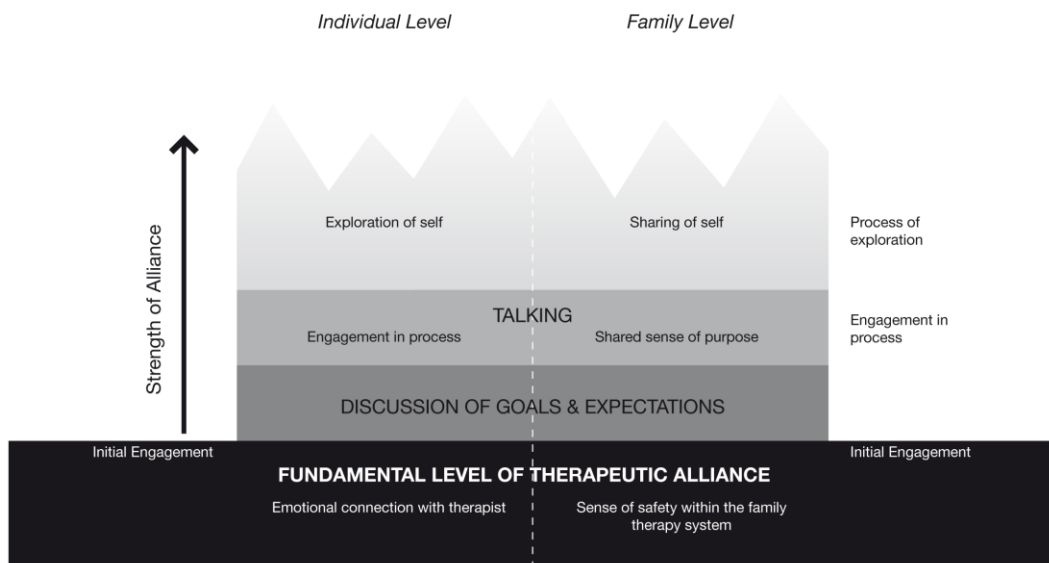
Figure 13. Possible mechanisms for the relationship between alliances and process of therapy

1.1 The therapeutic alliance in Family Therapy

The findings of this research suggest that - for the families in this study at least – the therapeutic alliance was an important aspect of the experience of family therapy. Moreover, the findings suggest that the therapeutic alliance may be related to outcomes of family therapy. The results further support Friedlander's (2006) conceptualisation of the therapeutic alliance in family therapy. In particular, family members in this study clearly described an emotional connection with their therapist

and a sense of safety within the family therapy system, as key to their ability to explore their relationships in therapy.

1.1.1 Emotional connection with the therapist

The families in this study highlighted the importance of the family's experience of the therapist as warm, understanding, empathic and non-judgemental. Previous researchers have reported similar descriptions of successful family therapists (Campbell, 2004; Howe, 1989; Stanbridge et al., 2003). These therapist qualities have long been believed by researchers and clinicians to be important in forming strong therapeutic alliances (Bordin, 1979; Escudero et al., 2008; Rogers, 1957). Moreover, some qualitative studies have found that families also report that therapists who lack these qualities and are experienced as 'robotic', pedantic or patronizing are unhelpful (Campbell, 2004; Howe, 1989).

Family members in this study felt that their therapist understood their point of view, as well as that of others in the family. This allowed family members to feel that they were able to talk openly in therapy. Again, this aspect of the alliance has been highlighted in previous studies (Campbell, 2004; Campbell, 1997; Sheridan et al., 2010; Strickland-Clark et al., 2000). Moreover, parents (Sheridan et al., 2010) and adolescents (Strickland-Clark et al., 2000) have previously reported that feeling safe enough to take risks and talk openly is a useful aspect of therapy. As such, this aspect of the alliance appeared to (in part at least) provide the basis for the process of exploring family relationships in therapy. In addition to feeling that the therapist understood their own perspective, family members described feeling that the therapist brought a sense of calm to therapy.

Although all family members described a level of trust and understanding with the therapist, this appeared to come more easily for the female members of the family. This was related to the benefits female members of the families experienced. The reasons for this apparent gender difference are unclear and may be manifold. It should be noted that all therapists in the study were female, and this may have

impacted on the experience of the males in this study, particularly as they were both also attending with all female family members. Thus, in a 'cross-gender' therapeutic dyad, the males in this study may have found it less easy to connect with a female therapist. As such, the gender difference may not be located so much in the male client or the female therapist, but in the relationship between the two. Moreover, issues of gender, power and diversity may also have impacted on the experience of the males in this study. Issues around gender in family therapy will be addressed in more detail later in this discussion.

1.1.2   Sense of safety in the family therapy system

Family members described how the therapist's ability to bring a sense of calm to the therapy allowed them to feel safe enough to be open. This was related for one family to being open about things which had not been talked about before, while for the other family it related to talking calmly about things which had been argued about. However, both families cited the importance of the conversation being 'controlled' and calm in having these conversations. This is related to the 'emotional connection' with the therapist, but also reflects a belief that others in the family will be kept safe, and conflict will be well managed (Friedlander et al., 2006). This sense of safety within the family therapy system (Friedlander et al., 2006) appeared to be equally as important as the emotional connection with the therapist in terms of family members ability to explore their own relationships openly in therapy.

Lever and Gmeiner (2000) found that families who dropped out of therapy after only one or two sessions reported they did not feel 'safe' enough to share their experiences. Lever and Gmeiner's research (2000) – although also based on only a small number of families – suggests that without this sense of safety, families may drop out from therapy. As such, this sense of safety may be seen as a fundamental aspect of the alliance.

Previous studies have also reported that children and adolescents are aware of the potential impact of the things they say on others in the family (Lobatto, 2002;

Strickland-Clark et al., 2000). This presents a particular challenge to the family therapist as children's beliefs about the potential harm to other family members may be governed not only by the therapist's ability to contain the family, but also their relationship with their parents, and children's own developing understanding of others' emotional worlds. Parents have also reported that they value feeling safe enough to take risks in therapy with their adolescent children (Sheridan et al., 2010). As found in this study, this risk-taking included talking about issues which had not previously been discussed in the family. Thus, as suggested by Byng-Hall (1995), the therapist must provide a 'secure base' for families to begin the work of exploring their relationships.

1.1.3   Engagement in the process of therapy

Family members in this study described varying levels of engagement with the process of therapy, such that female family members seemed to find the process of therapy 'more natural' to engage with than male family members. This was not clearly dichotomous, and may reflect a tendency for males to interact in a certain style, rather than a 'gender difference' per se. For example, the father interviewed related his experience of the process of therapy to his scientific professional background not easily relating to the therapeutic process.

Previous research has highlighted the importance of discussing expectations with families (Lever & Gmeiner, 2000; Ma, 2000; Reimers et al., 1995). Although this often relates to the process and equipment of therapy, it may also be helpful to discuss expectations relating to gender and other aspects of diversity in therapy. This could be related to the 'engagement with the process of therapy' dimension of Friedlander et al.'s (2006) model of the family therapy alliance. As such, individual expectations may need to be discussed in order to get agreement on the process of therapy from all family members. The father who found it difficult to understand the process of therapy from a scientist's perspective, also talked about wishing he had a 'road map' for the process of therapy.

1.1.4   A shared sense of purpose in therapy

Friedlander et al. (2006) propose that the final dimension of the family therapy alliance is a 'shared sense of purpose among the family'. As such the family must be working together towards shared family goals. This may also be assisted by a discussion of expectations and goals in therapy. There were differing views of the purpose of therapy among the participants of this research. For one family, who were being seen as part of their daughter's care for anorexia nervosa, the family therapy was viewed by all as focussed on helping their daughter. In contrast, the second family was seen for their daughter's behavioural problems and viewed the problems as family problems, rather than the daughter's problem. Lobatto (2002) found that younger children also tended to see themselves as 'problem carriers'. This may be in part due to the set up of CAMHS services as child focussed, such that children and their families tend to see problems as child focussed. This may be exacerbated by specific mental health diagnoses such as anorexia which suggest a problem is located 'within' the sufferer. As such, the discussion of goals and expectations of therapy may be paramount in helping families to develop a shared sense of purpose. However, the findings of this study suggest that this aspect of the therapeutic relationship may be dependent upon not only the behaviour and skills of the therapist, but also attitudes, beliefs and experiences which the family bring to therapy.

Robbins et al. (2003) investigated the impact of uneven alliances within families in therapy and found that families with uneven alliances were more likely to drop out of therapy. There are some clear methodological limitations with Robbins et al.'s (2003) study, including the use of trainee therapists who may have struggled to negotiate an 'imbalanced' alliance. However, the study highlights that many families will not come to therapy united, and negotiating an initially uneven alliance, where there may be many conflicting perspectives on the 'problem' successfully may be an important aspect of engaging families effectively. Moreover, although in this study

alliances appeared unevenly balanced, the families appeared to gain a lot from therapy despite this.

In addition to the importance of alliances in family therapy, the present study highlights the variation in experience in family therapy. In this study there was noticeable variation in the experiences of individual family members. In particular there were differences in levels of felt safety which may be understood in part within the context of existing literature investigating particular groups in therapy. Individual and family factors appeared to have had an impact on the experiences of individual family members of the process of building a therapeutic alliance.

It is important to understand some of the reasons why some family members may engage more easily than others. Initial alliances are likely to be strongly influenced by family members' expectations of the therapist, and of each other in therapy.

1.2   Gender and the therapeutic alliances in family therapy

A particular theme of note for the families in this study was the importance of gendered beliefs about therapy. There was an expectation among most of the participants, especially the two males that their therapist would be a woman, and that this was related to women's (assumed) superior skills in talking openly. This belief was shared by some of the female participants. There was also an assumption that women understood women better than men and vice versa. Gregory and Leslie (1996) found that in cross-racial therapy, women rated initial therapy sessions as less 'smooth', but that this difference disappeared by the time of the fourth session. This supports the idea that assumptions based on race and gender may impact on clients' expectations and initial experiences of family therapy. However, as the difference in alliance scores in Gregory and Leslie's study disappeared over time, this suggests that issues of difference do not necessarily constitute an insurmountable barrier. As all the therapists in this study were women, it is difficult to know how the families involved would have responded to a male therapist, but it is clear that among most

participants, there was an expectation that having a male therapist would be uncomfortable or at least unusual.

It is often accepted in UK CAMHS clinics that fathers may not be able to attend appointments due to work commitments (Walters et al., 2001). Moreover, within UK society, mothers are expected to be the parent who accompanies a child to appointments (Reimers et al., 1995; Walters et al., 2001). This may be reflective of a narrative that CAMHS clinics are for mothers and their children, and that fathers are 'too busy' to attend (Walters et al., 2001). Thus, while women are generally seen as holding less power in western societies as a result of gender inequalities, there may be a narrative that fathers do not belong in child focussed settings such as CAMHS clinics. Walters et al. (2001) found that some of the fathers interviewed began to attend sessions for a short time after the research interview, possibly as a result of having an opportunity to reflect on their own experiences of being parented. This may reflect a lack of focus on fathers as individuals in family therapy, which was noted by the (only) father in this study also. As such, in addition to the issue of difference in therapy, there may be important narratives about gender - and in particular fathers – within CAMHS settings.

1.3   Possible mechanisms of the therapeutic alliance in Family Therapy

The therapeutic alliance allowed participants to talk openly with each other in therapy. Furthermore, participants identified that talking and exploring their family relationships – and themselves – was an important aspect of therapy. This allowed family members to know more about each other, but also to be 'heard' by other members of the family. Again, experiences varied in relation to this, such that parents appeared to want to share more of themselves, while the adolescents in this study were more reluctant, wanting to restrict what was known of them by their parents to the necessities. Sheridan (2010) found that parents valued the opportunity to take risks in talking with their adolescent children in therapy. As such, these 'tasks' of therapy appeared to be facilitated by the alliance, and were important parts of the therapeutic process. Therefore, the safety of the alliance can

be seen as the foundations of the work that allows the process of talking and exploring to occur.

Much has been written about the relationship between the therapeutic alliance and outcomes of therapy (Blow et al., 2007; Byng-Hall, 1995; Lever & Gmeiner, 2000; Robbins et al., 2003). In the field of individual therapy, Rogers (1957) proposed that the therapeutic alliance – principally the emotional bond - between therapist and client represented the core work of his person-centred therapy. Bordin (1979) further developed the concept of the therapeutic working alliance, to incorporate the process of negotiation of tasks and goals in therapy that helped to strengthen the emotional bond between therapist and client. As such, the 'tasks' of therapy could be seen as providing opportunities for alliance building, and the alliance could be seen as providing the safety needed in order to carry out the tasks.

A large body of research has consistently demonstrated a relationship between the strength of alliances and the outcomes of therapy (Blow et al., 2007; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Moreover, despite major differences in the practice of different models of therapy, comparisons frequently show similar levels of efficacy (Ahn & Wampold, 2001). It is likely that 'common factors' such as the therapeutic alliance, as opposed to the model-specific 'ingredients' of therapy, do not act independently of each other and together may impact upon the outcomes of therapy. Their relationship therefore remains a challenge to researchers in the field of therapy process research, as it is difficult to control for any of these factors. The present research may provide some tentative suggestions as to the relationship between these factors, as seen by the families in the study.

For the families interviewed in this study, the two elements of the strength of the emotional bond with the therapist and the sense of safety within the therapeutic system appeared to be fundamental to the process of therapy. Given the retrospective nature of the study it is not possible to make any claims about the causality of this relationship, and it may be that aspects of the alliance continually impact upon each other. The following diagram illustrates the possible mechanisms

for the relationship between alliance, the 'tasks of therapy', and outcomes. Here, the emotional connection with the therapist and sense of safety within the family therapy system (Friedlander et al., 2006) are shown as the foundations of the therapy, without which, the therapy cannot happen. This reflects research around alliances and drop out from therapy (Lever & Gmeiner, 2000; Robbins et al., 2003). With these aspects of the alliance established, initial engagement is facilitated and the therapist can work with the family to deepen involvement with the process of therapy, such as sharing a similar sense of purpose in therapy, through discussions of expectations and goals (Lever & Gmeiner, 2000; Ma, 2000). If this is not possible, families may drop out of therapy, or be less willing to engage with the tasks of therapy. Beyond this initial level of alliance, it may be possible to build stronger alliances still, leading to greater engagement with the 'tasks' of therapy. The 'tasks of therapy' are hypothesised in the case of family therapy to be talking and exploring the self and each other, with outcomes being closely linked to the extent that this exploration is possible. Thus, where individuals and families have a stronger alliance with the therapist, they will feel safer to explore in greater depth. This may in turn allow families to gain more from family therapy.

2 Methodological strengths and limitations

2.1 Recruitment and participants

Previous research has focussed on either interviewing families together (although frequently with some family members absent), or on particular perspectives which are taken out of context of the family presentation. A strength of this research was that all family members involved in therapy were interviewed. This allowed for a more comprehensive analysis of all individual perspectives in the context of their families, enabling a more thorough understanding of the interplay between the family system and the therapeutic experience.

However, the design of the research also meant that recruitment of participant families was one of the most challenging aspects of the project. Although family therapists were able to identify a number of families who were nearing completion of therapy, in some cases one or more family members declined to take part.

The small number of participants may limit the transferability of the study's themes. It was felt that it was important to limit the number of participants, due to the constraints of the time available for analysis and the importance of the depth of the analysis. The use of two small families was a compromise due to recruitment difficulties and it would arguably have been preferable to be able to interview one larger family. However, the opportunity to compare and contrast the two family experiences was valuable for the research findings. The diversity of the two families was also limited due to the small number of participants, and therefore the results cannot be readily applied to more diverse populations.

2.2 Design

The difficulties in recruitment led to the recruitment of two small families instead of one larger family. This meant that the sample was less homogenous than was desirable, as the two families had received different forms of therapy. However, it can be argued that both were seen for therapy as a family and the sample was therefore to some extent homogenous. Moreover, the results suggest that despite

the differences in the therapy received, there were arguably fundamental aspects of therapy which were commonly experienced by both families.

The decision not to include a therapist perspective in order to privilege the experience of service users' experience of therapy does leave a gap in the interpretation of the data. For example, around the issue of gender, it would have been useful to have the therapist's perspective on gender in the therapy. As noted by one participant, their accounts were 'only as good as my memory'. Such a design could have answered a further research question, such as 'to what extent are family therapists' experiences of therapy congruent with the families they work with?'

As noted in the methods section, the interview schedule was too detailed, in part due to my anxiety about interviewing children and young people, who may have required more prompting. The interview schedule may have influenced the data, by guiding participants towards particular themes. However, in reviewing the themes and the transcripts, I was aware that my themes could be seen as reflecting the interview schedule. As such, I reviewed the themes and associated quotes, which arose throughout the interviews, and not just where indicated by the researcher's questions. Of course, the questions will still have influenced the participants, and this should be borne in mind in reviewing the results. However, I feel that I have re-analysed the data to a deeper interpretative level that has moved beyond the structure provided by the interview.

A possible way to manage the issue of children and adolescents being less forth-coming may have been to have more than one interview schedule aimed at different age groups. It may also be helpful to interview siblings together, so that they can prompt each other according to conversations they have already had. However, older and perhaps more powerful sibling voices may potentially be privileged in this alternative design.

2.3   Interpretative Phenomenological Analysis

As with any qualitative research method, IPA does not produce accounts which can be readily applied to larger populations. However, the inductive nature of IPA allows for unanticipated themes to emerge, allowing new understandings to be developed. The strength of this methodology therefore lies in gaining an in depth understanding of the ways in which individuals construct their experience. This allowed the researcher to bring to the fore the experiences of individual family members within their context. Thus it was possible to look in detail at the intra-family processes impacting upon participants' experiences as well as the experience of wider social and cultural contexts. Within individual therapy the therapeutic relationship between therapist and client is of a dyadic nature, although of course therapy does not occur within a social vacuum. However, in family therapy, the therapeutic relationship appears to be equally important, but more complex, as the therapist must attempt to form an alliance with several people who may hold conflicting views. It is hoped that this research has captured some of the richness and complexity of intra-family processes, which may impact varyingly upon the therapeutic alliance for the family and its members.

2.4   Personal reflections

A further strength of IPA is its levels of transparency about the researcher's own position in interpreting the research. Although qualitative methods require a greater level of subjective interpretation, it is also important to acknowledge that there is some level of personal interpretation in any research. IPA pays particular attention to the 'dance with reflexivity' (Finlay, 2008) which allows for researchers to be aware of their own assumptions, in order that their findings can be transparent and not unduly influenced by the researcher's own position.

This research was borne out of a desire to make sense of my own experience in therapy, and the reflexive elements of IPA allowed me to bring this to the foreground. My personal connection with the material could be seen as a weakness of the study, as clearly my interpretation of the data will have been influenced by my

own fore-understandings. However, I feel that the transparency with which the research has been conducted allows the reader to interpret the research findings from a more informed perspective. Moreover, although of course every therapeutic experience will be unique, my experience of being a service user, i.e. a client in family therapy, is perhaps more likely to be more informative of my participants' experience than that of someone who has only ever delivered therapy. Additionally, my fore-understandings do not only relate to my experience as a service user but also as a clinician and researcher. As such, I felt that I was in a strong position to make sense of the experiences of others in therapy from the outset. Moreover, many of the experiences reported in this research are starkly different to my own, which suggests that my experience of therapy has not unduly influenced my interpretation of the data.

3   Implications

3.1   Implications for future research

The results of this study suggest a number of avenues for future research. Firstly, further research investigating the experiences of fathers in family therapy and in CAMHS is needed. Previous research has identified that children are responsive to their parents feelings in therapy (Lobatto, 2002; Strickland-Clark et al., 2000). In addition, the balance in therapeutic alliance across families has been found to be important in maintaining engagement of families in therapy (Robbins et al., 2003). Fathers tend to be an under-researched group, as mothers continue to be seen as the main care-givers in the UK (Walters et al., 2001).

A recent web survey, however, suggests that 600,000 fathers (6%) in the UK report that they are primary caregivers for their children, while 18% of households supposedly 'share' the childcare responsibilities equally (Poulter, 2010). Although this was a relatively small-scale web survey, the authors suggest that there has been an increase in the number of fathers taking a more active role in caring for their children in recent years. Only one father was interviewed in this study, as the father of the second family was not involved in the therapy. The father who was interviewed appeared to find it more difficult to engage in therapy, despite a wish to help his daughter. Certainly, his wife had been the main attendee at CAMH appointments prior to the family sessions. Further research investigating the experiences of fathers in therapy (or those who do not engage) may help to identify barriers to engagement. Moreover, research investigating the experiences of family therapists working with or attempting to engage fathers in therapy may illuminate barriers for therapists in engaging fathers. This may include discourses about fathers not wishing to explore themselves, which has been challenged by previous research (Walters et al., 2001) as well as by the present research. There may also be issues around power for female family therapists working with fathers.

Wider issues of diversity (e.g. social class, ethnicity, sexuality, religion) and how these are incorporated in family therapy may also warrant further research. Related to

this, parents' beliefs about their role and societal discourses about the role of parents in their children's mental health problems, may be helpful in considering how to engage parents in family therapy. Research investigating societal discourses around blame and responsibility for mental health problems for different parental groups may illuminate the different ways in which parents may relate to blame and responsibility (Puchalska, 2010).

Narrative therapies represent a particular model of working, which seeks to develop and strengthen more helpful narratives, which may have been minimised or subjugated in the past (White & Epston, 1990). The present research suggests that the development of both new individual and family narratives may be helpful in family work. This raises questions about the development of new narratives outside of the use of narrative techniques. Thus, the development of new narratives and a greater understanding of each other's narratives may be a key beneficial outcome of family therapy. Further research into the role of narrative in different models of therapy may help to clarify this.

3.2 Clinical Implications

The clearest implication for clinical practice is the importance of building a strong and balanced therapeutic alliance with families in therapy. This provides the psychological safety for families to explore their relationships. This can be achieved through the therapist's calm non-judgemental stance, and unconditional positive regard for all family members. This may be more difficult in dealing with families in therapy, rather than individuals as the therapist has the difficult task of balancing different perspectives in the family (Escudero et al., 2008). The therapist's warmth and empathy may be key to conveying this to families. Moreover, families value therapist's ability to maintain a sense of calm containment during sessions where strong emotions may be prevalent.

Different family members may also respond to different ways of building a therapeutic relationship depending on their personal history, attachment style,

position in the family, and social and cultural context. Addressing these expectations of therapy appropriately may facilitate a trusting therapeutic relationship, thus reducing anxiety and allowing for work to begin.

Balancing the therapeutic alliances was also found to be an important factor in therapy for these families. The development of mutually agreed goals for therapy may facilitate the family feeling that they are working towards a common goal, an important factor in forming a cohesive group (Yalom & Leszcz, 2005). Moreover the active engagement of fathers may help to build stronger alliances where fathers feel valued and invested in the therapeutic endeavour. Previous research (Lobatto, 2002; Strickland-Clark et al., 2000) as well as my research suggests that children are highly sensitive to their parents attitude to therapy and their engagement may be influenced by the engagement of their parents.

In this research, the family where the problem was seen as a relational one (problems between mother and daughter) rather than a diagnostic one (anorexia) appeared to have engaged more 'whole-heartedly' with family therapy. Lobatto (2002) found that children tended to see themselves as 'problem carriers'. This may be exacerbated by a focus on individualised CBT interventions in CAMHS. Some anecdotal concerns have been expressed by a few CAMHS clinicians around the IAPT child initiative, which may well favour CBT over family therapy. The fear is that children may again be seen as the sole carriers of 'problems' within the family, neglecting the rich resources of families for engaging with - and managing - the 'problems' at a shared and systemic level.

Finally, it is notable that participants made specific reference to the physical surroundings of therapy: firstly that they were away from home, but also that they were calm places with a calming atmosphere. This allowed families to feel relaxed and contained, in order to talk about difficult emotions. In the current economic and political climate, it will be important to ensure that clinics maintain their physical surroundings and not be pushed into inappropriate therapeutic spaces, which are chaotic or uncomfortable, in order to save costs. It could also be argued that the

potential loss of some therapeutic efficacy, due to inappropriate settings, could potentially put the effectiveness of the service at risk in any case.

4   <u>Conclusions</u>

A key finding of this research was that a strong and balanced therapeutic alliance formed an important condition for the families interviewed to make use of therapy. Moreover, factors associated with this such as family members feeling listened to and understood hold therapeutic value, before any 'intervention' or therapeutic task is undertaken. Furthermore, having a chance to explore individual perspectives in family therapy was described as 'cathartic' by some participants. This exploration also led to new understandings of past events and current conflicts, which allowed families to explore new ways of being together. Factors such as gender, expectations of therapy, and relationships with the 'problem' brought to therapy affected individual family members' ability to form a strong therapeutic alliance.

This study sought to gain an in depth understanding of the processes and phenomena which may occur during family therapy, from individual perspectives. These processes are highly complex, and are likely to vary greatly between families and the findings reflect this complexity. As such, two familial case studies do not readily provide generalisable understandings of how all families experience therapy. Rather they highlight themes of importance for these families, and given the linkage with wider research, may have some transferable benefits for clinicians to reflect upon within their practice. These themes include the value of time spent building a relationship with everyone in the family, and latterly exploring new narratives. Additionally, issues of power relating to gender, family hierarchies, and family members expectations around blame and responsibility may all impact (and interact) on the process of building a therapeutic alliance with members of the family and the family as a whole. In particular, the field would benefit from further research specifically investigating the experiences of fathers and culturally diverse groups, and the experiences of therapists working with these groups in CAMHS settings.

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Appendices

Miss Lucy Mills
10 Norman Court,
Stapleton Hall Road,
London
N4 4QD

05 November 2009

Dear Miss Mills

Study Title:	**Individual experiences in family therapy: a comparison of perspectives over the course of therapy using Interpretative Phenomenological Analysis**
REC reference number:	**09/H0706/77**
Protocol number:	**3**

Thank you for your letter of 02 November 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		21 September 2009
REC application	26879/63992/1/497	21 September 2009
Protocol	3	21 September 2009
Investigator CV		
Participant Consent Form: Parents and Adult Children	1	21 September 2009
Participant Consent Form: Parents Consent on behalf of Children	1	21 September 2009
Evidence of insurance or indemnity		01 August 2009
Letter from Sponsor		21 September 2009
Referees or other scientific critique report		25 March 2009
Interview Schedules/Topic Guides	2	21 September 2009
Transcription Agreement	1	21 September 2009
Supervisor's CV		
Participant Consent Form: Assent for Young People	2	20 October 2009
Participant Consent Form: Assent for Children	2	20 October 2009
Response to Request for Further Information		26 October 2009
Participant Information Sheet: Ages 7-10	3	31 October 2009
Participant Information Sheet: Ages 11-16	3	31 October 2009
Participant Information Sheet: Young Adults	2	21 October 2009
Participant Information Sheet: Parents	2	20 October 2009
Response to Request for Further Information		02 November 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0706/77	Please quote this number on all correspondence

Yours sincerely

Dr Sabita Uthaya
Chair

Email: atul.patel@imperial.nhs.uk

Enclosures: *"After ethical review – guidance for researchers"*

Copy to: *Dr Nicholas Wood*
                     John Senior, University of Hertfordshire
                     Tim Gale, Hertfordshire partnership NHS Foundation Trust

Information Sheet for Children

What is the project about?

Research is a way to find out answers to questions. We would like to find out what it is like to come for family therapy.

Did anyone else check the study is ok to do?

Before any research is allowed to happen, it has to be checked by a group of people called a Research Ethics Committee. They make sure that the research is fair.

Do I have to join in?

No. You should only join in if you want to. If you decide not to join in you can still have family therapy.

What will I have to do?

You will be asked to come and draw pictures and talk to someone called Lucy who would like to know more about what it is like to come to family therapy.

Lucy will record the meetings so that she can listen to them and understand more about what you said.

Will joining in upset me?

Sometimes people get upset when they talk about their family. If you get upset, Lucy will stop the interview until you are ready to carry on. If you get upset and you don't want to carry on with the interview, you should tell Lucy and you can stop the interview. Lucy will talk to you about who you can talk to if you are upset.

Is taking part private?

Lucy she will not use your name in the project, but if people in your family read it they might know some of the things you said to Lucy.

Normally, Lucy won't tell any of your family or other people you know what you have said. Lucy would tell someone about what you have said if she thinks that you or someone else might be in danger.

Will joining in help me?

We cannot promise that the project will help you and your family. The information we get from the project may help us to help families more in the future.

What if I don't want to join in anymore?

If you do not want to be part of the research anymore just tell your parents or Lucy. They will not be cross with you. You will still be able to go to family therapy.

Appendix 3. Information sheet for adolescents (aged 11-15)

Information Sheet for Young People

What is the project about?

It is all about what coming to family therapy is like for you. This sheet will help you to decide if you want to take part. You can talk about it with your family, friends or any other adults if you want to.

Who is doing this project?

The study is being carried out by Lucy Mills, a Trainee Clinical Psychologist.

Why are we doing this project?

We want to know more about your experience of family therapy. We want to understand more about what happens during family therapy and what people like or don't like about it. We hope that this will help us to help other families.

What is involved?

If you and your family decide to take part, you will each be invited for an in-depth interview about your experiences of family therapy sessions. The interview will be recorded, and will last about one hour.

What will I have to talk about?

In the interview, you will be asked questions about your family and the help that family members have had before, what you expected from family therapy, your experiences in family therapy, and how you think your family has or hasn't changed since starting family therapy.

Do I have to take part?

No. Taking part is voluntary, and your involvement with the study will not affect the service that you and your family receive in any way. Your family therapist will not know whether you have decided to take part unless you decide to tell them. You can decide to stop taking part at any time during the study without giving a reason.

What do I have to do?

If you and your family decide to take part in the study you will be asked to sign a form saying you are happy to take part. If you are under 16 years old, your parents will also be asked to sign a consent form on your behalf.

Will joining in upset me?

Sometimes people get upset when they talk about their family. If you get upset, Lucy will stop the interview until you are ready to carry on. If you get upset and you don't want to carry on with the interview, you should tell Lucy and you can stop the interview. Lucy will talk to you about who you can talk to if you are upset.

Is taking part private?

All your information (personal details, recordings of your interviews and transcriptions) will be kept private in a secure location. Your name and address will not be used in the final project, so people who read the project will not know you took part.

When it is finished, the project will be given in to the University of Hertfordshire. This will be kept in the University of Hertfordshire library and may be put on the online database. The project might also be written about in magazines for other Psychologists and for the general public. This may include things that you have said, but your name would not be used. If members of your family read the quotes they might be able to guess what you said because they will know that you took part. If your family therapist read the project they might be able to guess what you said because the project will be about what happened in your family therapy sessions.

Lucy (the researcher) won't usually tell any of your family or other people you know what you have said in your interviews. The only time Lucy would tell someone you know about what you have said is if she thinks that you or someone else might be in danger. Then she would have to talk to an adult at your Child and Family Clinic about how to keep you and other people safe.

Will taking part help me?

Many people find it helpful to talk about their experiences. We cannot promise that taking part will benefit you directly, but we hope that the findings will help us to understand and enhance practice in family therapy for families needing help in the future.

If you wish, Lucy can send you a brief summary of the findings once she has completed the study. If you would like this, please tick the box on your assent form.

If you have to pay for travel to your interview Lucy will be able to reimburse you for the cost of your travel up to the value of £10, if you provide me with receipts. You will also be offered a £10 gift voucher each as a small thank you for your time.

What if I have questions or concerns?

If you want to know more about the project, you can telephone Lucy, email her or write to her in the post:

Email: lucy.mills1@nhs.net

Telephone number: 07767 003 781

Address: Doctorate in Clinical Psychology Training Course,
                    University of Hertfordshire, Hatfield, Herts., AL10 9AB

If you feel upset after your meeting, please contact Lucy so that she can tell you who else can help you.

Thank you for taking the time to read this.

Information Sheet for Young Adults

Title of Project: **I**ndividual experiences in family therapy: a comparison of perspectives over the course of therapy

Introduction

We are looking for one family to take part in a research study about what it is like to attend family therapy sessions. Please read this information sheet carefully and talk it over with your family, and if you would like, your family therapist.

The researchers

The study is being carried out by Lucy Mills, Trainee Clinical Psychologist as part of a Doctoral qualification in Clinical Psychology. The study is being supervised by Dr. Nicholas Wood, Research Tutor and Consultant Clinical Psychologist, Dr. Pieter Nel, Academic Tutor and Consultant Clinical Psychologist and Christine Jones, Clinical Social Worker and Systemic Family Therapist.

Why are we doing this research?

We are interested in learning more about your experiences of family therapy so that we can understand more about what happens during family therapy and how this impacts, both positively and negatively on families. We hope that this will help family therapists to develop and improve their practice.

What is involved?

If you and your family decide to take part, you will each be invited for an in-depth interview about your experiences of family therapy sessions. Interviews will take place somewhere that is quiet and private: this could be at your home, at the University of Hertfordshire or at another suitable place. You won't all be interviewed at the same time, and we will try to find a time and location which is convenient to you. The interview will take place after you have finished family therapy. Each interview will last approximately one hour. The interviews will mostly involve talking about your family, as well as drawing pictures of your family to help us understand how you see your family. In the interview, you will be asked about your experiences in family therapy, and how you think your family has or hasn't changed since starting family therapy.

Who is taking part?

We are interested in speaking to all members of one family who has recently started family therapy. It is important that we are able to interview everyone in the family, so you will only be asked to take part if everyone in your family has agreed to take part. Interpreters will not be available, so this study is only for families who speak English.

Do I have to take part?

No. Taking part is voluntary, and your involvement with the study will not affect the service that you and your family receive in any way. Your family therapist will only know whether you have decided to take part if you decide to tell them. You can decide to stop taking part at any time during the study without giving a reason and this will not affect your treatment.

What do I have to do?

If you decide to take part in the study you will be asked to sign a form giving your consent. You will be given a copy of this information sheet and your signed consent form to keep. The researchers will also keep a copy of your signed consent forms.

What are the risks of taking part?

The experience of being interviewed can be distressing. The researcher is also a clinician and has skills and experience in talking with people of all ages who are distressed. If you become distressed the researcher will stop the interview and will not continue unless the you feel able to do so. At the end of your interview there will also be time to 'debrief' and talk about what the interview was like.

When the research is written up, quotes from your interviews will be included. Members of your family would probably be able to identify things that you have said if they were to read any of the reports written about the research. Your family therapist might also be able to identify you if they were to read any of the reports. The types of reports that are likely to be written about the project are detailed below.

The only time when information from your interviews would be shared with other professionals involved with your family would be in exceptional circumstances if you revealed information that indicated that you or someone else might be at risk of harm.

Is taking part confidential?

All your information (personal details, recordings of your interviews and transcriptions) will be kept in a secure location and will be kept confidential.

Interview recordings will be transcribed and transcriptions will be anonymised by removing personal details, such as your real name and home town. It is possible that a non-researcher will be employed to transcribe the recordings, and if so they will be known to the University of Hertfordshire and will be asked to sign a confidentiality agreement.

The findings of the study will be submitted to the University of Hertfordshire as part of a Doctoral qualification in Clinical Psychology and will be kept in the academic library system. The findings may also be published in a shorter research paper in an academic journal, which may include direct quotes from your interviews. Finally, a short summary of the findings may also be published through charitable organisations such as Mind so that they can be read by members of the general public. If you decide to take part you should remember that the main report will be available in the academic library system and may be made available on the University of Hertfordshire's online research database. Members of your family and your family therapist would be able to access the report, and could identify quotes from your interview.

What are the benefits of taking part?

Many people find it helpful to talk about their experiences, and taking the time to reflect on therapy outside of sessions can enhance the effectiveness of therapy itself.

We cannot promise that taking part will benefit you and your family directly, but we hope that the findings will help us to understand and enhance practice in family therapy for families needing help in the future.

If you wish, Lucy can send you a brief summary of the findings once she has completed the study. If you would like this, please tick the box on your consent form.

If you have to travel to your interview Lucy will be able to reimburse you for the cost of your travel up to the value of £10 each, if you provide her with receipts. You will also be offered a £10 gift voucher each as a small thank you for your time.

What if I have questions or concerns?

If you have any questions or concerns about the study please contact me my telephone, email or post (contact details below). In the unlikely event that taking part in the study has upset you in any way please contact Lucy so that she can give you details of where you can access further help and support.

Who has reviewed this study?

Before any study goes ahead it has to be approved by a Research Ethics Committee. They make sure that the study is fair and has given consideration to the well-being of participants. This study has been checked by the Riverside Research Ethics Committee.

Thank you for taking the time to read this.

Contact details

Lucy Mills

Email: lucy.mills1@nhs.net

Telephone number: 07767 003 781

Address: Doctorate in Clinical Psychology Training Course, University of
                    Hertfordshire, Hatfield, Herts., AL10 9AB

Information Sheet for Parents

Title of Project: **I**ndividual experiences in family therapy: a comparison of perspectives over the course of therapy

Introduction

We are looking for one family to take part in a research study about what it is like to attend family therapy sessions. Please read this information sheet carefully and talk it over with your family, and if you would like, your family therapist. It is important that everyone in the family understands this information, so please also take the time to discuss it with your children before you agree to take part.

The researchers

The study is being carried out by Lucy Mills, Trainee Clinical Psychologist as part of a Doctoral qualification in Clinical Psychology. The study is being supervised by Dr. Nicholas Wood, Research Tutor and Consultant Clinical Psychologist, Dr. Pieter Nel, Academic Tutor and Consultant Clinical Psychologist and Christine Jones, Clinical Social Worker and Systemic Family Therapist.

Why are we doing this research?

We are interested in learning more about your experiences of family therapy so that we can understand more about what happens during family therapy and how this impacts, both positively and negatively on families. We hope that this will help family therapists to develop and improve their practice.

What is involved?

If you and your family decide to take part, you will each be invited for an in-depth interview about your experiences of family therapy sessions. Interviews will take place somewhere that is quiet and private: this could be at your home, at the University of Hertfordshire or at another suitable place. You won't all be interviewed at the same time, and we will try to find a time and location which is convenient to each of you. The interview will take place after you have finished family therapy. Each interview will last approximately one hour. The interview will mostly involve talking about your family, as well as drawing pictures of your family to help us understand how you see your family. In the interview, you will be asked about your experiences in family therapy, and how you think your family has or hasn't changed since starting family therapy.

Who is taking part?

We are interested in speaking to all members of one family who has recently started family therapy. It is important that we are able to interview everyone in the family, so you will only be asked to take part if everyone in your family has agreed to take part. Interpreters will not be available, so this study is only for families who speak English.

Do I have to take part?

No. Taking part is voluntary, and your involvement with the study will not affect the service that you and your family receive in any way. Your family therapist will only know whether you have decided to take part if you decide to tell them. You can decide to stop taking part at any time during the study without giving a reason and this will not affect your treatment.

What do I have to do?

If you and your family decide to take part in the study you will be asked to sign a form giving your consent. You will also be asked to sign a form giving your consent for your children who are under 16 years old to take part. You will be given a copy of this information sheet and your signed consent form to keep. The researchers will also keep a copy of your signed consent forms.

What are the risks of taking part?

The experience of being interviewed can be distressing. The researcher is also a clinician and has skills and experience in talking with people of all ages who are distressed. If you become distressed the researcher will stop the interview and will not continue unless the you feel able to do so. At the end of your interview there will also be time to 'debrief' and talk about what the interview was like.

When the research is written up, quotes from your interviews will be included. Members of your family would probably be able to identify things that you have said if they were to read any of the reports written about the research. Your family therapist might also be able to identify you if they were to read any of the reports. The types of reports that are likely to be written about the project are detailed below.

The only time when information from your interviews would be shared with other professionals involved with your family would be in exceptional circumstances if you revealed information that indicated that you or someone else might be at risk of harm.

Is taking part confidential?

All your information (personal details, recordings of your interviews and transcriptions) will be kept in a secure location and will be kept confidential.

Interview recordings will be transcribed and transcriptions will be anonymised by removing personal details, such as your real name and home town. It is possible that a non-researcher will be employed to transcribe the recordings, and if so they will be known to the University of Hertfordshire and will be asked to sign a confidentiality agreement.

The findings of the study will be submitted to the University of Hertfordshire as part of a Doctoral qualification in Clinical Psychology and will be kept in the academic library system. The findings may also be published in a shorter research paper in an academic journal, which may include direct quotes from your interviews. Finally, a short summary of the findings may also be published through charitable organisations such as Mind so that they can be read by members of the general public. If you decide to take part you should remember that the main report will be available in the academic library system and may be made available on the University of Hertfordshire's online research database. Members

of your family and your family therapist would be able to access the report, and could identify quotes from your interview.

What are the benefits of taking part?

Many people find it helpful to talk about their experiences, and taking the time to reflect on therapy outside of sessions can enhance the effectiveness of therapy itself.

We cannot promise that taking part will benefit you and your family directly, but we hope that the findings will help us to understand and enhance practice in family therapy for families needing help in the future.

If you wish, Lucy can send you a brief summary of the findings once she has completed the study. If you would like this, please tick the box on your consent form.

If you have to travel to your interview Lucy will be able to reimburse you for the cost of your travel up to the value of £10 each, if you provide her with receipts. You and your children will also be offered a £10 gift voucher each as a small thank you for your time.

What if I have questions or concerns?

If you have any questions or concerns about the study please contact Lucy by telephone, email or post (contact details below). In the unlikely event that taking part in the study has upset you in any way please contact Lucy so that she can give you details of where you can access further help and support.

Who has reviewed this study?

Before any study goes ahead it has to be approved by a Research Ethics Committee. They make sure that the study is fair and has given consideration to the well-being of participants. This study has been checked by the Riverside Research Ethics Committee.

Thank you for taking the time to read this.

Contact details

Lucy Mills

Email: lucy.mills1@nhs.net

Telephone number: 07767 003 781

Address: Doctorate in Clinical Psychology Training Course, University of Hertfordshire, Hatfield, Herts., AL10 9AB

Appendix 6. Assent forms for young children (aged 7-10)

Assent Form for Children

Project: What it is like for you to come to family therapy

Researcher: Lucy Mills, Trainee Clinical Psychologist

1. I understood the information sheet for the project. I have asked any questions I had and I understood the answers.

2. I understand that I only have to take part if I want to. I can change my mind at any time without saying why. I can still come to family therapy if I decide not to take part.

3. I agree to take part in the project

4. I agree for the meeting to be audio-recorded

5. Please tell me what you found out

....
Name of participant   Date   Signature

....
Name of researcher   Date   Signature

Appendix 7. Assent forms for adolescents (aged 11-15)

Assent Form for Young People

Title of Project: A study of the individual's experience in family therapy: a comparison of perspectives

Researcher: Lucy Mills, Trainee Clinical Psychologist

1. I understood the information sheet for the project. I have asked any questions I had and I understood the answers. ☐

2. I understand that I only have to take part if I want to. I can change my mind at any time without saying why. I can still come to family therapy if I decide not to take part. ☐

3. I agree to take part in the above study ☐

4. I agree for the interview to be audio-recorded ☐

5. Please send me a summary of the findings of the research ☐

....
Name of participant   Date   Signature

....
Name of researcher   Date   Signature

Consent Form for Parents and Adult Children

Title of Project: A study of the individual's experience in family therapy: a comparison of perspectives

Researcher: Lucy Mills, Trainee Clinical Psychologist

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information and ask any questions I had, which were answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, and my healthcare and legal rights will not be affected. ☐

3. I agree to take part in the above study ☐

4. I agree for the interview to be audio-recorded ☐

5. Please send me a summary of the findings of the research ☐

....
Name of participant   Date   Signature

....
Name of researcher   Date   Signature

Consent Form for Parents consenting on behalf of children

Title of Project: A study of the individual's experience in family therapy: a comparison of perspectives

Researcher: Lucy Mills, Trainee Clinical Psychologist

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information and ask any questions I had, which were answered satisfactorily.

2. I understand that my child's participation is voluntary and that he/she is free to withdraw at any time without giving a reason, and his/her/our healthcare and legal rights will not be affected.

3. I agree for my son/daughter to take part in the above study

4. I agree for his/her interview to be audio-recorded

....
Name of participant   Date   Signature

....
Name of researcher   Date   Signature

Interview Guide

Kinetic Family Drawing (Burns & Kaufman, 1972)

1. Please draw a picture of everyone in your family, including you, DOING something. Try to draw whole people, not cartoons or stick people. Remember make everyone DOING something – some kind of action.

2. Can you tell me a bit about your picture

   a) Prompt: Who's in your picture?

   b) Prompt: What are they/you doing in the picture?

Expectations of Family Therapy

1. What did you know about family therapy before you started it?

   a) Prompt: what did people tell you about what happens when you go to family therapy?

2. Why did you think your family was coming to family therapy?

   a) Prompt: what did people tell you/you think it might help with?

3. Who has tried to help your family with this problem before?

   a) Prompt: What do you think/feel about the help you've had before?

4. What did you think it would be like to come to family therapy?

   a) Prompt: What did you think/hope the therapist would be like?

5. What did your mum/dad/sister/brother think about coming to family therapy?

   a) Prompt: why do you think that was?

Experiences of Family Therapy

3. What happened in the first session(s)?

   a) Prompt: What surprising things happened?

   b) Prompt: What did you think about it?

   c) Prompt: How did you feel about it?

4. What was your therapist like?

   a) Was your therapist(s) a man or a woman (or both) and did this make a difference?

5. What happened in family therapy?

Interview Guides (Version 3; 31/01/10)

a) Prompt: What did you talk about?

b) Prompt: What did you do?

c) Prompt: How did you feel about saying/doing those things?

Talking about Family Therapy

6. Have you spoken to others about what family therapy is like – if so, what did you tell them?

7. What do you think your mother/father/sister/brother/daughter/son think about family therapy?

a) Prompt: How do you know that and what do you think about it?

Outcomes of Family Therapy

8. What, if anything, has changed since you started family therapy?

a) Prompt: Did you change? If so, how?

b) Prompt: Who else changed? If so, how?

9. Who noticed the changes?

a) Prompt: Did they tell you what they thought had changed?

10. Why do you think things changed?

11. How did you feel about ending family therapy?

a) Prompt: how easy/difficult was it?

Debriefing and Final Queries

12. Is there anything else that you think it's important for me to know?

13. How has it been talking with me today?

14. What was it like to talk to me without your family?

Appendix 11. Emergent and Superordinate themes for interview transcript

Table 1. Themes for 'Joan Smith'

Subordinate themes	Emergent themes
Unveiling of the self in the transition to parenting adult children	Unveiling of the self in the transition to parenting adult children
	Learning to take the cotton wool off
	Everybody together
	Focus of helping daughter
Emotional support in parenting an adolescent with anorexia	Feeling appreciated
	Learning not to blame self, despite feelings of guilt
	Learning to cope with the uncertainty of the future without worry – enjoying the moment
	Needing to share the experience with others - getting things off your chest
A safe place to find your way out of the fog	Talking is more possible in therapy
	Talking and unravelling – a weird experience
	Letters as a significant part of the healing process for the family
	Recovery journey: emerging from the fog
	Expectations are restrictive
Formation and closure of the therapeutic relationship	Being prepared for therapy
	Women as natural in therapy, men unimportant in therapy
	Therapeutic relationship
	Wanting to put the full stop at the end of therapy

Figure 1. Map of Themes for the 'Smith' Family

Over-arching theme

Safety of the theraputic relationship

Safe place
for talking

Superordinate themes

Exploring the family
landscape

Talking and
unravelling
feelings

Seeing
things
differently

Negotiating
the boundaries
of safety

Moving from blame to
responsibility

Subordinate themes

Discovering
and sharing
new identities

Feeling lost
in therapy

Rejecting the
label of
dysfunctional
family

Letting
go of
blame