AN EXPLORATION OF THE PROCESS OF CHANGE IN SYSTEMIC FAMILY THERAPY:

THE THERAPISTS' PERSPECTIVE.

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2012

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Dissertation submitted in partial fulfilment of the requirement for the degree of D.Clin.Psy. at Cardiff University and the South Wales Doctoral Programme in Clinical Psychology

ACKNOWLEDGEMENTS

Firstly, I would like to thank the family therapists who kindly agreed to participate in this research. I have appreciated your time and generosity in helping me to better understand processes of change in family therapy, and for the 'humanised interactions' with which you have done so.

I am extremely grateful for the support of my supervisors Andrew and Billy, who generated the topic of this thesis. To Andrew: thank you for your constant guidance, encouragement and positivity throughout the research process, and Billy: thank you for always providing another perspective and widening my gaze.

To my cohort I would like to say thank you, not only for the midnight e-mails, reference games, and grammar-related jokes throughout the thesis process, but also for your support and friendships for the duration of my training.

I would like to thank my friends and family for sustaining me throughout this journey. To my sister Eloisa: thank you for your playfulness, pep talks, and songs, and for always knowing which to use when. Thank you Dad for all your support, despite your consternation that I am 'still studying?'. And to Mam: thank you for all your kisses and cakes that have kept me replenished during the depths of the thesis, and whose love and kindness I carry through everything I endeavour to do. Diolch Mami.

Finally, I would like to thank my husband Alex; not only for all your proof-reads, pancakes, and ponderings, when I have needed them the most, but also for your constant love, calmness and belief in me, that infuses everything that I do.

ABSTRACT

There is a large body of literature that identifies the effectiveness of family therapy in creating change for clients. What is less understood is *how* this change comes about. Whilst therapists have been identified as having a significant effect on outcomes, within psychotherapies broadly and family therapy specifically, little research has been conducted on the role of the therapist in processes of change. An understanding of processes of change in family therapy is considered important in order to support therapists working systemically with clients in a way that maximises possibilities for change. This study presents an exploration of family therapists' understandings and experiences of processes of change in family therapy. Semi-structured qualitative interviews were conducted with eleven qualified systemic therapists working in a variety of mental health settings across South Wales and the South West of England. A Constructivist Grounded Theory approach was employed to analyse participants' accounts. Three themes relating to processes of change in family therapy were identified in the study: 'Conceptualisations of change', 'creating a context of change' and 'the context of the therapist'. The emergent themes were compared to wider literature on the family therapist's role in processes of change, which included empirical qualitative research that was generated through a systematic review. The findings have a range of implications for systemic therapists as well as other professionals working systemically with clients. Implications for clinical practice, training and the development of the role of the therapist working systemically with clients are discussed, and recommendations for future research are made.

CONTENTS

Page

LIST OF FIGURES AND TABLES

LIST OF APPENDICES

CHAPTER ONE

INTRODUCTION

1.1. OVERVIEW

This chapter presents an overview of the relevant literature on processes of change in family therapy, with particular focus on the role of the therapist. An introduction to family therapy will be provided, with particular attention on how processes of change, and the role of the therapist in relation to this, have been conceptualised and developed. The current evidence base of outcome studies for family therapy will be presented and critiqued, before moving on to a systematic review of research conducted that explores processes of change in family therapy, from the perspective of the therapist specifically. Finally, the rationale for exploring systemic family therapists' understanding and experiences of the process of change in family therapy will be provided in the context of the present study.

1.2 INTRODUCTION TO FAMILY THERAPY

'In a very general way, therapeutic work has to do with bringing about change in individual persons so they are able to continue with others in their ordinary, daily interactions while experiencing a good enough sense of well-being as they do so' (Stacey, 2006, p. 191). All psychotherapies are concerned with bringing about change (Fosha, 2005), and a theory of change would specify how we might recognise change and the process by which it came about (Jones, 2007). Family therapy is a specific type of psychotherapy with distinct ways of conceptualising the individual and change processes, which are understood to be defined by an interest in *context* and *relationship* (Flaskas, 2005). These ideas can be understood through the ongoing development of family therapy over many years. Presenting an accurate narrative of the history and development of family therapy is problematic however (Rivett & Street, 2003; Dallos & Draper, 2010). Different textbooks tell the story of family therapy slightly differently, with each author privileging different characters, settings and story lines. In addition, it is argued that: *'in the story of family therapy, there is no first cause, there is a circular cause, in which the beginning, which does not exist, meets the end, which is impossible'* (Maurice Maeterlinck, cited in Rivett & Street, 2003, p. 1), thereby making what

is already a pragmatic problem, a philosophical one also. Acknowledging these difficulties, a story of the history of family therapy will be presented, guided by the account of Rivett and Street (2003), and Dallos and Draper (2010). Whilst it is beyond the scope of this thesis to depict each contribution to family therapy faithfully, the author will attempt to identify key issues and principles, as they apply to this study, acknowledging where possible what has also been 'untold'.

This introduction will begin with an overview of the emergence of family therapy through the 1950s and 1960s, in regards to theory, practice and research. An account of the development of family therapy will be organised into: systems theory, first-order and second-order cybernetics, and the impact of postmodernist ideas on family therapy theory and practice through the 1980s and 1990s. An overview will be provided of each theme and key differences will be explored and critiqued. The section will conclude with a summary of family therapy as it is understood, at this time of writing.

1.2.1 EMERGENCE OF FAMILY THERAPY

The emergence of family therapy is proposed to have developed from a number of movements, including that of therapists (Jones, 1993; Hayley, cited in Rivett & Street, 2003), the work of theorists, and research (Dallos & Draper, 2010).

1.2.1.1 Influence of Therapists

Various accounts have been documented that demonstrate therapists' growing dissatisfaction with traditional psychoanalytic and other psychological treatments when working clinically with individuals who had been diagnosed with serious mental health problems, in particular schizophrenia (Dallos & Draper, 2010; Jones, 1993). As such, therapists began to involve family members in therapy (e.g. Bell, 1967; Boszormenyi-Nagy & Framo, 1965, cited in Jones, 1993). This movement towards interviewing an entire family together was described as a somewhat 'secret' one, during a time where the influence of family members on the nature and 'cure' of 'psychopathology' had been considered irrelevant (see Rivett & Street, 2003).

1.2.1.2 Influence of theory developments

During this period, issues of communication and feedback were also being explored in the world of science, engineering, mathematicians and social scientists. Influential figures identified during the 1940s included Ludwig von Bertalanffy, a biologist who proposed that in order to understand how an organism works it is necessary to understand the patterns and organised relationships that occur between the different components of a system (Dallos & Draper, 2010). This was referred to as 'general systems theory' (*ibid*). Norbert Wiener, a mathematician coined the word 'cybernetics' to describe the study of feedback within mechanical and human systems, specifically, how information could loop back into a system in order to enable control and for adjustments to be made (*ibid*). Gregory Bateson, an anthropologist applied these concepts to the social sciences, proposing that a family could be viewed as a cybernetic system, where the organisation of events could only be understood in terms of pattern and information, thus making a distinction between the 'paradigm of things' to the 'paradigm of pattern and connection' (Rivett & Street, 2003). Importantly, Bateson's application of cybernetics to family social systems introduced a different understanding of causation. Rather than seeing events in *linear* sequences, it was understood to be a continuous *circular* process taking place over time. Indeed, in the history of family therapy Bateson is credited particularly with providing the theoretical foundation, from which family therapy developed (*ibid*).

1.2.1.3 Influence of research

During the 1950s, a failure of traditional clinical treatment, together with the emerging theories of cybernetics of family systems, led to funding for research into the causation of conditions, particularly schizophrenia (Lidz *et al.,* 1957; Wynne *et al.,* 1958; Haley, 1963; Bateson, 1972; The Palo Alto group 1956; The Mental Research Institute, 1959, cited in Dallos & Draper, 2010). This research suggested that communication played a significant role in aetiology, understanding schizophrenia not as an *intrapsychic* phenomenon but as an *interactional* one (Rivett & Street, 2003), which led to explorations in therapy with families to provide further research data (Jones, 1993).

1.2.2 SYSTEMS THEORY

Developed from von Bertalanffy's 'general systems theory' in 1968, 'systems theory' in its application to family therapy, has been conceptualised to include a number of central propositions (Jones, 1993). These include: that a family is a system with boundaries organised into sub-systems; each family member's behaviour is determined by a *pattern of interactions* that are *repetitious* and conform to rules that evolve over time; these patterns ensure that it is impossible to determine linear causality but instead promote an appreciation of the *circularity* of interaction; some of these patterns prevent change (homeostasis) whilst others promote change (morphogenesis); *feedback* determines which of these mechanisms takes place and; if the system is unable to adapt to change, one element will develop a 'symptom' (Rivett & Street, 2003). These propositions are understood to represent a merging of general systems theory and cybernetics, to form the basis of 'systems theory' of family therapy.

Systems theory is referenced widely as the theoretical foundation of family therapy, and is understood to inform many therapists' fundamental understandings when working with families today (Rivett & Street, 2003). However, it has received criticism and been rejected as an adequate theory for family therapy by many influential practitioners (Hoffman, 2002; Anderson & Goolishan, 1988; White & Epson, 1990; and Luepnitz, 1988, cited in Dallos & Draper, 2010). Specifically, systems theory was criticised for the emphasis that it placed on the 'system' over the individual, which was argued to inflate the role of the family and conflate the *experience* and *meanings* of the individual (Rivett & Street, 2003). As well as the loss of the uniqueness of individual actions, feminist critique argued that systems theory decontextualised an *individual family* and failed to account for the societal, cultural and political pressures which led families into having difficulties (Rivett & Street, 2003). Whilst systems theory continues to be presented as the theoretical underpinnings of family therapy, it is important to note this 'other story' of family therapists' rejection of systems theory entirely.

The 1960s and 1970s produced a variety of new models developed from systems theory, and distinct schools of family therapy began to emerge including: *communication and validation*

(Satir, 1964); *structural* (Minuchin, 1965); *strategic* (Hayley & Madanes, 1976), the *Milan approach* (Palazzoli, *et al.*, 1971), and *brief therapy* (De Shazer, 1985), all of these supported the interventionist role of the therapist (cited in Draper & Dallos, 2010). These are known as 'first-order' family therapy approaches, as they place the therapist as an observer *outside* of the family system.

1.2.3 FIRST-ORDER CYBERNETICS

The term 'first-order cybernetics' is used to locate the particular thinking that emerged out of early systems theory (Jones, 1993). Broadly, first-order cybernetics is described as adopting a functionalist view of problems: families were seen as interacting systems in which 'symptoms' functioned to preserve stability, and distract from, or divert conflicts, anxieties and fears (often unconsciously held) from other areas of the family's experience (Dallos & Draper, 2010). Thus, the focus in therapy was on: *patterns* and *regularity* in families' lives. Working from within early systems approach, the therapist was viewed as an *observer* of the system and therefore independent from the system. In this way the therapist was seen as the 'expert', who identified patterns in the family and the functions that symptoms were serving, in a detached and objective manner, before intervening to fix or alter the unhealthy function that the symptoms were serving (Rivett & Street, 2003). Intentionality on the part of the therapist therefore, was an important component of change in therapy. The phrase 'first-order change' is used to describe change of a particular *behaviour* that occurs within the system but that does not alter the basic organisation of the system itself (Nichols & Schwartz, 1998). First-order change however was seen as being underpinned by *modernist* assumptions and the emerging dissatisfaction with systems theory led family therapists to seek a different philosophical paradigm for their practice (Rivett & Street, 2003).

1.2.4 SECOND-ORDER CYBERNETICS

'Second-order cybernetics' is the term used to describe the critique of the first application of 'systems theory', which was understood as offering an overly mechanistic view of families (Dallos & Draper, 2010), and can be seen to be influenced more broadly by the emergence of post-modern ideas. Three prominent themes often cited as second-order perspectives include: *the position of the therapist*; *the focus on meaning*; and *second-order change*.

Inherent in the movement to second-order cybernetics was an important shift in the perceived role of the therapist, and an acknowledgment of the complexity of the layers of cybernetic processes, or 'processes of feedback'. In contrast to first order cybernetics, second-order cybernetics conceptualised the 'observer' as part of that which is being observed (Jones, 1993). As such the therapist inevitably 'perturbs' or changes the family system by the very act of observing it (Rivett & Street, 2003). Concepts of *reflexivity* developed in response to this new position of the therapist who, moving from an objective stance, was now required to continuously reflect and monitor their own perceptions, beliefs, expectations, needs and feelings, especially in terms of how these might have an influence on the family (Jones, 1993; Dallos & Draper, 2010).

In second-order cybernetics, there was a move away from an emphasis on patterns in families in general, and the focus shifted towards consideration of the *uniqueness* on what actions mean to *a* particular family (Dallos & Draper, 2010). Difficulties within families were contextualised and understood as related to wider conflicts in society rather than being seen as fundamentally interpersonal, as was marked by the first-order cybernetics. In addition, the emphasis shifted to an exploration of the meanings, beliefs, explanations and stories held by family members (Rivett & Street, 2001; White & Epston, 1990). 'Second-order change' is described as changes in the *structure* and *functioning* of the family system and takes place when there is a modification or alteration to the *underlying beliefs* or *premises* that governs the system (Nicols & Schwartz, 1998). These important shifts in understanding were very much influenced by the post-modern movement, which provided an alternative theoretical framework entirely (Rivett & Street, 2003).

1.2.5 POSTMODERNISM AND FAMILY THERAPY

'Postmodernism'; the culture of ideas, is defined in relation to that which is called 'modernist'; the view that science is built from a firm base of observable facts (Lyon, 1994, cited in Rivett & Street, 2003). Postmodernism therefore refers to the 'exhaustion of modernity' (*ibid*), and has important implications for theories of reality and therapy. In proclaiming her loss of enthusiasm with cybernetics, Hoffman commented: *'Postmodernism,*

whatever that meant, was a small black cloud on the horizon for many of us systemic people for several years, then it burst with thunder storm force on the field of family therapy' (1993, p. 83). Three essential elements of a postmodernism epistemology that family therapists adopted include: a questioning about 'metanarratives'; a regard for 'local' knowledges and; a view that all knowledge is socially constructed (Rivett & Street, 2003). Metanarratives refer to the narratives that have come to dominate Western societies such as a positivist epistemology, and postmodernism highlights the importance of the questioning such metanarratives. Instead, emphasis is placed on the privileging of 'local' or 'alternative' knowledges, which have been rejected or silenced in society (Foucault, 1965). Postmodernism therefore moved towards the 'unpicking of local discourses', so a 'multiplicity of voices' can be represented (Rivett & Street, 2003). Finally, social constructionism asserted that 'reality' was determined not by the individual, but by social structures (*ibid*). Within this the importance of language is identified in initiating processes of social construction, which in turn become 'reality/ies'. The development of family therapy can be understood as being underpinned by these three postmodernist ideas, from which a number of significant approach were developed (*ibid*; Jones, 1993).

1.2.5.1 Social constructionist approaches

Anderson and Goolishian (1992) defined their practice as postmodern therapy, which drew largely on social constructionist ideas (Boston, 2000). The philosophical culture of *hermeneutics:* the science of interpretation and explanation, also was an important influence on this model (*ibid*). In this way, the structure of therapy is less about beginning, middle and end points, and more about creating a space for a *specific kind of conversation between* participants (Dallos & Draper, 2010; Rivett & Street, 2003). The role of the therapist would be to ask questions aimed at the expansion and uncovering of *meanings* for the individuals in the system; as such they move from a position of 'expert', to that of 'collaborator' (Hoffman, 1993; Anderson, & Goolishian, 1992). In this way, advice or research evidence in relation to a particular problem might be offered as one of *many* potential ideas. The therapist would appreciate that some explanations might not fit with the client's experience and would be genuinely respectful of and interested in the client's thoughts and reactions (Boston, 2000). The therapist's primary contribution to the process of change is therefore understood as the construction of a particular style of conversation. Working from within the social

constructionist understanding that reality was created through language in an ongoing interactional and relational process (Gergen, 1985), difficulties are understood to be constructed within this language system and can therefore be 'dissolved' through language (Boston, 2000). An example is the technique of 'reframing', where language is used to give new meaning to a situation; through this process the therapist would offer a new or different way of understanding a problem, as an intervention (Piercy, 1996, cited in Dallos & Draper, 2010). Similarly, 'reflecting team conversations'; where team members speak to one another in front of the family, are used to comment on and participate in the co-construction of alternative meanings (Anderson, 1991). Anderson and Goolishian (1988), also considered the system within which therapy occurred, as one which could encourage 'problem-saturated' ways of talking about difficulties, which they argued maintains an idea of 'pathology'. Whilst the therapist is positioned as the 'co-creator' of the conditions that promote change, this process is driven by the *recursive links between people* rather than the unilateral decisions or actions of one member (Jones, 2007).

1.2.5.2 Narrative approaches

Whilst also based on social constructionism, the narrative model drew more on the postmodernist concepts of the deconstruction of dominant and subjugated discourses, and focused on the importance of narrative structure in meaning-making for humans (White & Epston, 1990). Within the narrative model the idea of 'story' is used as a metaphor to describe how individuals integrate their social experience and make sense of this (Jones, 2007); in this way, story or metaphor was understood as more effective than the use of direct language and 'logic' alone (White & Epston, 1990). Narrative approaches understand an individual's identity as embodying a personal narrative that includes different versions of the self (Rivett & Street, 2003). When attending therapy, a client is understood to present with a 'problem-saturated narrative' that has become internalised as their primary self-description (*ibid*). According to this approach, these narratives are created and maintained by their connections to important others in their lives. The therapist therefore would be particularly interested in the description of the presenting problem from the 'instigator of the referral' (e.g. the parent/s) and that given by the 'identified client' (e.g. the child) (Boston, 2000). The technique of 'externalisation' is used, not only to disconnect the problem from the client's self-descriptions but also to allow for the influence of the problem to be 'mapped', thus

connecting the problem narrative to relevant others (*ibid*). The therapist therefore aims to help people to vary narrative descriptions that dominate their lives, and find 'alternative stories'. Since narratives are understood to be socially determined, therapy often involves *resisting* potentially socially repressive narratives, and also the *deconstructing* of self-narratives and the dominant cultural knowledges that persons live by (White & Epston, 1990; Rivett & Street, 2003). In the telling of a client's story is the realisation that their narration is but a selection of certain events out of a virtually unlimited number (Rivett & Street, 2003). The therapists' role therefore is to explore different interpretations of a story and help the client construct a story that is *their own*.

1.2.5.3 Dialogical approaches

In recent years, a 'dialogical' perspective has emerged within the family therapy field inspired by Mikhail Bakhtin's concept of 'dialogism' (1981), and developed from Bateson's system's theory (1979). Working from within a postmodernist frame, and consistent with the view of language as a meaning making system (Anderson & Goolishan, 1988), it focuses on *how* psychotherapy participants *jointly construct* meaning (Jones, 2007). As with narrative approaches, dialogical ideas engage with the contextual nature of meaning that is considered central to social constructionist thought (Hendy, 2007). Bakhtin challenged the notion that 'things' have a distinctive existence in complete separation from their surroundings. He referred to this as an 'aboutness' or 'monological' thinking, where the 'other' is understood to be merely an object; passive and controlled by the explanations of the dominant (Rober *et al.,* 2008). Instead, Bakhtin argued for a 'withness', or 'dialogic' thinking. This assumes interconnectivity with an 'object' to its surroundings/environment. He wrote, *'Life by its very nature is dialogic. To live means to participate in dialogue: to ask questions, to heed, to respond, to agree, and so forth. In this dialogue a person participates wholly and throughout his whole life: with his eyes, lips, hands, soul, spirit, with his whole body and deeds'* (Bakhtin, 1984, cited in Rober, 2005, p. 481).

Using this frame, the process of understanding is not passive, in which meanings are conveyed by the client and received by the therapist; rather, understanding becomes an *active, creative* process in which the meanings of the client make contact with the meanings of the therapist. It is in *the space between*, in which living movements are intertwining with

each other that new possibilities of experiences and meanings are understood to emerge, which are different from the original meanings of both the client and therapist (Rober, 2005). It is argued that what changes within an individual in such encounters is not the learning of new facts or bits of information, but the learning of new *ways of relating* with an other, and the otherness in the world around them, and an understanding of 'how to go on together' (Rober, 2005). The search for repetitive patterns therefore is understood as misleading, as each new circumstance an individual confronts is *unique* (Rober *et al.*, 2008). Importantly, dialogue is not necessarily synonymous with conversation; two people may converse, but they are likely to do so in a monologic way, and are consequently unable to generate new meaning in each other (Hendy, 2007). The conversations between teacher and pupil, or doctor and patient for example, may produce new knowledge in the pupil and patient but only as a duplication of the already existing authoritative knowledge (*ibid*). Thus, instead of change being located as a variable within a model, client or therapist, it is understood to be within the *dialogical space* that the meaning of change, for two people, at that time is co-constructed (Shotter, 2011).

Despite the significant contributions of postmodernism to the developments of family therapy, the 'grand' or 'metanarratives' of systems theory remain. As well as the paradoxical critique that 'postmodernity' is itself a new 'grand narrative' (Rivett & Street, 2003), feminist critique has argued that the post-modernist view reduces the self to that which is linguistic in origin only, and thus denies the pre-linguistic mother-infant relationship (Sanders, 1998). This critique also includes that of the post-modernist assumptions that conceptualise emotions as an expression of a historically contingent social role, rather than an internal state (*ibid*). Sanders expresses concerns that this 'untheorised' emotionality may lead to the ignoring of the non-verbal in therapy, and together with the emphasis on language, would silence notions of the emotional self, existing as a chance component of therapeutic interaction only, and one that is difficult to justify (*ibid*). In response to social constructionist's claims that there is no reality, Speed argues that there *is* a reality, but that there are competing descriptions of it (1999; cited in Rivett & Street, 2003). Held (1996), further proposes that postmodernist therapists have confused 'constructing' understandings of reality with reality itself and that reducing all stories to 'stories' is 'ethically demeaning' for clients. She writes that *'as therapists we have no business turning our backs in the all-too-*

harsh realities that our clients have not invented, but nonetheless must face in their quest for better lives' (1996, cited in Rivett & Street, 2003, p. 39). Within the last decade, a 'third-order cybernetic' movement has been identified within current family therapy approaches which acknowledges social inequality as a given rather than a construction (Dallos & Urry 1999).

1.2.6 CURRENT FAMILY THERAPY PRACTICE

Whilst family therapy started from a common basis in systems thinking, it has developed in many directions during its 50-year history (Sexton *et al.*, 2004), where there are now several different models contained within the systemic paradigm (Boston, 2000). Broadly, 'systemic family therapy' is currently described not as a single treatment method but a generic term for a number of principles such as: *strategic, structural, Milan, post-Milan, feminist, Bowenian, narrative, solution-focused, social constructionist* and so on (Dallos & Draper, 2010; Rivett & Street, 2003; Larner, 2004), incorporating *both* modern *and* postmodern approaches (Dallos & Draper, 2010; Boston, 2000). Whilst these approaches differ in important ways, they continue to understand family therapy as a *relational* process rather than a discrete application of an operational method (Larner, 2004). As a *collaborative* and *reflective* form of therapy, the person's *language* and *agency* is given priority rather than a particular model or technique, and special consideration is given to issues of culture, gender, politics and spirituality (*ibid*).

Systemic thinking and approaches are described as being increasingly more accepted and used in a variety of settings and with a variety of problems or issues (Dallos & Draper, 2010; Stratton, 2010; Carr, 2009a, 2009b). As such, the application of systemic ideas can be seen in public and voluntary health and welfare agencies, as well as in private practice, and systemic family therapists are often located within multidisciplinary teams (Stratton, 2010). It is argued that the embracing of integration within family therapy's differing models and approaches, has also allowed for conversations to occur across the boundaries of different disciplines also, in a collaborative way (Speed, 2004). For example, Dallos and Draper (2010) note that systemic family therapists are well placed to facilitate connections across the boundaries of different professionals involved in a case where communication and coordination appear to be poor or ineffective. In response to this, Speed (2004) declares in

her paper: 'All aboard the NHS', and describes the ways in which family therapists can continue to develop this role in current practice.

1.3 FAMILY THERAPY RESEARCH

There is growing recognition of family therapy approaches, which are used for a range of specific conditions; as such family therapy approaches are recommended by the National Institute of Health and Clinical Excellence (NICE). Specifically, it is recommended that 'family interventions' should be made available to: the families of people diagnosed with 'schizophrenia' (NICE, 2002); 'bipolar disorder' (NICE, 2006); OCD (NICE, 2005); children and adolescents with anorexia nervosa (NICE 2004a); and clients diagnosed with 'depression' who have a regular partner (NICE 2004b). Family therapy research can be understood by differentiating that which investigates either the therapeutic *outcome* or the therapeutic *process*. Whilst a large amount of *outcome* research has been conducted demonstrating that family therapy works (Shadish & Baldwin, 2003; Carr, 2009a, 2009b; Crane, 2008; Stratton, 2010), little is understood about the *process*, specifically how interpersonal change actually comes about in the context of family therapy (Heatherington, *et al.,* 2005; Larner, 2004). The literature has identified the therapist as an important factor within the change process (Sprenkle & Blow, 2004; Sexton, *et al.*, 2004; Blow, *et al.*, 2007), however little research has been conducted that explores *how* therapists work to bring about change for clients in family therapy (Sexton, 2007; Simon, 2006; Sexton & Ridley, 2004). This section will review and critique the outcome research and process literature that has been published to date, before moving onto a complete systematic review of published qualitative research conducted with therapists on the process of change in family therapy.

1.3.1 OUTCOME RESEARCH FOR FAMILY THERAPY: SUMMARY AND CRITIQUE

The most recent comprehensive reviews of the effectiveness of systemic therapy for both adults and children, presenting with a range of difficulties were published by Carr in 2009 (2009a, 2009b). Carr (2009a) reported the effectiveness of couples and family therapy with adults, either alone or as part of multi-modal programme, for a range of difficulties including anxiety, depression and schizophrenia. A companion paper (Carr, 2009b) published at the

same time reported the effectiveness of systemic interventions either alone, or as part of multi-modal programmes for a range of child-focused problems, including conduct problems, emotional problems, eating disorders and somatic problems. The systemic interventions identified were also reported to be brief; rarely involving more than 20 sessions, and were effective at follow-up. These reviews drew upon a range of types of evidence: primarily published meta-analyses and systematic literature reviews, as well as controlled trials; but in the absence of any of the above, uncontrolled studies were selected (Carr, 2009a, 2009b).

Where economic analyses have been carried out, family therapy is found to be no more costly, and sometimes significantly cheaper, than alternative treatments, without loss of efficacy (Crane, 2008). Whilst it is difficult to accurately gauge the cost of different treatments, these findings are thought to be an underestimate of the full cost saving implications; for example, research has not been able to capture the longer term gains and also the gains for the wider family system (Crane, 2008; Stratton, 2010).

While the development of the evidence base through outcome research is encouraging, there are important limitations of the research that need to be considered. These include inconsistencies with classification and sub-classification of family therapy, and a relative lack of research on postmodern approaches. Whilst attempts to classify family therapy approaches in studies have been identified as problematic (Shadish *et al.*, 1993, cited in Stratton, 2010), using a broad definition for 'family therapy' also presents with challenges (Carr, 2009b). It is argued that the wider definition of 'systemic intervention' potentially blurs the contribution of those practices developed within the tradition of family therapy, as distinct from interventions in which parents/significant others are included as an *adjunctive* role to facilitate *individually* focused therapy (*ibid*). This 'blurring' is observed in the current NICE guidelines as identified by Eisler (2005), in which there is a lack of distinction between family 'therapy', family 'intervention', and family 'work'*;* whilst 'therapy' is used in the full guidelines, the summary uses 'intervention' and 'work' descriptions only (NICE, 2002; 2004). While 'therapy' typically refers to treatment delivered by a qualified therapist, the terms 'work', and 'intervention' describe treatments delivered by allied professionals, without the same level of training. Furthermore, whilst recent reviews (Carr, 2009a, 2009b) included a broad range of interventions, the majority; particularly in the controlled trials,

drew on cognitive-behavioural and structural-strategic forms of systemic interventions, which were more reflective of earlier approaches of family therapy (Stratton, 2010). As discussed, the past 50 years has seen significant increases in social constructionist and narrative approaches used in family therapy (Dallos & Draper, 2010; Stratton, 2010), yet these approaches are under-represented in the evidence base (Heatherington *et al.,* 2005; Roy-Chowdhury 2003).

1.3.2 LITERATURE ON THE ROLE OF THE THERAPIST IN THE PROCESSES OF CHANGE

Despite the growing outcome research on the efficacy of family therapy, little is known about *how* interpersonal change actually comes about in this context (Heatherington, *et al.,* 2005; Eisler, 2006; Blow *et al.,* 2007; Dallos & Draper, 2010). Empirical evidence of psychotherapies broadly however, indicates that the therapist is an important factor in therapeutic change (Wampold, 2001; Elkin *et al.,* 1989). For example, The National Institute of Mental Health (NIMH) Collaborative Depression Study (Elkin, *et al.,* 1989), reported to be the best and most comprehensive outcome study of its kind (Blow *et al.,* 2007), reported significant differences in the efficacy among therapists, which were independent of the treatment model, setting, and experience level of the clinician. Such were the effects of therapists that it is argued that the NIMH depression study may say more about 'empirically validated *therapists'* than about 'empirically validated *therapies'* (*ibid*). Similarly, in his meta-analysis Wampold demonstrates the statistically significant effects of therapists in treatment (2001). Despite there being considerable evidence of therapist variability in change outcomes, little is understood about *why* it exists both in psychotherapies broadly, and also systemic family therapy specifically (Blow *et al.,* 2007). Much of the early work on the role of the therapist variables focused on the personal characteristics of the therapist such as: gender, race, age, values, type of training, experience, and so on, which were viewed as static, and regardless of the client, problem or therapy (Beutler *et al.,* 2004; Bowman *et al.,* 2001), while other approaches considered the core skill of the therapist (*ibid*). Despite these endeavours, research has so far failed to reveal a clear 'profile' of a good therapist (Sexton, 2007).

More recently attempts have been made in the family therapy literature and research to conceptualise family therapists' *role* in the process of change. Much of the literature to date has been organised around constructions of 'common factors' both within psychotherapies broadly (Wampold, 2001) and family therapy specifically (Blow *et al.*, 2007; Sprenkle & Blow, 2004). This approach draws on meta-analyses to argue that, since no quantitative differences have been found among the differing approaches, there must be no differences in mechanisms of change (Shadish & Baldwin, 2003; Wampold, 2001). As such, understanding processes of change has been concerned with exploring the factors thought to be common to all psychotherapies, rather than a specific model, approach or technique. These included: client variables, therapist variables, the therapeutic relationship (e.g. the therapeutic alliance), and expectancy (Sprenkle & Blow, 2004). In this way, common factors are understood to work through models, and models in turn work through therapists, thereby highlighting the therapists' role within processes of change. Not only are therapist variables/factors identified explicitly within this theory, but it is argued that most key changes are either initiated, or influenced by the therapist (*ibid*). Furthermore, the therapist's ability to identify and maximise these change opportunities largely determines the *therapist's*, and hence, *therapy's* effectiveness. Sprenkle *et al.* therefore argue for an intensified focus on the role of the therapist in research within a common factors lens (2004).

'Common factors' theory however has received significant criticism within the family therapy field (Sexton & Ridley, 2004; Sexton *et al.*, 2004). It is argued that common factors are derived from conclusions of meta-analysis of weak clinical studies, which: group complex variables together; code only the most general variables for statistical analysis; lack statistical power and; given the small sample sizes of many of the studies used, the probability of type II errors are increased, i.e. *not* finding something that is there (Sexton *et al.*, 2004). The meta-analysis drawn on are also argued to be outdated drawing heavily on data from the 1980s; systemic family therapy models and practice have developed significantly over the last quarter of a century, as has the context within which family therapy is practiced, therefore any comparison of differing models needs to include a detailed review of the most current practice and research (Sexton & Ridley, 2004). It is further argued that common factors are broad labels that are poorly defined, and more often than not describe *outcomes* of otherwise unspecified change mechanisms (*ibid*). In consideration of these criticisms, future research of processes of change in family therapy needs to take a broader,

more in-depth perspective which can account for the complexity inherent in therapeutic change processes which, rather than being a static list of variables, are able to inform the therapist about *what* to do and *when* in the process of therapy (Simon, 2006; Sexton *et al.*, 2004).

In response to the argument of common factors (Sprenkle *et al.*, 2004), versus model specific factors (Sexton *et al.*, 2004) in understanding processes of change in family therapy, a theory of '*the self of the therapist*' was proposed as a way to integrate both approaches (Simon, 2006), and in doing so places the therapist at 'the heart of the matter' (Eisler, 2006). It is suggested that therapists achieve maximum effectiveness when they adopt an effective model of change that is congruent with their worldview (Simon, 2006). This congruency between worldviews (of model/approach and therapist), then allows the model's intended change qualities to be maximised through being *authentically* practiced through the person of the therapist (Blow *et al.*, 2007). Within this theory it is argued that it is the *human therapist-client encounter* that provides the best explanation as to *how* treatment works in most psychotherapies (Simon, 2006). Whilst raising important questions, this theory has been criticised as presenting a somewhat constricting, one-sided view of the change process; neglecting the diversity of the families encountered in therapy and *their* own world views (Blow *et al.*, 2007), and also the complicated contexts within which they are seen (Eisler, 2006).

In response to Simon's theory, Sexton (2007) argues that there are multiple influences of the therapist on outcomes of therapy, beyond that of the 'self', which interact in complex ways. In this 'multi-layered change process' the therapist is understood as both a *mediator* and *moderator* of change in the relationship between the model, the therapist, the client and the outcome (*ibid*). In this way the therapist is conceptualised to be both an *independent factor* and a *key link* within the therapy process. In this way the goals of therapy are successful only because the therapist is or behaves in particular ways, with particular clients, in particular therapeutic situations, and within certain specific therapeutic processes. The author draws on research linking model adherence of therapists to successful outcomes and also the importance of the therapeutic alliance, to support these ideas (Barnoski, 2003; Schoenwald *et al.*, 2000; Robbins *et al.*, 2003, 2006, cited in Sexton, 2007). They concluded that what is

needed is a comprehensive view of the therapist within a larger change model that can help us to understand *how* the therapist moderates and mediates the change process in both common and specific models of therapy, in a dynamic, rather than static way (Sexton, 2007).

Attempts to better understand *how* therapists moderate and mediate change process can be identified in the emergent work of Rober (2005; 2008; 2011). Working within a dialogical framework, it is proposed that dialogues exist not only between the self and other/s but also *within* the self. In this way, utterances offered by the therapist are simultaneously influenced by his/her own inner dialogue, as well as the evolving interplay between the external and inner dialogues (Shotter, 2005). The inner dialogue of the therapist therefore has become of recent interest within the family therapy field (Rober, 2005; 2008). Whilst the therapist's inner dialogues have mainly been discussed conceptually in the literature (Shotter, 2005; Rober, 2005), Rober (2011, 2008) has begun to study it empirically, and has identified a broad range of thoughts, feelings and ideas on the therapist's mind during their work with families. These include: monitoring the implicit invitations to join family members in potentially destructive relational scenarios; reflecting on the possible negative and perpetuating effects of their interactions with the family; and exploring opportunities to proceed with the session in new and constructive ways (*ibid*). Whilst this research is in its infancy, and has not yet been explicitly discussed in terms of change, it draws attention to the therapist's experiencing, which is seen as an important tool that may be used to further the therapeutic process (*ibid*). Whilst the validity of these concepts and how they might relate to process of change need further study, they begin to open out some of the complex and multi-faceted ways in which therapists moderate and mediate processes of change in family therapy.

Despite the significant role of the therapist identified in therapeutic change throughout both the broad psychotherapy literature (Wampold, 2001; Elkin, *et al.,* 1989), as well as family therapy specifically (Simon, 2006; Sprenkle, *et al.*, 2004; Sexton, *et al.*, 2004), significant gaps are identified in our knowledge of *how* therapists work to bring about change in therapy. Surprisingly little is understood about the variables and characteristics that exemplify an

effective family therapist and also how these therapist variables interact with varying therapy approaches, clients, or presenting problems (Davis & Piercy 2007a; 2007b). As such, the literature calls for an intensified focus on the role of the therapist in processes of change, exploring *how* therapists think and make decisions in therapy about *'what to do when, with what clients, with their specific presenting problem, and in their specific familial and cultural context ... so that therapy moves forward and deepens'* (Blow *et al.*, 2007, p. 313). The current study aims to address this through exploring family therapists' understandings and experiences of processes of change in family therapy.

1.3.4 CONTEXTUALISING RESEARCH ON SYSTEMIC FAMILY THERAPISTS

Given that little is understood about the role of the therapist in processes of change in family therapy, despite empirical evidence that demonstrates their importance, it seems important to consider the context in which this knowledge, or lack of knowledge, is constructed, so that challenges might be addressed. Congruent with postmodernist thinking, this section will offer a brief deconstruction of the concept of 'evidence', paying particular attention to *how* it is defined, and *who* defines it.

The critique of the construction of the current evidence-base can be broadly understood as both the *limitations* of the methodologies used, and also the way that they are *privileged* in the construction of the 'evidence-base'. Specifically, it is argued that the methodologies traditionally privileged in the construction of an evidence-base, particularly those of RCTs which are highly valued, are *inadequate* for understanding change in family therapy, in which they oversimplify the complexity of social phenomenon (Larner, 2004; Roy-Chowdhury, 2003). Therapy is understood as an infinitely complex *shifting* web of interactions, feelings, beliefs and emotions (Larner, 2004; Jones, 1993). Therefore in seeking to quantify the complex human activity that occurs through therapy using *static* and *controlled* variables is argued to lead to a simplistic and reductive account of the work (Roy-Chowdhury, 2003).

While the role of the therapist has been identified as having a significant effect on outcomes, RCTs continue to attempt to control for therapist variables, by assuming that there exists a

group of '*identically cloned therapists, mechanistically using the same words in the same manner in the same sequence to a group of identical clients, who 'manifest' the same problem'* (Larner, 2004, p. 99). Research conducted in this way is argued to be far removed from real, clinical practice, where clients often have more severe, complex, and co-morbid presentations and live in more complex and disadvantaged environments, than those recruited for research (Larner, 2004). Through the controlling of variables, the client, the therapist and the process of therapy is completely uprooted and decontextualised. In contrast to the medical model, Wampold (2001) instead calls for a 'contextual view' and argues that *who* delivers the treatment in psychotherapy is actually far more important than the specific ingredients used (cited in Blow *et al.*, 2004).

In this economic and political climate there is a strong emphasis on delivering evidence-based practice within healthcare settings (Dallos & Draper, 2010). Understandably commissioning decisions need to be made based upon 'evidence'. However, where resources are limited the reliance upon cost-benefit analysis to inform commissioning has typically favoured research into, and commissioning of therapies that can be manualised and applied to specific client populations (Larner, 2004), as is observed in the recommendations of Carr's recent meta-review (2009a, 2009b). However, evidencing and delivering family therapy en masse poses significant difficulties not least because manualisation requires that effects relating to the therapist be controlled. Furthermore, social construction and narrative approaches, which are widely practiced and have defined theory and practice in the field for well over a decade, have been less amenable to manualisation and replication (Dallos & Draper, 2010). Blow *et al.*, (2007) observed that *'in chasing the government carrot, our consideration of variables influencing therapeutic change becomes increasingly narrow'* (p. 301). Unless research methods that are able to explore and understand the role of the therapist are employed, there is likely to remain a tendency towards inadequate manualised treatments, which fail to take into account the therapist-client relationship.

Whilst much of the discourse of this critique has included an *either/or* position; *either* modern, 'scientific' quantitative methodologies *or* post-modern, qualitative methodologies, Larner proposes that a *both/and* position is instead adopted (2004; Roy-Chowdhury, 2003; Rivett & Street, 2003). Larner refers to this as '*paramodern'*, in which a *collaborative* stance

is taken, which does not reject modern science of psychotherapies but seeks to critique, deconstruct and enrich it from within. *"Here, narrative and science, quantitative and qualitative, modern and postmodern perspectives sit together as a necessary tension, sharing an investigative, ethical and pragmatic curiosity about what is helpful in the difficult work of therapy"* (Larner, 2004, p. 34). Again, congruent with systemic thinking, this makes use of *multiple* discourses in seeking to construct explanations for processes of change in family therapy. If, as Dallos and Draper (2010) argue, the challenge for research into family therapy is for the research to be compatible with the process of the clinical work itself, then there is a compelling case that more flexible, broader methodologies are needed. These methodologies must be sophisticated enough to explore the dynamic and complex processes of family therapy (Larner, 2004; Roy-Chowdhury, 2003), and in particular family therapy research can no longer afford to ignore the role of the therapist (Blow *et al.*, 2004).

Despite its importance, little is known about the process of change in family therapy, particularly with regards to the role of therapist. Some research has attempted to explore these processes, with a focus on the role of the therapist, in an attempt to better understand *how* change occurs in family therapy. A systematic review of the literature exploring the role of the therapist in processes of change in family therapy will now be presented.

1.4 SYSTEMATIC REVIEW OF THE PROCESS OF CHANGE IN FAMILY THERAPY

1.4.1 INTRODUCTION

This study aimed to understand systemic family therapists' understandings and experiences of the process of change in family therapy. Following a review of the literature that explored processes of change in family therapy, with particular focus on the role of the therapist, a 'systematic review' was conducted to identify what is currently known and not known about processes of change in family therapy, from the view of the therapist. This structured and critical review of previous research aimed to provide an up-to-date knowledge about processes of change in family therapist. Whilst outcome studies demonstrate that family therapy is effective (Carr, 2009a; 2009b), little is understood about *how* family therapy works

to bring about change (Sexton *et al.*, 2004; Sprekle *et al.*, 2004; Roy-Chowdhury, 2003; Eisler, 2006). The therapist has been identified as a crucial part of this process in research, despite significant attempts to 'control' for their differences in outcome studies (Wampold, 2001; Elkin, 1989), however little is understood about *what it is that they do* to bring about this change and *how they do it*. This systematic literature review therefore attempts to critique the current research that has been conducted on the role of the therapist in processes of change in family therapy. A detailed description of each procedure will now be provided.

1.4.2 METHOD

1.4.2.1 Search strategy

The systematic review included a number of key procedures. Articles were initially identified by conducting searches using the Ovid database which included 'PsycINFO' and 'PsycARCTICLES Full Text'. A search was conducted to identify specific articles that yielded empirical research on *therapists' contributions to/experiences of, the change process* within broad family therapy structures (for example 'marital therapy'). The following search terms and combinations of Boolean operators were applied: Change, AND couple* therap* OR couple* psychotherap* OR marital therap* OR marital psychotherap* OR family therap* OR family psychotherap* OR system* therap* OR system* psychotherap*. These terms were searched in titles only and limited to articles in English and published after 1980. The search was conducted on the 19th of March 2012, and generated a total of 123 articles. The articles generated were reviewed manually and screened using the following exclusion criteria: papers that did not examine the process of change, theoretical review papers, duplicate papers and quantitative studies. Quantitative studies were excluded from the review due to the focus of the research on issues of *process*, rather than *outcome*. Articles that fulfilled any one of the exclusion criteria were rejected. Twenty-eight studies remained after applying the limitation criteria. Full articles were then reviewed manually and those not relevant to the research question or those that met the exclusion criteria were rejected. The Cochrane Library, Google and Google Scholar were also utilised in an attempt to identify other publications that were relevant to this study. An examination of citations and references in key articles was also conducted and yielded a further one article. A total of seven articles were retained for the review. A summary of the search strategy is presented in Appendix I.

Table 1: Summary of studies used in systematic review

No.	Author	Aim	Method (design, data collection & analysis)	Participants	Quality	Findings	Discussion
1	Blow, Morrison, Tamaren, Wright, Schaafsma and Nadaud (2009) Conducted in North America	To understand how the process of change occurs for one couple with one therapist during MFT.	Qualitative and quantitative study, utilising a single case design. Collection of data from a number of sources including: questionnaires completed following sessions; videos of therapeutic sessions and; individual couple and therapist interviews post therapy. No one specific framework of analysis stated.	One couple (Caucasian male, 48 years old; Caucasian female 46 years old), attended therapy over a 13 month period, included 15 therapy sessions. One therapist (female, experienced MFT, specialising in an 'Emotionally Focused approach').	The researchers (n=5) employed a detailed and rigorous analysis of data; viewing and re-viewing of data; working towards consensus; high level of reflection throughout and; the triangulation of data from a multiple perspectives (couple and therapist).	Key factors identified as impacting on the process of change: the role of client factors & extratherapeutic events; the therapeutic alliance; hope and expectancy; therapist factors; specific techniques & interventions used by therapist &; other surprises.	Importance of therapist identified in the process of change. Potential conflict of 'discovery-orientated' approach vs. using a 'common factor' lens. Description of 'what works' rather than 'how it works'.
2	Davis and Piercy (2007a) Conducted in North America	To investigate couple, therapists and model developers perspectives of change in couple therapy: with a focus on model-dependent common factors.	Semi-structured, open-ended qualitative interviews with model developers, former students and former clients. Modified Grounded Theory used to analysis data from interviews	Three different MFT model developers: One 'Emotionally Focused Therapy'; One 'Cognitive-behavioural therapy' and; 'Internal Family Systems Therapy'. A former student of each and their former couple/clients (3 couples and 2 individuals in total, ages ranging from 38-77 yrs, all white, time in therapy ranging from 5-78 months).	A detailed analysis of data reported. Used 'constant comparative method' and 'triangulation'. High level of reflection regarding researchers' assumptions of therapeutic change.	Model-dependent common factors identified across the three different therapies: common conceptualisation; common interventions and; common outcomes.	Working from pre-existing theories (common factors theory) and therefore potentially deductive. Limitations of homogeneity of client sample (demographics and socio-cultural status and 'successful therapy'). Triangulation with researchers only.
3	Davis and Piercy (2007b) Conducted in North America	As above, however with a focus on model-independent common factors.	As above.	As above.	As above	Model-independent variables identified: client variables; therapist variables; therapeutic alliance; therapeutic process and; expectancy and motivational factors. Also present a conceptual framework that outlines how model-	As Above. Concluded that successful therapy seems to be a combination of model-independent (e.g. client, therapist) and model-independent (e.g. model-driven interventions) variables.

						dependent and independent factors may interact to produce change.	Questioning of validity of entire research.
4	Helmeke and Sprenkle (2000) Conducted in North America	Couple and therapists perceptions and experiences of pivotal moments in couple therapy.	Analysis of transcripts of therapy sessions, post session questionnaires (following each session), and two post therapy interviews with each client was interviewed separately. 1st interview included viewing of clips of therapy that had been identified as pivotal by client and then explored further. 2nd interview included researcher, couple and their therapist, and involved presenting initial findings from 1st interview. Interviews and therapy sessions transcribed and analysed using 'constant comparative method' associated with Grounded Theory.	Three couples (all white and heterosexual, ages ranged from 26 – 33 years, received therapy sessions ranged from 3 – 14), and their therapist (one). The therapist was a doctoral student in MFT and had 5 yrs clinical experience.	In-depth analysis of data. High level of reflexivity of researcher and position declared regarding assumptions about change. Data collected at multiple points in therapy, including during the therapy process. Triangulation of data with couples and therapist.	Findings revealed that: pivotal moments can be identified by clients and lack of congruence between husband and wife, and between therapist and client.	Data collection at multiple points in therapy and from a number of sources. Taken back to participants: triangulation. Not able to assume that therapy is enhanced with more awareness of pivotal moment, or between therapist's level of congruence with clients' identification of pivotal moments and the outcome of therapy.
5	Burck, C., Frosh, S., Strickland-Clark, L., & Morgan, K. (1998) Conducted in North America	To explore how therapists contribute to changes in the ways family members discuss their situation.	Initial generation of themes using a *grounded theory analysis* of transcripts. Focused on that of 'control' (which was similar to previous research Frosh et al., 1996) Re-examination of transcripts in relation to this theme, identifying changes in discourse of the family. Used one family's therapy sessions to examine (i)*how* the therapist contributions to the new meanings that emerge, and (ii) the *interventions used* in relation to the production of these new meanings. using *discourse analysis.* Author re-examined transcripts, using discourse analysis.	One female family therapist of many years' experience, and one family (including Mother, Father and three children). Attended 30 Family Therapy sessions.	In-depth analysis of therapist's contribution to the processes of therapy. Exerts of transcription sand analysis reported, which allows for transparency for the reader. No reflective account reported. No reported methods of triangulation.	Identified ways in which the therapist contributed to client's extended use of discourses, with regards to both content and process. Including: engagement and establishing multi-positionality; an emotional connection to the alternative discourse and at the same time declaring of view and; confirming the family's repositioning in discourse.	Discourse analysis an effective and rich way in which to explore processes of change. Detailed attention to the contribution of therapist on change processes. Lack of triangulation of analysis at different stages of the research, potentially compromising validation of conclusions drawn.
6	Wark (1994) Conducted in North America	To examine client couples' and their therapists' views of change in	Data was collected from participants directly after their therapy sessions (every third session), using the 'Critical incident Technique', looked specifically at views of the most important positive and negative events of therapy. Couples interviewed conjointly, interviews audiotaped and transcribed.	Five therapists and their client couples. The couples were all heterosexual and ranged in ages between 21 – 34 years. All but one couple were	Inter-rater cross checking of categories. Data collected at multiple points in therapy, including during the therapy process.	Categories emerged which provided descriptions of important positive and negative events of therapy for both client and therapist.	Interviewed couples and therapists directly and also directly after therapy, therefore exploring processes of change as they were happening throughout therapy.

		couple's therapy; using an exploration of critical incidents.	Data then sorted to form categories and analysed inductively. 'Positive' and 'negative' events for client and therapist separately. A further analysis was conducted to compare significant incidences between therapist and clients.	married. Sessions lasted between 11 – 16 sessions. Therapists were training in MFT doctoral programme. Ages ranged from 32 – 39 years and were a mix of male and female. Three models of family therapy were used among the therapists: experiential, solution-focused, and structural.		Findings indicated that therapists' views of what was helpful and not helpful to therapeutic change diverged greatly from their clients' views.	Congruence in perceptions not necessarily understood to facilitate change, therefore further research is needed.
7	Jackson (1986) Conducted in Australia	Compared therapist's views of the possible catalysis of change in therapy with one family's ideas.	Single-case qualitative study design. Twelve months after termination of therapy. Specific moments that can be recalled as helpful and unhelpful and those being of significance in promoting change. These then to be compared with therapist and the therapeutic team. Researcher also therapist. Semi-structured open-ended interviews. Used a diagnostic label for client.	Therapist (also researcher) and the therapeutic team. One family (Mother and Father and 'patient' daughter diagnosed with 'anorexia', the middle of three sisters.) Attended 6 sessions of therapy, each at monthly intervals. Approach of therapy described as 'strategic/systemic'.	Unclear how the data was analysed. No triangulation of data reported. Length of time of 'follow-up' possibly limits recall. Of family and therapist.	High degree of congruence between the therapist and family. Key themes identified: engagement processes; circular questions; validation of client's uniqueness; shifts in the family's belief system and; a 'flight to health' of the anorexic client.	The need for more clear and robust methodology.

1.4.2.2 Critical Appraisal

In-depth summaries of key articles identified are presented in table format (see Table 1 above). A brief narrative review is provided for each study, which included a summary of key findings and identified limitations. Finally, a discussion is presented which attempts to synthesize the research findings and consider implications for future research.

1.4.3 RESULTS

This section will describe the key studies identified, with a focus on the methodologies employed and key issues as they relate to this research question. A synthesis of the studies including methodological issues will be described below (section 1.4.4.2).

Blow *et al*., (2009), used a single case design to explore the process of change for one couple and their therapist. Researchers use an in-depth qualitatively analyse of videotaped therapy sessions to generated themes, which were then explored through interviews with the couple and therapist separately immediately post therapy and again at 18 months post-therapy. No particular framework of analysis was specified, however the researchers were reported to have employed a detailed and rigorous analysis of data: viewing and re-viewing of data; working towards consensus; demonstrating a high level of reflection throughout, including triangulation of data from multiple perspectives (couple and therapist). A number of key factors were identified by the researchers to have impacted on the process of change for this couple: client factors; therapist factors; the therapeutic alliance; and other events. A particular strength of this study is the detail and rigour that was employed by the researchers in their varied analysis, particularly the processes of reflection throughout and use of triangulation. However, whilst the authors described using a 'discovery-orientated' approach, it is noted that they used a 'common factor' lens within which to analyse and report the data. Thus, it could be argued that an explicit preconceived theory was imposed onto the analysis of the data and therefore was not truly 'discovery-orientated'. This is more reflective of 'top down approaches' rather than working from the data up. It is also noted that the main researcher of this study is a co-founder of the common factor theory, which might in part explain the apparent bias. Furthermore, it could be argued that instead of describing *how* change

occurred, the researchers instead generated another description of variables that describe *what* works.

Two companion articles by Davis and Piercy (2007a, 2007b) outlined a qualitative study that attempted to discover model-dependent (2007a), and model-independent (2007b) common factors of change across different Marital and Family Therapy (MFT) models. Semi-structured interviews were conducted over the phone for 30-60 minutes with three different model developers ('Emotionally Focused Therapy', 'Cognitive-behavioural therapy' and 'Internal Family Systems Therapy'), former students of each, and their clients (couples and individuals). 'Modified' grounded theory methods were used to analyse the data, which were informed by the researchers' explicit assumptions that they held about the data prior to commencement: *"that there are common factors across models at least partially responsible for change"* (Davis & Piercy, 2007a, p. 323). A 'constant comparative method' was utilised as well as 'triangulation', with the three different researchers.

In the first article, the authors outlined the model-dependent results that were aimed at discovering common factors of change across the different approaches (2007a). 'Model-dependent' themes were described as elements of therapy that were directly informed by the therapist's model. In their results, model dependent themes fell into three categories: common conceptualisations, common interventions and common outcomes. All therapists were reported to have conceptualisations of their client's presenting problem, and use interventions that were informed by their specific model; however they were reported to also have elements that were common to other models. Quality issues were addressed to a high standard in this study and were well reported in the paper. For example, numerous quotes were provided to clarify each category and subcategory so that readers could assess for themselves the relevance of the conclusions drawn, and a table was presented, in addition to a detailed narrative, that catalogued the different levels of analysis throughout each component of the study, demonstrating a transparent reflection processes throughout. Whilst the technique of triangulation was adopted, it is observed that it was with the researchers only, which presents as a potential weakness of the study, particularly given the assumptions of the researchers' of common factors, which were used to generate several hypotheses prior to data collection. As with the study of Blow *et al.* (2009), it could be argued that this study to some extent serves as a self-fulfilling prophecy. This might have been better managed with triangulation extending to the participants in the study. Limitations identified by the authors

themselves included the homogeneity of the client sample; with regard to demographics and socio-cultural status as well as a bias towards clients for whom therapy that had worked well (Davis & Piercy, 2007a). In addition, conclusions were drawn from very brief telephone interviews (some for as little as half an hour), in which interventions recalled by participants were described by the researchers as '*looking'* similar, and were therefore categorised as 'common'. In agreement with previous criticisms of common factors research more generally, it appears that these findings are a broad and rudimentary snapshot of complex processes.

In the second article (Davis & Piercy, 2007b) the model-independent results were reported using the same data and method of analysis described above (Davis & Piercy, 2007a). 'Model-independent' themes were described as elements of therapy that appear to be related to outcome but are not directly related to model. Model-independent themes were reported to fall into five categories: client variables; therapist variables; therapeutic alliance; therapeutic process; and expectancy and motivational factors. Therapist specific variables included: being patient; caring yet firm and boundaried and cultural and religious sensitivity. In the final stage of data analysis a conceptual framework is presented that outlines how model-dependent and independent factors may interact to produce change. The authors describe it as a 'supplemental road map', which instead of being exclusively focused on model-specific tenets, can be superimposed on a wide range of existing models. They concluded that successful therapy seems to be a combination of model-independent (e.g. client, therapist) and model-independent (e.g. model-driven interventions) variables.

Strengths and limitations with regards to the design of the study, as identified by the first paper (2007a), apply to these results also. Furthermore, both papers by Davis and Piercy (2007a, 2007b) produce another description of *what* works, but not *how* it works. Whilst issues regarding *how* the factors identified in the research interact, are addressed in this paper, it is informed by the researchers own theory, rather than the participants themselves, and drawn from categories that are problematic, therefore raising questions of credibility. Once again, triangulation of the emergent theory with the participants might have allowed for greater credibility, and ensured that the theory remained as grounded in the data as much as possible. It is not surprising perhaps that the researchers' account of therapist variables are so sparse (listing three qualities only) and devoid of a sense of the therapists' humanity, given

that interviews were conducted, some for 30 minutes only, over the telephone. It could therefore be argued that given the empirical support for a significant therapist effect on outcomes throughout psychotherapies (Wampold, 2001; Elkin *et al.*, 1989), the brief explanation offered by the researchers in this study are inadequate. As such, it seems reasonable to question the validity of the conclusions drawn more generally. Whilst there are glimpses into the complex processes involved; for example the authors described briefly the therapists' experiencing and managing the 'parts' of a client that were frightening, which thus helped the client to manage those within herself, the process of *how* the therapist did this was lost, and instead this complex interaction was categorised as 'trust', within the broad variable of 'therapeutic alliance'. It is difficult to see what is gained from both these studies beyond another list of broad variables that have been drawn from a pre-existing theory. One wonders if more meaningful understandings of the process of change might have emerged from the data in both studies by removing the reductivist common factor lens through which data was filtered.

Helmeke and Sprenkle (2000) focused on a specific type of change process: pivotal moments. Transcripts of therapy sessions of three couples and one therapist were first analysed using grounded theory. In addition, couples completed post-session questionnaires, and two post-therapy interviews were then conducted. In the first interview, clients were interviewed separately, and were shown video clips of sections of therapy that had been identified as important by the client in their questionnaires. These moments were then explored further in the interview; specifically, individuals were asked to identify and describe what, if anything had changed in that therapy session and what they thought accounted for that change. The second interview, which occurred within two weeks after the first, included the researcher, the couple together, and their therapist, and involved presentation and conjoint discussion of the findings from the first interview. Interviews were then transcribed and analysed using 'constant comparative method' associated with grounded theory. Lists of categories were developed and the researchers found that clients were able to identify pivotal moments. Early pivotal moments were reported to play an important role in establishing the tone and direction of future sessions, and moments identified by the client often differed from those identified by their spouse, and by the therapist, indicating that pivotal moments tended to be highly personal and private experiences.

This paper outlined a clear and detailed methodology, where data were collected at multiple points in therapy, including during the therapy process itself. In addition, the paper used interviews with the client as an individual, as well as conjoint couple, and made effort to 'check out' emerging categories with participants. As such, the quality checks of this research were of a high standard, with explanations of the processes of change remaining 'grounded' in the participants' experiences and understandings. As the authors themselves identify however, it is not possible to conclude from these findings is that therapy is enhanced with more awareness of pivotal moment, nor is it clear whether therapy outcome is linked to the degree of congruence in the perception of a pivotal moment between therapist and client. Further research is needed to support these inferences. In addition, there is little exploration of *how* therapists worked to bring about these 'pivotal moments' that are understood to reflect change; instead therapists are accounted for under the sub-heading of 'non-pivotal factors', where further variables of *what* rather than *how* are listed.

Burck, *et al.,* (1998), extended findings from an earlier published study (Frosh, *et al.*, 1998), and used a single case study to explore *how* one therapist contributed to the emergence of a wider range of discourses of a couple during their therapy sessions. The paper also explored the interventions used in relation to the production of new meanings. One initial theme, 'control', was identified from transcripts of the therapy sessions using grounded theory, and the data was then re-examined using this central theme. The transcripts were analysed again using discourse analysis, with a focus on the therapist's contributions to the couple's developing use of discourse of the theme of 'control'. The author observed a number of ways in which the therapist contributed to this. This included: noting and acknowledging ways in which the family currently take charge whilst also affirming their own account of their experiences; addressing their own position in the discourses and continuing to challenge the process through which the family keeps handing control and expertise over to the therapist; and becoming directly challenging towards the end of therapy. This study has detailed many ways in which discourse analysis can be an effective means to explore processes of change. Given that the therapists were not asked directly themselves however (the data was taken from transcripts of therapy sessions only), the quality of the study could have benefited from a triangulation of the data at various stages, for example in identifying the theme of 'control', or in the analysis made of the therapist's contributions and techniques, so as to provide further validation of the analysis/conclusions drawn.

Wark (1994) examined five couples' and their therapists' views of change in couple's therapy using the 'Critical Incident Technique' (CIT) in semi-structured interviews. Couples were interviewed conjointly directly after therapy sessions, as were their therapists. Interviewees were asked to describe important positive and negative events during the therapy session, and were asked to relate these events to change or lack of change in the concerns that brought them to therapy. Data was sorted and analysed inductively resulting in four categories: positive events according to couple (i) and therapist (ii), and negative events for couple (iii) and therapist (iv). A further analysis was conducted to compare significant incidences between therapists and couples. A lack of congruence was identified in perceptions between therapist and clients and recommendations were made that addressed this. Four categories emerged that reflected therapists' experiences of positive changes in therapy: signs of readiness to change; techniques for change; client interaction in the session; and change outcome. Two categories were identified within therapists' reported negative critical incidents: the therapist taking responsibility for change, and not enough data gathering. The conducting of interviews directly after therapy sessions is a strength in this research; with the aim of exploring processes of change as they were happening, rather than retrospective 'memories' of processes of change. Whilst the study highlights concerns of incongruence between therapists and their clients in their understanding of critical incidences, it is not understood whether congruence in perceptions necessarily facilitates change; as with Helmenke & Sprenkle's (2000) study, further research is needed to understand this better. In addition, the research appears to be presenting another list of *what* variables. For example, in the 'clients' identified positive critical incident' category, different participants identified both 'non-directive', and 'directive' styles of the therapist as positive. As such the research appears to miss important information about the processes at play in negotiating how different clients experience therapeutic approaches in different ways.

Jackson (1986) used a single-case design and interviewed one family; twelve months post therapy, on their views of helpful and unhelpful aspects, as well as possible catalysis of change during their course of therapy. The family's responses were then compared with those of the therapist and therapy team. The therapist is noted to also be the researcher in this study. Unlike the previous studies discussed (Helmenke & Sprenkle, 2000; Wark, 1994), a high degree of congruence was reported between the therapist and the family. Key themes

identified included engagement processes, the pattern of circular questions, validation of the client's uniqueness, shifts in the family's belief system, and a 'flight to health' of the anorexic client. Whilst this study benefit from in-depth single case design, it lacked clear methodological details, such as how the data was analysed, and whether there was any method of triangulation or any other quality checks beyond consulting with the therapy team involved. Issues of objectivity are also of concern with the researcher holding the position of therapist also.

1.4.4 DISCUSSION

1.4.4.1 Methodological considerations

Sample

Of the seven papers reviewed, six interviewed both couple/s and therapist/s directly (1,2,3,4,6,7). Burck *et al.*, (1998) was the only study to explore only the therapist's processes of change (5). Four studies recruited one therapist only (1,4,5,7). Of the seven studies, five specified that therapists were trained/training in Martial and Family Therapy (MFT) specifically (1,2,3,4,6), one specified a 'family therapist' (Burck *et al.*, 1998) (5), and one specified using a 'strategic/systemic' approach (7.). The way 'MFT' was described in theoretical orientation and/or therapeutic approaches varied through the studies. For example Davis and Piercy (2007a; 2007b), recruited MFT therapists whose orientations ranged from 'Emotionally Focused Therapy' and 'Internal Family Systems Therapy' to 'Cognitive-behavioural Therapy' (2,3). All research reviewed had been conducted in the North America, bar one in Australia (7), and where reported, ethnicity of clients was identified as white or Caucasian (1,2,3,4). Ethnicity was not reported for any of the therapist participants.

Design

Three articles (1,5,7) used a single case design, with the number of participants in the remaining studies ranging from to seven to fifteen (2,3,4,6). Two articles gathered data from a number of sources (1,4), which included questionnaires completed following sessions, videos of therapeutic sessions, and client/therapist interviews. Four studies reported using semi-structured interviews alone (2,3,6,7), one analysed transcripts from videotaped sessions alone (Burck *et al.*, 1998). Grounded theory or an adapted grounded theory was the most frequently used analysis (2,3,4,5), one study drew on discourse analysis (Burck *et al.*, 1998) (5), and the remainder reported no specific analysis (1,6,7). Three articles gathered data post

therapy only (2,3,7); intervals post therapy ranged from between two weeks to 18 months, one article gathered data during therapy only (Burke, 1998), (5), and three gathered data both during and post therapy (1,4,6).

Quality issues

The quality of research papers reviewed varied greatly. Despite working from within a 'discovery orientated' position, it was noted that the most recent studies, conducted over the last decade, used a 'common factors lens', to assess the data (1,2,3). Whilst triangulation was reported in the majority of the studies reviewed, this was most commonly by the researcher/s only (1,2,3,4). Only one study brought data back to the participants to check that the developing analysis accurately represented their experiences (Helmeke and Sprenkle, 2000), (4). Of note, the only study to explore specifically the therapist's contributions to the process of change did so through observation, rather than asking the therapist directly (Burke *et al.*, 1998). The most recent studies (Blow *et al.*, 2009; Davis & Piercy, 2007a; 2007b), presented a high level of reflection regarding both their methodologies, and their own assumptions regarding processes of change that might have impacting on the different stages of research. The detailed and thorough account of the research process that was presented conformed to the principles of good qualitative research as described by Elliott *et al.*, (1999).

1.4.4.2 Synthesis of research findings

The articles reviewed present a broad analysis of research that has attempted to explore process of change in family therapy, with a focus on the therapists' role. Whilst the studies differ, for example in methodologies and inter-variability of MFT reported, some general conclusions can be drawn with regards to their findings. Firstly, there appears to be a number of variables that both clients and therapist understand to contribute to processes of change. These include: client factors, such as motivational factors and extratherapeutic events; therapist factors, such as the repetition of key messages and authentic relating; the therapeutic alliance, for example a feeling of safety so that risks can be taken; and therapist's specific interventions and techniques. There was some evidence to suggest a lack of congruence between a client and their therapist's view of what was helpful (Helmeke & Sprenkle, 2000; Wark, 1994), however this incongruence was also found between husband and wife (Helmeke & Sprenkle, 2000), and did not necessarily facilitate less or more change, indeed the same clients reported feeling that the therapist was very much in tune with them. Whilst

the research reviewed has highlighted the importance of therapist factors in the processes of change, many of the studies appear to be continuing to be asking '*what'* works questions, rather than '*how'* it works (1,2,3,6), where studies that better address how therapists work to bring about change are few, and require development of more robust methodologies and quality checks (4,5,7).

1.4.4.3 Implications for research

As is clear from the amount of research published in the last thirty years, further research is needed to better understand processes of change in family therapy. In particular, to better understand the body of outcome data that demonstrates therapist effects on outcome (Wampold, 2001; Elkin, 1989), research is needed which investigates change as it is understood and experienced by the therapists themselves. Those studies that have included family therapists as participants, have all been conducted outside of the UK, with the majority in North America. This presents potential difficulties in attempting to translate these findings to the UK. For example, differences can be observed in the training programmes within the different countries, as well as referral pathways within mental health organisations. Most of the studies published appeared to be mostly based in university MFT clinics, with university-based therapists; which may have in part accounted for the homogeneity of participants used in the studies. Given the diverse ethnic/racial make-up of North America it appears that the findings reported represent that of a relatively select group; white and (where reported) middle class. In addition, the therapist participants appeared to lack diversity in terms of work context. Further research therefore is needed that includes family therapists working in diverse contexts, with diverse client groups, in order to be more representative of the developing family therapy practice in the UK at present. In addition is it observed that the research published on processes of change in family therapy during the last decade has been organised around a 'common factors' discourse, which as discussed presents theoretical, as well as empirical problems (Simon, 2006; Eisler, 2006; Sexton *et al.*, 2004). The research approaches used can be argued to be reductivist in their quest to simplify and quantify the exact ingredients of how to bring about change in therapy, without any credible explanation of *how* they go together; in doing so rich information is lost or shutdown and we drift further away from developing our understandings of *how* change is brought about in systemic family therapy.

1.4.4.4 Conclusions

A detailed and systematic review has been presented of seven articles that were identified as relevant to the research topic. A summary and critique for each was provided, followed by an attempt to synthesis the articles, with consideration of methodologies and findings, before drawing conclusions for the implications for practice and future research. Given the limited amount of research on processes of change, specifically with family therapists practicing in the UK, in diverse contexts, it is recommended that further research be conducted to respond to this gap.

1.5 STUDY AIMS AND RATIONALE

1.5.1 STUDY RATIONALE

The rationale for the current study is reflected in the paucity of research on processes of change in psychotherapies generally, and family therapy specifically. Whilst outcome research demonstrates that family therapy works, what remains to be understood is *how* it works. Convincing empirical research demonstrates the significant role therapists have on outcomes in family therapy; yet despite this, therapists continue to be neglected in research. The findings outlined in this chapter demonstrate that most of the research conducted on family therapy has used quantitative, outcome methodologies, argued to be influenced by political pressures of accountability and cost-effectiveness. Whilst these methodologies have value, they are argued to be inadequate in exploring the complex processes of change that occur in family therapy and the therapist's role within this, and are also understood to be incompatible with family therapy approaches themselves. Whilst a handful of qualitative studies on the therapist's role in the processes of change in family therapy have begun to emerge, this is an under-used field of investigation. Due to the lack of evidence available, there is a limited understanding regarding this subject area, which has implications for systemic family therapists working with clients, and for the profession as a whole. As such, it is argued that further qualitative studies are needed that are better able to explore processes of change in family therapy from the perspectives of the therapists themselves.

1.5.2 STUDY AIMS

A focus on systemic family therapists' experiences and understanding of the processes of change in family therapy were the areas of investigation in this current study. A qualitative research methodology was considered the most appropriate means to gain access to the experiences of individual participants. In addition, the lack of available qualitative research indicated that his approach would enable a broader understanding of the relevant issues. The aim of this study was to identify emergent themes from within the data, using the Constructivist Grounded Theory approach (Charmaz, 2006).

A qualitative investigation of systemic family therapists will provide a rich and detailed understanding of their experiences of working therapeutically with clients. It will provide an important piece of evidence in the area where there is little understood at present. It is expected that the exploration of systemic family therapists' work will provide an increased understanding of systemic family therapy, specifically with regards to *how* therapy works. As such, it is intended to inform, support and sustain the role of family therapists and other professionals working systemically with families, as well as contribute to the current discourse on the development of theory, and also the subsequent training of systemic therapies. Given the quickly changing landscape of access to psychological therapies and the pressures that exist on accountability, this research will be an important contribution to the development of the evidence-base, which is used to influence commissioning and development of family therapy provisions.

CHAPTER TWO

METHODOLOGY

2.1 OVERVIEW

A qualitative approach using semi-structured interviews was deemed the most appropriate in meeting the aims of this research. Interviews were conducted with individual participants who were qualified systemic family therapists, working in Mental Health settings in South West England and South Wales at the time of the study. Data were analysed using a Constructivist Grounded Theory approach, to explore and develop a deeper understanding of the process of change during family therapy. This chapter considers the rationale behind this methodology and describes in detail the design and procedures through which the research was carried out. Ethical issues and research governance procedures are also considered in this chapter.

2.2 QUALITATIVE METHODOLOGY

2.2.1 PHILOSOPHICAL UNDERPINNING

Whereas traditional scientific forms of enquiry are concerned with identifying cause and effect relationships, qualitative methodologies are concerned with meaning; how people understand and make sense of the world, and how they experience events. A qualitative methodology therefore aims to provide a description and possible explanation of events and/or experiences (Willig, 2008).

Within this broad methodology exists a number of different approaches, which can perhaps be best understood through the epistemological stance they assume, and the way in which they conceptualise the role of the researcher in the research process (Willig, 2008). *Epistemology,* the theory of knowledge, attempts to answer the question of 'how, and what, can we know?' (*ibid*). Epistemological positions adopted can be understood to be on a continuum, with *positivism* at one end and *relativism* on the other. Positivism can be

understood in varying degrees on this continuum (Charmaz, 2000). At its purest is an assumption that one is able to 'discover' *objective knowledge* or *truth* that exists in the world, and supposes an *unbiased* and *passive observer* or *witness* in the researcher. Within the social sciences this position has received extensive criticism regarding its failure to acknowledge the role of historical, social and cultural factors (Willig, 2008). In response to this, 'critical realism' evolved. Continuing to position itself firmly within the positivist tradition, 'critical realism' acknowledge the *subjectivity* of any observation and/or description made, therefore rendering 'knowledge' to be partial, at best (Charmaz, 2000). 'Social constructionism' breaks from positivist traditions entirely in its argument that there is no *objective* reality. Instead of being *discovered,* it understands reality to be a *construction* of the mind, and therefore asserts there to be *multiple* truths (Mills, *et al.*, 2006). This position asserts that human experience is *mediated,* rather than merely *influenced* by historical, social and cultural factors and therefore knowledge is a *co-construction* of both the researcher and participant. Beyond 'social constructionism', at the far end of the continuum is '*extreme relativism'*, which rejects concepts such as 'truth' and 'knowledge' altogether.

2.2.2 RATIONALE FOR USE OF QUALITATIVE APPROACH

The primary aim of this study was to develop a deeper understanding of therapists' understanding of the process of change in systemic family therapy; *what* they understood change to mean, and *how* they understood it to occur. It is understood that the development of an understanding of individual's experiences is difficult to investigate quantitatively (Strauss & Corbin, 1998), particularly when there is an interest in exploring a substantive area, as opposed to a specific research question (Willig, 2008). Qualitative research methods on the other hand allow access to, and exploration of, personal experiences and meaning making of research participants, and are considered appropriate to use in areas where research literature is currently limited (*ibid*).

2.3 CONSTRUCTIVIST GROUNDED THEORY

2.3.1 PRINCIPLES

As its name suggests, constructivist grounded theory positions itself within the 'social construction' epistemology. It was established by Charmaz (1995a, 1995b, 2000, 2006), and

was developed from the established qualitative research methodology of *grounded theory* (Glaser & Strauss, 1969). Grounded theory emerged in response to the then prevailing positivist methodologies, which were driven by existing theory, and also the critique that, what qualitative methodologies there were, lacked rigor and validity in their application. As such, the methodology of grounded theory provides systematic, yet flexible guidelines for collecting and analysing qualitative data, that attempts to construct theories *grounded* in the data themselves (Charmaz, 2006), and is therefore *inductive* in its enquiry. Whilst early grounded theory was criticised for its positivist assumptions (Willig, 2008); that there was a *truth* to be *discovered* in the data, constructivist grounded theory offered an approach that was influenced by a social constructionist epistemology. Continuing to adhere to the well-established grounded theory guidelines (Strauss & Corbin, 1997; Willig, 2008), constructionist grounded theory redefines the researcher as the *co-constructor* of experience and meaning. Mills *et al.,* (2006), further position the researcher as the *author* of this co-construction.

In its application, grounded theory aims to identify themes from qualitative data. This involves a process of 'coding' and 'categorisation' of the data, using a 'constant comparative method', where data collection and analysis occur simultaneously. Codes and categories are constantly revised, so as to capture the richness of variation within each category, and to also analyse instances that do not fit the emerging categories, 'negative case analysis', with the overall aim of progressing focus upon an emerging theory, grounded in the participants' experiences. 'Memo-writing' is an important tool that enables a continuous process of evaluation throughout the analysis. In a constructivist grounded theory approach, memo-writing forms a fundamental part of this analytical process. In this approach the researcher's role is considered beyond that of the *affect* they have on the data collection and analysis; instead considering their role in both the *co-construction* of the data, and also their *authoring* of this co-construction. Working from an epistemological position that meanings are co-constructed, memo-writing therefore becomes part of the data itself, rather than simply a critical tool. Original grounded theory founders invited researchers to use grounded theory strategies flexibly and creatively (Glaser & Strauss, 1967), to which constructivist grounded theorists have responded, maintaining the overarching aim of reconstructing participants' stories, as faithfully as possible into theoretical interpretations (Charmaz, 2006). The

strategies involved in the process of this research will be discussed in greater detail in the data analysis section (Section 2.9).

2.3.2 RATIONALE FOR USE OF CONSTRUCTIVIST GROUNDED THEORY

The qualitative methodology of grounded theory is frequently used to generate theories in areas where little is known (Strauss & Corbin, 1998), and was considered appropriate for the current study. Specifically, a constructivist grounded theory approach was adopted to explore the research question. This approach was understood to be consistent with the epistemological position of the therapeutic approach under examination, and also offered a method of enquiry that was understood to facilitate a deeper understanding of the issues being explored. This approach therefore understood that emerging meanings would be a *co-construction* of both the researcher and participants. Furthermore, the strategies employed within this approach would allow for transparency in this *authoring* process of the researcher, with the overall aim of grounding the data in the participants' story, as faithfully as possible. It is argued that a 'fit' with the researcher's own ontological and epistemological position with their chosen methodology is important in enabling the researcher to live out their beliefs in the process of enquiry (Willig, 2008), which was appropriate in this study (see section 2.4.1). This important distinction will be acknowledged in the body of this thesis, with the traditional 'researcher' being instead referred to as 'author'.

Taken together, the qualitative methodology of constructivist grounded theory was considered most suitable for the current research. Central to this methodology is the assumption that the resultant theory offers an interpretative portrayal of the experienced world, rather than providing a 'complete' theory (Charmaz, 2000, 2006).

2.4 ENSURING QUALITY

Qualitative research methods have received a number of criticisms. These have included: a lack of scientific rigour; unsystematic methods of enquiry; over-reliance on anecdotal evidence; and a lack of reproducibility and generalisability (Mays & Pope, 1995). In response

to these criticisms, a number of evaluative guidelines have been developed for use with the various qualitative approaches. Guidelines developed by Elliott, *et al.,* (1999), were utilised in this study to ensure methodological rigour. These guidelines, and a description of how they have been addressed throughout this study, are outlined below:

1. Owning one's perspective: Researchers are required to specify their theoretical orientations and assumptions, both in advance and as they develop throughout the research, in an attempt to consider ways in which these may have influenced the analysis of the data. In the current study this was achieved by providing a statement outlining the author's position at the start of the study (see Section 2.4.1), and also through punctuating the development of the research process with a statement on the development of the author's position, and its impact on the analysis (see Appendix II).

2. Situating the sample: Research participants should be described in order to assist the reader in judging the range of individuals and situations to which the findings might be relevant. In order to do this, details regarding participants that were deemed relevant to the research, for example demographics and years of experience, are reported (see Table 2).

3. Grounding in examples: Examples of raw data should be provided, to illustrate both the analytical procedures used, and the understanding that is developed from the data. This allows the reader to appraise the fit between the data and interpretations made by the author. Therefore, illustrations of themes and concepts gained from the data in this study are provided in the results section (Chapter 3) and extracts of a sample interview transcript are detailed in Appendix III.

4. Providing credibility checks: A number of methods should be used for checking the credibility of the data and interpretations made. These include: checking understandings with the original informants, multiple analysts, and triangulation with data from other sources. In this study the researcher discussed the analysed transcripts and emergent concepts and categories with the clinical and academic supervisors. In addition, triangulation was sought

through the presentation of emergent categories to a sample of participants, so that feedback and verification could be obtained (see Appendix IV).

5. Coherence: The presentation of data, analysis and findings should take place in a consistent and integrated way, through diagrammatic maps or frameworks, and a coherent narrative account. As above, the data was discussed with the clinical and academic supervisors throughout the process of data analysis. Diagrams, narrative, and interpretation of the data can be found in the Results and Discussion sections (Chapters Three and Four), and the process of triangulation was used to ensure that the emergence analysis was consistent with participants' accounts.

6. Accomplishing general vs. specific research tasks: Researchers are required to provide clarity about whether the research aims to develop a general understanding of a phenomenon, or to provide an in-depth insight into a specific instance or case. Limitations of the applicability of the findings beyond their original context should be addressed. The current study is representative of a sample of systemic family therapists based across England and Wales. The findings are not considered to be generalised to any other group. Details regarding the participants are provided so that the reader can decide on the degree to which the findings can be applied to other research settings. The limitations of the research are outlined in Chapter Four.

7. Resonating with readers: The research material and emergent theory should be clear, and contribute to the readers' understanding of the study area. In order to ensure this, draft versions of the theory, as well as the final version were read by both supervisors, in addition a sample of participants were presented with the emergent theory for feedback (see Appendix IV and section 4, above). An overview of relevant clinical and theoretical issues in relation to the research is outlined within the literature review in Chapter One. The resultant subcategories, categories, core categories and themes are also presented in Chapter Three, in an attempt to facilitate ways in which the reader can assess the extent to which the theory resonates.

2.4.1 PERSONAL AND PROFESSIONAL REFLEXIVITY

In qualitative research, particularly constructivist grounded theory, it is recommended that the researcher take the position of *reflexivity*. Broadly, *reflexivity* refers to one's own process of reflection on the ways in which their own understanding and experiences have impacted on the research being conducted. Whilst qualitative researchers differ in the emphasis they place upon reflexivity in their research, constructivist grounded theory positions reflexivity as central to the research process and forms an integral part of the research report (Willig, 2008). It is therefore recommended that researchers 'own' their perspective through the disclosure of their values, social identities and experiences (Elliott *et al.*, 1999), and also their 'gut' sense about the subject matter of the research (Strauss & Corbin, 1998; Charmaz, 2006), which allow the reader to consider the ways in which these have affected the story of co-construction, of which the researcher has authored.

For these reasons a position will be declared by the researcher that addresses their role as author (see below). Working from a social constructionist epistemology, it is important to understand not only the researcher's position more broadly, but also their position in relation to the question being asked. This attempts to make as transparent as possible the position from which the author is construct*ing*. Reflexivity in the research process was considered through the accessing of regular supervision with both clinical and research supervisors throughout the research process. These sessions were utilised to identify and discuss the researchers own shifting position, and consideration of how this may be impacting on the construction of meaning throughout each interview. The author also kept a working reflective journal to facilitate transparency through the entire research process, as recommended by guidelines (Charmaz, 2006).

2.4.1.1 POSITION OF SELF

The author positions herself, in the context of writing her thesis, as a female, 32 years of age, white, welsh, and in her third and final year of her doctoral training in clinical psychology. She punctuates her professional story with the completion of a Psychology Honours Degree, English Honours Degree and post-graduate research module. Her training and experience as a

Primary School teacher, and subsequent work in various mental health settings in South Wales, forms an important part of her professional identity in this story. Epistemologically she identifies with the concept of the 'social construction' of meaning, yet she works from within a 'critical realism' position. She would identify herself as a feminist and has an interest in how power and knowledge is constructed, particularly within mental health systems; as such she positions herself as anti-psychiatry. This position is offered to ensure transparency, and demonstrate a commitment to engage in a research process with awareness of the ways in which the researcher might construct and author the piece of work. The research topic was of interest to her following her time working with children and families, and more recently family therapists, which left the author with a sense of wonder, and intrigue about how 'it' worked.

At the commencement of this study, the author understood change to refer to 'something that is made different', through therapy. In her position of trainee clinical psychologist, she broadly linked this to 'outcomes' that could be measured or observed both at the beginning and end of an intervention. However, through her experiences, she began to understand change to be far more intricate and complex than this explanation allows. An understanding of the *process* of change was even more perplexing to the researcher by the way in which she had begun to feel overwhelmed and bewildered with the 'pick n mix' menu of therapies that she had experienced through training. Amongst all the theories and explanations, she found herself organised by 'common factors' and 'model specific' theories, however at the same time experienced these explanations as both limit*ed* and limit*ing*.

2.5 DESIGN

The study employed a qualitative design using semi-structured interviews, as a means of exploring participants' understanding and experiences of the process of change during systemic family therapy. Data were collected through individual interviews with 11 systemic family therapists working in mental health settings in South West England and South Wales. Participants were invited to an individual interview, led by the author, and were encouraged to discuss their understanding and experiences of the process of change during family therapy. The interview was based on four main questions generated by the author, clinical

and academic supervisors prior to the interviews (see Appendix V). These questions were revised following each interview, so that they remained focused on the relevant areas of the study, and were responsive to the data, in line with the inductive nature of grounded theory approaches (Glaser & Strauss, 1967). Each interview was recorded using audio equipment, and where possible DVD equipment, and transcribed. The transcripts were then analysed using a constructivist grounded theory approach (Charmaz, 2000, 2006).

2.5.1 RESEARCH CONTEXT

The research was conducted within a range of private, third sector and National Health Service (NHS) health settings across South West England and South Wales. Participants worked with a range of client groups including: child and family, learning disabilities, and adult, across a number of different NHS health boards/trusts. The author travelled to interview individual participants in their place of work at mutually convenient times. These ranged from private practice rooms, family therapy clinics, and offices.

2.6 CLINICAL GOVERNANCE

2.6.1 ETHICAL APPROVAL

Prior to commencing the study, Research and Development (R&D) approval was sought from the Cardiff and Vale NHS Local Health Board and was granted in January 2011 (see Appendix VI). Following this full ethical approval was sought from the Cardiff and South East Wales Local Research Ethics Committee, and was granted in March 2011, following presentation of the project to the committee (see Appendix VII). The Ethics Committee Panel was compromised of a variety of individuals from various backgrounds and professions to maximise the perspectives assessing the suitability of the author.

2.7 PARTICIPANTS

2.7.1 INFORMED CONSENT AND CONFIDENTIALITY

Consent was sought from individuals to ensure that they could make an informed decision about whether or not to participate in the study. Information was provided to the participant

at each stage to facilitate this process. Prior to involvement in the study, participants were provided with information sheets (Appendix VIII), which detailed:

- The aims and purpose of the research study
- Information detailing the procedures and what would be required of the participants
- Details of regarding the storage and analysis of the data
- A statement regarding their right to withdraw from the study at any time.

Before commencement of the interviews, participants were provided an opportunity to ask questions in relation to the study. Following this participants were then asked to complete a consent form (Appendix IX), confirming that they had read the information provided and indicating that they agreed to participate. In addition, they were asked to complete a personal details form (Appendix X). Participants were reminded that they were free to withdraw from the study at any time and that any data provided would then not be used in analysis.

Confidentiality was addressed by the author in a number of ways: participants were ensured that all personal details provided would be kept anonymous; they were informed that quotes provided during the interview process were likely to be included in the final write-up; and that a pseudonym would be ascribed to quotes in an attempt to protect the confidentiality of their responses. Participants were also reminded of the importance of preserving client confidentiality, in their responses during the interview process.

The length of each interview ranged from between 50-70 minutes. Following each interview the data was transcribed verbatim by the author. Any details that pertained to the participant's identity through the interviews were removed during transcription. The complete transcripts were available to the author only, and were kept in a locked filing cabinet.

2.7.2 SAMPLE

The sample consisted of qualified systemic family therapists, working in a variety of health care settings, across South West England and South Wales. These settings ranged from adult, child and family and learning disability services, as well as private practices. A total of 11

individuals were recruited to participate in individual semi-structured interviews. This was considered a 'sufficient' number, based on criteria recommended for Grounded Theory analysis (Charmaz, 2006). All participants met the inclusion criteria (see below) for the research.

2.7.2.1 INCLUSION CRITERIA

In order to participate in the study, individuals were required to meet the following criteria:

- Be qualified systemic family therapists (registered with the United Kingdom Council for Psychotherapy (UKCP), as Systemic Psychotherapists)
- Have a minimum of two years of experience working therapeutically with families or adults
- Be able to commit to an interview that may last up to 90 minutes
- Ability to communicate in English

Individuals who met the inclusion criteria were deemed eligible for the study.

2.7.3 PARTICIPANTS DEMOGRAPHICS

A total of 11 participants were recruited to the study. This group of 11 was comprised of three males and eight females, with ages at the time of study ranging from 31-60, with the modal age bracket being 46-60 years. All of the research participants were qualified systemic psychotherapists, accredited by the UKCP and regulated by the Health Professions Council at the time of this study. The amount of experience practicing as a qualified systemic family therapist ranged from 2 to 22 years, with the average being 10 years. Of the participants, six worked in NHS settings including an adult Community Mental Health team (CMHT), as well as inpatient and community child and family services. Two worked for a children's charity project, and the remaining three worked privately. Nine of the participants worked in South Wales and the remaining two worked in the South West of England. Detailed demographic data regarding participants is presented in the Table 2:

Table 2: Participants Characteristics

Participant	Gender (Female:**F**, Male:**M**)	Age	Years qualified	Work (sector/client group)
1	F	46-60	16	Third Sector (Child and family)
2	F	31-45	2	Third Sector (Child and family)
3	M	46-60	11	Private
4	F	46-60	11	Private
5	F	31-45	2	NHS (Adult)
6	M	46-60	6	NHS (Adult)
7	F	46-60	4	NHS (Learning Disabilities)
8	M	46-60	22	NHS (Child)
9	F	46-60	11	NHS (Child)
10	F	46-60	14	Private
11	F	46-60	6	NHS (Child)

2.8 PROCEDURE

2.8.1 RECRUITMENT PROCEDURE

Following full approval of the study, discussions were held between the author, and academic and clinical supervisors which explored ways to access participants. Given the limited number of professionals that met the inclusion criteria, it was decided that individuals would be approached by the Clinical and Academic Supervisor, and invited to participate in the research. Individuals who indicated that they would be happy to participate were sent an information sheet via e-mail from the author, detailing the nature of the research and their proposed involvement (Appendix XI). Following confirmation, a time and date was arranged for the author to meet with participants to complete the interview. Written consent was obtained at the time of interview.

2.8.2 CONSTRUCTION OF INTERVIEW QUESTIONS

The qualitative semi-structured interview schedule was chosen as a method of gathering data that was detailed and personal to the participants' own experiences. Interview stem questions were developed with the aim of exploring participants experience and understanding of the

process of change in their work with clients. Whilst the overarching aim of each interview was to be guided by the accounts of the participants, literature was considered in this process so as to ensure that a number of broad ideas could be opened up. In addition, preliminary questions were discussed and revised with the clinical and academic supervisors, both prior to commencing data collection, and as interviews progressed in an attempt to ensure that questions were in line with the aims of the research. The stem questions developed (see Appendix V) were used as an adaptable guide and were modified as data collection commenced, as recommended by Grounded Theory guidelines (Charmaz, 2006).

2.8.3 INTERVIEW PROCEDURE

In preparation for conducting the interviews, the 'Interview Checklist' (Duffy *et al.*, 2004) was considered to ensure that the author was sufficiently prepared and that each interview was conducted effectively. Interviews were undertaken at a variety of clinical bases across England and Wales from October 2011 to January 2012. Written and verbal assurance of confidentiality and anonymity were provided at the commencement of each interview, and the author reiterated the aims of the research, and answered any outstanding questions from participants. The author introduced the interview and drew on stem questions, which had been developed in collaboration with the academic and clinical supervisor, as well as available literature, to guide the interview process. The stem questions were used flexibly, as the collection of data was considered to be an evolving process. The co-constructions and the author's interpretations of these from early interviews were understood to constantly be impacting on later data collection, and emerging themes were explored further in following interviews. In this way, the initial stem questions were developed throughout the data collection, in response to each interview, so to ensure that the data collection and continuous analysis remained guided by participants' stories, and to provide opportunities for emerging data to be explored. Prompts were also identified in the interview schedule and used flexibly by the author, so to facilitate opportunities for a deeper understanding and/or clarification of key themes as they emerged throughout the data. At the end of each interview, participants were invited to ask any questions they may have, in response to issues that had arisen during the interview.

2.8.4 DATA RECORDING AND MANAGEMENT

All of the 11 interviews were recorded on a digital audio recorder; seven of these were also recorded using DVD recording. Each interview was then fully transcribed by the author, which included a verbatim copy of all speech, and also non-verbal communication, where it was possible (see Appendix III for a sample of transcript extracts). Participants' names were not used in the transcripts and instead pseudonyms were used so to ensure that anonymity was protected in the data.

2.9 DATA ANALYSIS

2.9.1 TRANSCRIPTION OF INTERVIEW DATA

Each interview was transcribed within one week of the interviews taking place. Whilst the process of transcription is labour intensive, it allowed for the author to be fully immersed in the data collection, and is considered to form part of the analysis in the grounded theory approaches. The process of transcription for each interview ranged from 6 to 8 hours. Interviews were transcribed verbatim, with non-word utterances excluded. For interviews that were recorded using DVD recording equipment, non-verbal communication was also noted. Each transcript was assigned a label summarising the date, time, place, and duration of the interview.

Following each interview the author completed an entry in her reflective journal and memo, which documented both content and process issues (see Appendix XII and XIII for an example). Content issues included: themes that were generated in the participant's and author's co-construction; emergent ideas of the author; and additional information to be gathered at subsequent interviews. This process of identifying emergent ideas to potentially explore in subsequent interviews is considered important an aspect of the iterative process of grounded theory, and in line with guidance (Elliott *et al.,* 1999). Process issues were also explored, as experienced by the author both during and after each interview. This attempts to make as transparent as possible the ways in which the researcher is constructing the information and authoring it for the reader. In addition it allows for the researcher to reflect on the ways in which their positioning may be shifting in relation to the questions being asked, and provides an opportunity to respond to any 'closing down' of any one line of

enquiry (see Appendix II). This attention to reflexivity forms an important part of constructionist grounded theory (Charmaz, 2006).

2.9.2 ANALYSIS OF INTERVIEW DATA

The data analysis process firstly consisted of the author listening to audio recordings, viewing the visual recordings, and reading through the transcripts several times, in order to gain an initial sense of the data. This immersion in the data is considered an important process that facilitates the author in gaining an overall impression for the data. Throughout the analysis, key principles of grounded theory were adhered to, namely:

Coding

The process of coding refers to the categorisation of discrete segments of data with a short name that both summarizes and accounts for each piece of data (Charmaz, 2006). Coding labels were used based upon participants' words, and the coding was conducted for the smallest discrete phenomena instances in each case (Willig, 2008). Concepts that emerged were illustrated with data to ensure that they were grounded in examples, as recommended by Elliott, *et al.,* (1999) (see Chapter Three).

Categories

Following the generation of concepts from the data, categories were created by grouping together instances of the most frequent or significant concepts. Initially a number of 'lower-level analytic 'sub-categories' were developed, which were then integrated into higher-level analytic 'categories' (Willig, 2008), thus creating a tree-like formation displaying the different levels of analysis.

Constant Comparative Analysis

The process of constant comparative analysis ensures that coding process and generation of categories remains integrated. In moving back and forth between codes and emerging

categories, similarities and differences are explored both *between* and *within* categories, which enable the identification of emerging sub-categories (Willig, 2008). This type of analysis aims to exploration all instances of variation, within the emerging theory.

Negative Case Analysis

Having identified categories or links between categories, 'negative case'; instances that do not fit, were then explored. This allowed further development of the emerging theory, adding further depth to it. This process was linked to quality issues in the data in providing credibility checks and led to an increased possibility of the full complexity of the data being captured.

Memo-Writing

The author maintained a written record, which documented the development of theory throughout the data collection and analysis. These memos included the definition of codes and categories, an account of the labels chosen for them, making comparisons between codes and categories and identifying gaps in the analysis (Willig, 2008). An example of memo writing can be found in Appendix XIII.

2.9.3 TRIANGULATION OF EMERGENT ANALYSIS

Following the initial analysis of data, a focus group was held in an attempt to 'triangulate' the emergent analysis (see Appendix IV and XIV). Due to time limitations, four participants were invited to the focus group, three of which were able to attend (participants 1, 2 & 3). The focus group was conducted over one hour, at a location that was convenient to the participants. The author presented initial themes to participants, who were then asked to comment and reflect on the information presented, paying particular attention to what did and did not 'fit' with their accounts. The author observed the ensuing conversation from behind a one-way mirror, so to ensure that participants could feel ownership over the conversation and analysis. The focus group was recorded using audio equipment, and comments that participants made with regard to the initial analysis were noted and responded to by the

author in her subsequent analysis (see Appendix IV). This ensured that the analysis remained grounded with the data at various stages of the research process, as per the guidelines for good qualitative research (Elliott *et al.*, 1999), and in response to identified limitations in previous research identified.

In addition to the above, consultation with the academic and clinical supervisors was also accessed and key principles of constructivist grounded theory were adhered, thus ensuring quality throughout the process of data analysis. Analysis of the data generated is presented in the following chapter.

CHAPTER THREE

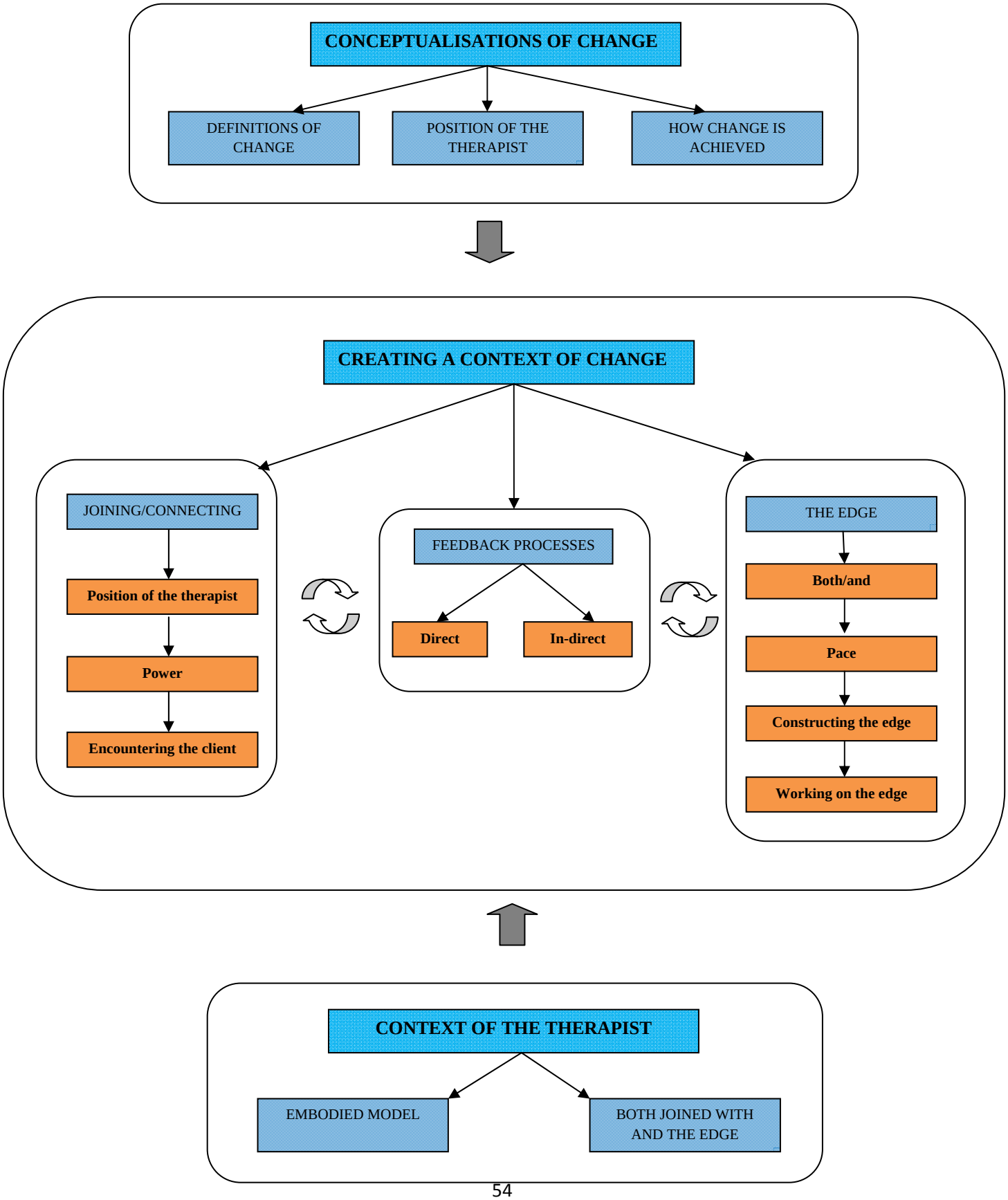
RESULTS

3.1 OVERVIEW

This chapter presents the Constructionist Grounded Theory arising from the analysis of the data collected from 11 individual interviews. Three key **THEMES** were identified, along with eight CORE CATEGORIES, 16 **categories** and 27 sub-categories. For ease of reading, **THEMES** are highlighted in capital and bold lettering, CORE CATEGORIES in capital lettering, **categories** in lower case and bold lettering and sub-categories in lower case and underlined lettering. .

A diagrammatic summary of the three **THEMES,** eight CORE CATEGORIES and 16 **categories** is presented in Figure 1. In addition, a diagram of each of the eight CORE CATEGORIES, associated **categories** and sub-categories are presented in figures 2-7. These diagrams serve as visual representation of the relationships between the **THEMES,** CORE CATEGORIES, **categories** and sub-categories. Each sub-category has been described in detail and provides illustrative quotes.

Figure 1. DIAGRAMMATIC SUMMARY OF THEMES, CORE CATEGORIES AND CATEGORIES

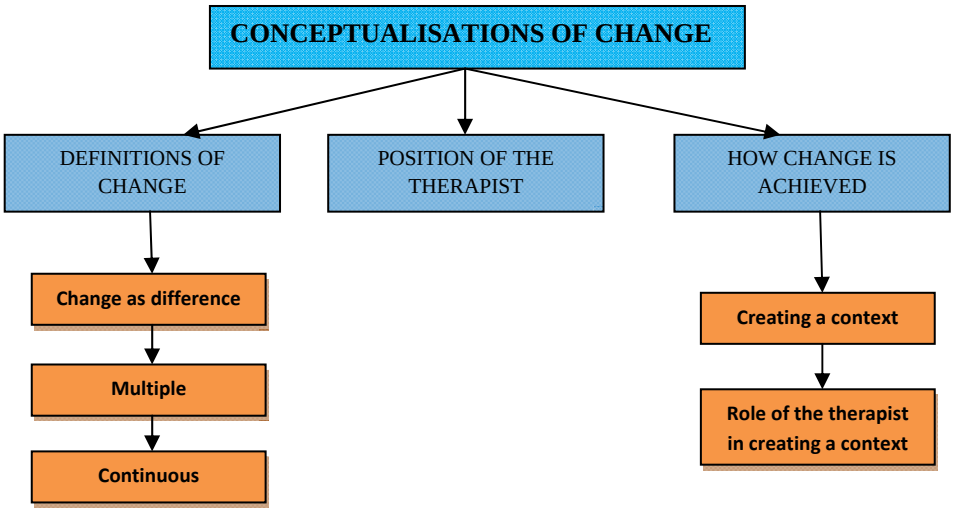


3.2 PRESENTATION OF RESULTS

3.2.1 THEME ONE: CONCEPTUALISATIONS OF CHANGE

This theme comprises three core categories in which definitions of change are outlined, with consideration of the position of the therapist in relation to change, and also how they understand their work in bringing about change with families. Each core category will be considered in turn, before moving on to explore *processes* of change specifically.

Figure 2: Diagrammatic Summary of Theme One: 'Conceptualisation of Change'



CORE CATEGORY ONE: DEFINITIONS OF CHANGE

This core category explores the ways in which participants defined 'change' as they understood it in their work with families in therapy. It consists of three categories: 'change as difference'; 'multiple ideas of change'; and 'change happening all the time'. These conceptualisations of change were understood to underpin the work that the participants saw themselves undertaking with clients.

Category One: Change as difference

Participants identified the importance of language in attempting to define constructions of 'change'. For many of the participants, the term 'change' was experienced as limiting, particularly in mental health settings, with associations mainly linked to more behavioural, linear and tangible outcomes. One participant expressed a sense of 'resistance' to this construction and application of 'change'. As such, participants described talking in terms of 'difference' instead with families; 'what they [the families] want to be different', 'how their understandings may be different', 'how their relationship to a difficulty may be different', and so on. In this way, their understanding of their work was; to bring about a sense of difference with their clients. One participant distinguished between 'making' something different and 'becoming' different themselves, which creates another dimension of where possibilities of 'difference' may be understood to occur.

Gwen: "I don't generally talk in terms of change ... I think change can be seen as quite behavioural ... I tend to talk in terms of 'difference' ... when I talk to families I talk about what might they want to be different, what do they notice is different in terms of the last time we met".

Meg: "I've very resistant to that kind of idea of going in that linear direction of, we have an objective and we're gonna have to meet it and if you don't, you fail the clients… So, the whole notion of change, I just start to kind of push against a little bit."

Hannah: "When people who are troubled have means to understand their trouble in a different way, which then frees them up to do something differently, a person learns or comes to stand in a different relationship to their difficulty. The difficulty doesn't necessarily go away but they manage to stand in a different place or view it in a different place."

Blake: "There's many ways of thinking about change... the oxford English dictionary says 'an act, or instance of making or becoming different', now look at that, so even the oxford English dictionary.... it's an act, or something happens of <u>making</u> or <u>becoming</u> different. That's very interesting. Making something different or becoming different yourself."

In understanding change as 'difference', a number of ideas were expressed about the range of multiple differences that were possible in the context of their work.

Category Two: Multiple ideas of change

Participants identified multiple ideas of change held by different people in a system at any one time. In this way, change would look like different things to different people, for example, referrers, individual clients and family members. In this way, change was understood to be defined by multiple perspectives. One participant commented that only when preconceived ideas of change were 'let go' could one then be free to understand what change, or difference might mean for a client. The multiplicity of ideas of change was described as being held in 'tension', where most often it is the dominant idea of change that prevails in mental health settings i.e. privileging change that can be identified on an 'outcome measure'.

Ellen: "There's a constant tension between other people's expectations of change and actually what happens in the therapy."

Gwen: "There's an expectation of change ... the person referring might have an expectation of what they want to see change..."

Kate: "There's something about when you kind of let go of the idea of what change should or shouldn't look like, you can go with what the family or what the person is talking actually about, because this is what's important for them, rather than the referrer."

Kate: "What's the change? Is the change for her to become less depressed or is the change for them to talk about themselves? You're not going to find that on an outcome measure."

As well as understandings of change being one of 'difference' and 'multiple', participants described change to be happening all of the time; continuously, and to differing extents.

Category Three: Continuous

In their constructions of change a number of participants described the idea of change as happening all of the time, 'regardless' of, or 'despite' any activity, and in doing so drawing on post modernist ideas. In this way, change was understood to be *both* occurring within *and* outside of therapy. However others, whilst tolerating these postmodern ideas, expanded that for clients, there was not *enough* change happening and therefore whilst change was

continuously evolving, these change 'moments' needed to be utilised to create more meaningful experiences of change for clients.

Kate: "The other thing I hold now about change is that it happens anyway ... the leaves on the trees will fall off every autumn regardless of what we do or don't do."

Dylan: "The potential for change is huge. It's beyond us in a sense. It happens almost despite of us."

Rhys: "It's about acknowledging what else goes on other than what's happening in the room. It's only one part of… I think it's both. I think it goes on out there and in here."

Blake: "There's the post-modernist view that things are changing all the time- yes, but. The experience of people when they come to a therapist is that it's not changing all the time, it's like waiting for Godot, it's the same damn thing over and over again, and they're frustrated and angry and feel betrayed. So while we could argue philosophically that things are changing all the time- I think that's a neat idea, but I think we need to utilise those change moments."

Having deconstructed ideas of what change was understood to mean, participants described the position that they assumed within therapy in relation to the change process.

CORE CATEGORY TWO: POSITION OF THE THERAPIST IN RELATION TO CHANGE

Participants described the ways in which their position in relation to change had developed over time. Initially they saw their role as being 'instigators' of change, where they assumed all responsibility for it in therapy. Participants then described their realisation that in doing so, they were denying clients important opportunities within the change process, where less change was likely to occur. One participant positioned themselves as a 'facilitator' of the change process. Another participant described repositioning her role more centrally as the 'co-constructor' of a relationship with the client, within which they understood the possibility of change to occur.

Kate: "I suddenly realised I was assuming responsibility for other peoples' change. And I suddenly realised what a nonsense that was. And it was quite liberating to think I'm not responsible for peoples' change."

Dylan: "If we always feel that we have to be the instruments of our clients change we may be robbing them of an important aspect of that change process."

Rhys: "It's probably not unusual to imagine that greater change is likely to occur in this in a person's experience of their lives if they feel that they've been the author of it, so we construct that together."

Jane: "Therapy helps stories to emerge and get uncovered in a way that was their [the client] story, they can own that because it did come from them, it's not my story."

Rhian: "It's not that we create the change, we facilitate what's already there... in a way that will lead to a better outcome".

Gwen: "I think systemic is for me is more, how I am in relation to others ... that needs paying attention to because that's the fundamental thing that you're doing … and in this way the client and the therapist co-construct a relationship."

Working from within a position of facilitator, or co-constructor of change, participants went on to explore the ways in which they understood change to be achieved when working therapeutically with families.

CORE CATEGORY THREE: HOW IS CHANGE ACHIEVED

This core category refers to participants' accounts of how they understood the work of bringing about change. It consists of two categories that explore this: **creating a context** and **the role of the therapist in creating a context.**

Category One: Creating a context

A significant number of participants described their work as creating a context within which change is most likely to occur. This context was understood to provide a sense of space and movement, within which *different* kinds of conversations could occur. Specific interventions and techniques were understood to be secondary to the creation of this 'change' context, however two participants identified clients' 're-authoring' of their story about self and other, as fundamental to the process of change within this space.

Rhys: "Giving people the opportunity to experience a different context within which they can have a different type of conversation to others that they might have in mental health."

Dylan: "Jon Franchini asked: 'why are you trying to create excellent therapy?' Why not just good enough? Safe. Competent. Let them deal with their own excellence; you just give them a space to learn how to do that, to learn how to do enough."

Rhys: "How you might create a space rather than not just coming up with a really useful intervention that you hoped the person could use. So for me it was that idea of creating a space, within which change happens, that you could move around in, and within that space what ideas are… there's a kind of an intervention you can use here if you want..."

Gwen: "I think therapy is about creating a context in which some kind of new stories, new stories about self ... and about others can emerge... and that is extremely powerful."

In understanding change as a context, participants described the way that they understood their role in creating a context of change. The role of the therapist extended beyond the traditional therapy session and out to the broader contexts within which clients are seen.

Category Two: Role of the therapist in creating a context of change

This category refers to participants' questioning and opening out of ideas regarding what constitutes as a 'therapeutic context', and thus moving beyond the confinement of a therapy session. Examples provided include dance therapy, music therapy, art therapy and so on. The role of the family therapist in identifying the appropriate therapeutic context is explored, where their role is extended to identifying and enhancing resources within any particular system. The need for 'humility' was identified here in recognising others' resources and different therapeutic contexts that they provided outside of the traditional therapy session. Participants also included a critique of the language currently used to define 'therapy' and the meaning and possible barriers that it may present for different clients. They identified a need to open out the language used when inviting people to the context which is 'therapeutic'.

Emma: "So if change is a context, then the psychologist's job is to, have a certain amount of skill in spotting where the resources lie and then mobilise them. Or at least notice them and enhancing them."

Dylan: "So when we think of change in the arena of a family therapy setting, we're talking about a very context bound scenario."

Blake: "You've got to be open to possibilities that come and there's a humility in that because I think sometimes residential workers, working with kids, good teachers with special edginess that's an important context for change."

Blake: "The problem for me is that we've been so bound that the change process is something to do with sitting on chairs and talking through stuff that all those other forms of therapy, music therapy, art therapy, drama therapy, dance and movement therapist, … the systemic family therapist, myself included, I think we've confined ourselves to a mirror and a camera and chairs which, are absolutely good... but it's much more."

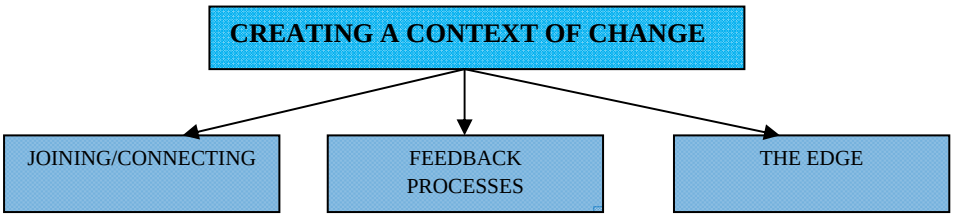
Jane: "What happens if we define our meetings as something other than therapy?... sometimes when people come for therapy, that puts pressure on them to change, and sometimes they don't actually want to change particularly, but they're coming for therapy so somehow they've come to change. And you kind of get stuck in this loop ... so what happens if you take away the therapy title and call it, something else, perhaps you free yourself up to create more."

Theme one outlined the ways in which 'change' was understood and conceptualised by the participants, paying particular attention to the language used. Emergent from this was a shared understanding of the work that they do which was described as creating a context within which change was most likely to occur. Building on this, the participants saw this process of creating a context for change with clients as complex, which will be outlined in the following theme.

3.2.1 THEME TWO: CREATING A CONTEXT OF CHANGE

This theme encapsulated three core categories: the *joining/connecting* of participants with families, working on *the edge* within this relationship, and also *feedback processes* that were understood to mediate both joining/connecting and 'the edge'. Each core category will be considered in turn in the following sections.

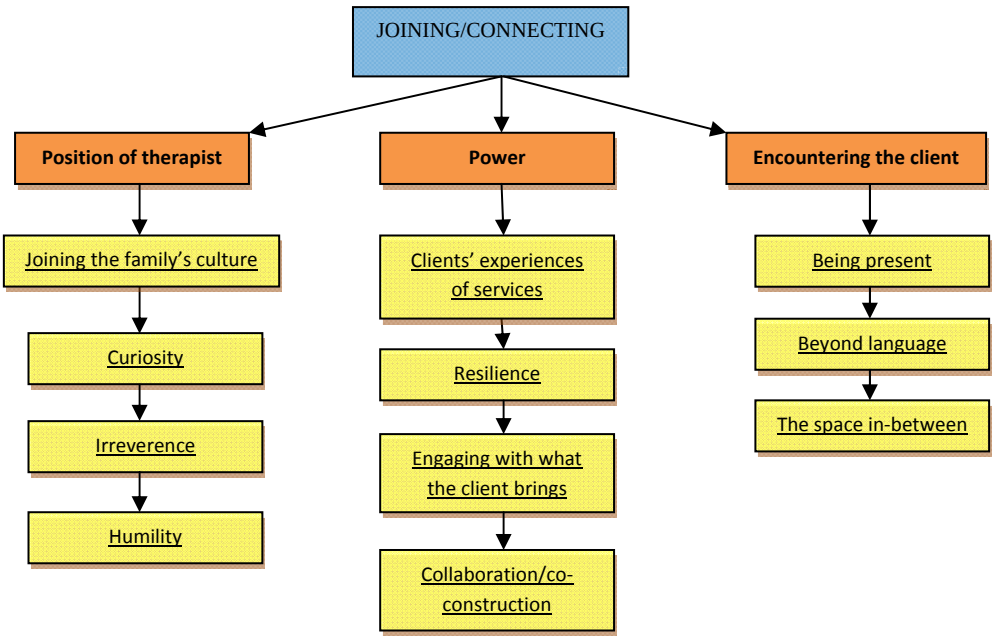
Figure 3: Diagrammatic Summary of Theme Two: 'Creating a Context of Change'



CORE CATEGORY ONE: JOINING/CONNECTING

This core category is composed of participants' motivations and intentions of joining/connecting with families during therapy and the significance of this in creating a context of change. Their responses were organised into three categories: **Position of therapist**, **power** and **encountering the client.**

Figure 4: Diagrammatic Summary of Core Category One: 'Joining/Connecting'



Category One: Position of therapist

This focused on the position that participants assumed in relation to the client which was understood to be important in allowing the therapist to join or connect with them. Within this, participants' motivations and intentions are explored. Four sub-categories were identified which included: joining the families' culture, curiosity, irreverence and humility.

Sub-category One: Joining the families' culture

This sub-category specifically related to participants' position in joining with families and the culture of their lives, which was described to be an important part of connecting with families. This was described as 'an immersion', 'getting along side', and 'finding something to connect with'. One participant also went as far to describe it as connecting with, and taking on part of their client's identity. Another participant described this joining as 'engagement'.

Emma: "This is the bit about the engagement I think, you know if you're thinking about change, or models of change, what they're [therapists] very skilled at is getting alongside the [the client]."

Blake: "The therapist has to join, to some extent that culture before you can possibly help you to shift forward."

Rhys: "Trying to find something, trying to become aware of something with this person that you feel you can connect with. It might be their humour, it might be the words they use, it might be their position that they take, literally their physical position in the room. They might sit upright, so when I talk to them I'm going to sit upright … so that the person you're having a conversation with gets some sense of idea that you're joining them, you know, that you're connecting with them in a way that they're familiar with ... so it's about kind of being aware of that with every family member. So that's about getting in there with them."

Rhian: "It's about being with and sharing part of yourself, but also taking on part of somebody else's sense of self."

Joining with a family's culture was identified as an important part of engagement, or 'setting the scene' in creating a context of change, and was at the fore of participants intentions when meeting with a family with the aim of building a safe and trusting relationship. However in

order to *do* this, the participants described the importance of adopting a position of 'curiosity', from within which they could work.

Sub-category Two: Curiosity

The sub-category describes participants' accounts of the importance of taking a position of curiosity in connecting with families and their lives. Specifically, participants described the value of 'not knowing' and a sense of 'ignorance' that were observed to precede the feeling of curiosity. The value in receiving information critically; never presuming that you've fully understood, was identified as an important way in which to explore and open out opportunities and to connect with clients' understandings and experiences in a way that was genuine. Whilst curiosity is described as being operationalised using systemic questions, one participant identified the sense of stimulation that was provoked in them in response to a client, as being the essence of curiosity.

Blake: "I know it's a bit of a cliché term but the sense of 'curiosity' I think has got to be there … I think a sense of curiosity is crucial."

Hannah: "But what I've learned it the skill of asking about things I don't know about."

Jane: "I also use my ignorance, because I think that's important too. And sometimes I find it's easier if I know nothing about something that the client's talking to me about, because it's easier then to be, to be curious, to say, 'Tell me, because I don't know.' If you think you do know then you make assumptions that may not be the right or helpful ones."

Ellen: "I think you are constantly inviting people to join with you, to explore meaning. I'll often say 'I'm really interested in what all this means to you'. And there's an imbedded message there: 'This has some meaning to you and I'm interested in it'."

Kate: "I've become far more interested in learning about the person I'm sitting in the room with and what it is that kind of sparks them, what's their relationship with the world, rather than just they've done this or we've got a job to do here today".

Rhian: "I tend to not be so concerned with the technique of the questioning as the stimulation from the client to stimulate me into being curious about that."

Part of this process of being curious for participants was being able to hold a position of 'not knowing', from which curiosity can then be stimulated. The importance of holding a position of 'irreverence' was identified as closely linked to curiosity.

Sub-category Three: Irreverence

This sub-category explores participants' positioning of irreverence, which was understood to facilitate curiosity and be an important part of the connecting with each client/family. The irreverence that participants referred to was in relation to their own theories and hypotheses that they may be working from at any given time. Whilst identified as important, they are also described as being potentially distracting and misguiding, where there is an assumed understanding, which may at times close down opportunities to connect with families. A sense of tension was expressed in holding and exploring hypotheses and also knowing when to let go. Specifically participants found that the holding of hypotheses/theories at times compromised their ability to attend closely to feedback that occurred moment by moment with families, and so opportunities to be curious and connect were missed.

Emma: "You have to keep being irreverent of your own ideas. That's the trick I think."

Ellen: "We're offered these definitions of the family and I think we have to treat those quite irreverently and kind of say "oh okay, well these are ideas about the family, lets entertain the idea that they might not actually be the reality or the realities for this family."

Kate: "So if we come in with all our theories and our ideas, we're holding an 'aboutness' knowledge. I think that can actually stop us becoming curious about how we figure out with that person how to be, how to go on."

Jane: "I think it's about really being present with somebody and really being there … which does mean attending to everything. And to do that you can't sit with your hypotheses and your theories, otherwise you're not attending, you know, and you miss those opportunities to feel curious, to connect."

Kate: "I think getting a sense of irreverence to our own theories, they're great but they are theories, there are other ways of making sense of the world, you can become more irreverent, more playful."

Whilst positions of curiosity and irreverence were identified as integral to joining with a families' culture, participants also described the importance of holding a position of humility, in their endeavour to understand and connect with clients and their lives.

Sub-category Four: Humility

This sub-category presents participants' descriptions of humility, and the importance of this position in creating space within therapy, when attempting to understand and join with families. Underpinning this position is an appreciation for the ultimately unknown sense of potential of both their own, and their clients' resourcefulness and resilience. Within this was an acknowledgment by participants that they could never understand the totality of a person and their lives and that position was to be respected.

Hannah: "It's about being humble in the face of not knowing why people are the way they are but also having a belief that people are the way they are for reasons that will make sense if I can unravel and understand it from a different perspective."

Dylan: "Of course I'm calling on the resources of the person, I'm calling on a whole range of possibilities beyond what I know myself even, beyond what I can even imagine. So working from the principle that everyone's experiences are far far greater that I can comprehend, or even they can probably."

Ellen: "You know, my simply held belief is that actually for every single person [the difference that makes the difference] is going to be a totally different process. I don't know what your experiences are, the sum of your knowledge about the world and how you interact with it. It's not known to me. So I don't know what... the next thing I say is going to have an impact on you somehow. I have no idea of predicting what that is."

Whilst consideration of the position of the therapist was identified as an important part of joining with a family, participants also provided an account of the importance of attending to issues of power, which they identified holding in the context of therapy.

Category Two: Power

This category refers to issues of power that exists within the therapeutic relationship of the client and therapist and also that of the client and mental health systems more broadly. These considerations were identified as an important factor in forming a connection with clients, as participants believed that without attention to the power imbalance that exist within the relationship, important opportunities to connect with clients and *their* experiences, particular in relating with an other, would be missed. There were five sub-categories identified within this category: Clients' experiences of services, resilience, engaging with what the client brings, and collaboration and co-construction.

Sub-category One: Clients' experiences of services

This sub-category relates to participants' accounts of the experiences that some clients have had with mental health services prior to meeting with a family therapist. These experiences were described as largely negative and were believed to impact on the process of connecting with clients. Participants described clients' experiences of professionals working from an 'expert driven' position using 'top down' approaches, which locate power and knowledge within the professional, rather than the client. Clients were also described as being treated as having a 'deficit' by virtue of being referred, which was felt to be held not only by professionals themselves but also the services within which they are seen. In addition, participants described clients' experiences of being defined by others and/or their experiences being reduced to a label/diagnosis. As such, the contextualisation of clients and their past experiences of services were perceived to be important to understand and attend to in the development of their own relationship, within the context of mental health services. One participant commented on the inevitability of power imbalances in the context of therapy, and their attempts to work within this.

Blake: "Some people have trained in expert driven approaches … but it lends a kind of hierarchical relationship towards the client where, in a crude way, where they're implying they know a bit better than the client".

Rhys: "The top down stuff, the certainty that some professionals have about clients, to put it frankly, they don't work. You get people who'll comply, or compelled to comply because they've been locked up."

Emma: "[The client] said 'I was suspicious in the beginning, I did think they were going to come in and tell me what to do, judge me'. She felt like she was a crap Mum anyway and she thought that we were going to make her feel worse, because a lot of them have experienced that kind of intervention in the past … and so there's that that we need to work through, through therapy."

Ellen: "Lots of young people when they get here have often … had lots of professionals in their lives. They've had lots of assessments. They may or may not come with some diagnoses or labels. And, you know, I think they're very used to people telling them ... defining their life in some way or defining their behaviour in some way."

Ellen: "There is always a power. You have to hold that very tentatively because ... this is my space... it's not their home. So this space in itself has inherent in it messages about power. Who has it. Whose definition of reality holds sway here? You know, it's not the family's. And I think you always have to be weary of that."

Clients' past experiences of mental health services and professionals were understood by participants to be largely negative, underpinned by power imbalances and impact on the process of connecting with families. A deconstruction of these power imbalances allow for new ways of understanding and relating with the client in the context of therapy. In response to the identified 'deficit' position that clients were felt to be placed within by services and professionals, the following sub-category referred to participants re-positioning of clients as 'resilient'.

Sub-category Three: Resilience

Participants identified the strengths and resourcefulness of clients, which marked a shift away from 'problem focused' talk. In this way the relationship between therapist and client is defined in a different way, and allows for power imbalances to begin to be deconstructed and 'connections' to be made. One participant described how this repositioning of the client opens up some space with the context of therapy and creates a sense of difference immediately.

Emma: "The difficulties- that's often the thing that's referred and by virtue of the fact that it's been referred it becomes bigger. So whatever that might be, it becomes highlighted every time a referral is made so, 'I'm making this referral because you're anxious' 'I'm making this referral because you're depressed' that's the bit that gets highlighted."

Jane: "I think the underpinning thing for me through from beginning to end is I always have in mind what are their own strength, resources, and areas of competence are."

Rhys: "I hope they take away with them a sense that their own resources and their own ways of thinking, regardless of how psychotic or distorted they might have been at times, … it's for them to have a sense of their own self-worth … and encouraging people to pay attention to that it is that they bring to the, not just the difficulties but all the resources, it's kind of opened up their sense of selves."

Dylan: "By being very respectful of peoples resilience, rather than, to buy into an idea that because they're seeking therapy that somehow they're disabled in every way. That they must be looked after. That's the only kind of relationship you can have with your client. That I'm the therapist and you're the one in need. So that becomes one important aspect of the definition of the relationship."

Ellen: "To shine a light on the strengths and resources that are already there for the client but that might be overshadowed by the difficulties that they're facing at the time. Something about them that has been defined in another way."

In working from a position in which families are understood to be resilient rather than as having deficits, participants identified the importance of listening to, and engaging with how clients think and understand their own lives and difficulties, in the process of connecting with them.

Sub-category Three: Engaging with what the client brings

In understanding clients as resilient, this sub-category related to participants descriptions of the need for a person-centred approach when joining with families. Specifically, participants referred to the closing down of a person's experience that diagnoses and labels often result in, and describe such descriptions as being 'dehumanising' and 'meaningless'. Instead participants described an 'opening out', and acknowledgement of the 'richness' and 'complexity' of a person's experience, and a valuing of what is important to *them*. This approach included participants' views of joining not only with clients' experiences but also the way in which they understand and make sense of the world. This included the way in which a client may want to work in therapy, which may at times differ somewhat with a therapist's own orientation, for example a client who expresses a need for a more direct approach. The importance of engaging with what a client brings was highlighted and whilst

one participant struggled with the difficulties that this can at times present when their approach does not 'fit' necessarily with a client's preference, another participant described this way of working as 'exciting'.

Dylan: "The description of depression is too broad, it doesn't really name it, it doesn't really... begin to describe the fullness, richness, complexity of a person's experience, so people remain stuck. They'll get a treatment for depression but what they won't get is a treatment for themselves, they won't be met, they'll be met as a diagnostic category, rather than a person, with a whole range of resources."

Ellen: "They can often be involved in quite a serious battle, you know, with the people around them, around definition of meaning in their life. So young people and families will often come into the clinic with a whole set of descriptions from the wider team 'the father is too over-involved with the daughter, the mother is ...."

Rhys: "So I think it's about respecting that if that's the view, the world view of the person in the room with you, it's very logical, very positivistic, then you have to go with that. You have to live and engage in whatever it is that they bring to the occasion if you like."

Blake: "To be professionals in this job we need to have a range. We need to fit with the music the client brings, he's playing a b flat there, I can kind of manage that. That's the thing. If we shove the clients into a CBT model when they're existentially wrecked.... then you know we're getting them to play to our tune too much."

In the meeting of the resilient client, participants described the development of the therapeutic relationship with families as a 'collaboration' and 'co-construction', in an attempt to readdress perceived power imbalances.

Sub-category Five: Collaboration and co-construction

This sub-category refers to participants' descriptions of handing power back to clients, affirming that the context of therapy is the client's space; 'their hour', as opposed to being governed by 'expert' driven models and approaches. Participants described this as a 'negotiation' of what the therapy space could be for clients, where power was located within the clients. One participant noted the importance of considering the reflecting team within this negotiation, and the possible power dynamics that it sets up with families. Through this negotiation, participants described setting the context of therapy as a 'co-construction' of both themselves and the clients. This co-construction was used to describe the therapy space

itself and also the stories of the clients. One participant used the metaphor of both therapist and client containing 'pools of resources', that 'flowed into the room' during therapy.

Gwen: "It's really important to pay attention to that detail at the beginning ... their ideas about what this space can and will do for them, and by virtue of paying attention to that there is a collaborative process and I'm always reminded of the idea that this is their space, their time, their hour."

Ellen: "We spend a lot of time trying to elicit some therapeutic agenda. Their therapeutic agenda, not ours, I think once you've got that...then you can start to work with that."

Gwen: "There's this kind of co-creating that happens as the therapist and client engage in those stories about self and stories about others … and that is extremely powerful."

Blake: "What we're involved in is a mutual construction of a context in which both the client and the therapist, invest their competencies, their ideas about what it takes to be a psychotherapeautic context."

Gwen: "There's a different kind of negotiation that goes on through that in family therapy - there's another layer because you've also got the team behind the screen and we've got to negotiate how that is for the client, how do they feel about that."

Dylan: "If I think for myself, as a big pool of resources and you as a big pool of resources and we're trying to flow into this room and do something useful for you and me."

In addition to the position within which the participants described working from, and consideration of issues of power, the experience of 'encountering the client' was also identified as being an important part of connecting with a family.

Category Four: Encountering the client

This category focuses on participants' descriptions of 'encountering the client', which was understood to facilitate a deeper sense of connection within the context of therapy. Three sub-categories were identified within this: Being present, beyond language and the space in-between.

Sub-category One: Being present

This sub-category captures participants' descriptions of the importance of being fully present with the client, in order to make a connection and join with them. This idea of 'being' was juxtaposed with 'doing', and whilst the later was described as usually what was privileged by the therapist, for example in their attempts to 'espouse' an approach or theoretical perspective, it was the 'being' that was felt to be of significance, in making a genuine connection with families. One participant described the need for a 'humanised' interaction as part of this. Participants also commented on the sense of 'intimacy' that they experienced with clients, as a result of being fully present in this relationship. Part of being present to experience this intimacy was described as involving a sense of vulnerability on the part of the therapist and client, and consequent risk, in the 'giving of self'.

Kate: "I think it's about really being present with somebody and really being there"

Dylan: "You know we tell ourselves this is what systemic therapists or clinical psychologist or a brief therapist or whatever it is that we describe ourselves to be, but we already reduce what that might be in the room, often to a set of kind of principles that we think are coming out of that theoretical perspective that we espouse, we try to embody these espousals rather than do what we do. So I think that kind of shift between the idea of what we're doing to what we're actually doing - actually being in the room."

Dylan: "So rather than worrying about whether I've got it, you know somehow boxed, nailed, whether that's a formulation or a hypothesis or whatever way you describe that, it becomes an encounter then, rather than a more narrative initial form of an assessment."

Emma: "We need to somehow create a context where we can be with the client … and to do that you need a humanised interaction."

Jane: "And that's where I come back to the idea of intimacy, you know, when you're really present with a human being."

Kate: "The intimacy changes, you know, because you really are connecting from a different place. So there is that shared vulnerability, there is that shared relational risk taking I suppose they talk about, but it will make for a more intimate relationship between yourself and the client."

Sub-category two: Beyond Language

This sub-category captures participants' descriptions of their encounter, or being present with clients as being something beyond language itself. This was understood to refer to not necessarily the articulation of their experience of the client, but that encountering a person required an experience that was more than what language could facilitate alone. This encountering was related specifically to encountering of *meaning*, which was understood to be 'embodied' by the therapist in their experiencing of the client and their relationship. One participant described an appreciation and value in not having the language to describe the experience of 'what goes on between two people in conversation', where there is a risk that it becomes understood as a 'mechanisation of human beings'.

Meg: "When you're really present with a human being, it does transcend language."

Dylan: "It's an intellectual understanding, but it's appreciating that it's going to be far greater that any reduction in language. That language will restrain, to hold. So meaning has to be in that sense 'encountered', you relate meaning, you might embody it better that you can speak it or you can paint it .... or you can dance it as it were, in the room ... That's a good start".

Jane: "I'm not convinced that we really have the language to describe everything that happens between people when they're in a dialogical conversation, and I'm not sure I'd want that really. Because then it becomes too much of a mechanisation of human beings. So I think I'd like to keep a little bit that perhaps we can't describe ... I don't want to be able to describe everything about what it is to be human I don't think!"

Sub-category Three: The space in-between

Participants extended ideas of 'being present', and experiences which were beyond language, through their descriptions of the space *in-between* themselves and their clients, in which both the therapist and client was encountered, and where meanings were generated. Significantly, this was thought to be fundamental to both joining with clients and creating a context within which change could occur. Participants described these ideas in different ways, drawing on descriptions which included: 'dialogical relationship', a sense of 'withness', and the 'relational aspects of the therapeutic endeavour'. These ideas included a sense of

interconnectivity between not only the therapist and client, but also their connection to the environment around them. In this sense, 'we' was understood as being more than one person, in relation to the other, but involving something more, beyond two people. This experience of the 'space in-between' people was described as organic and authentic, occurring 'in the moment', rather than something that could be predicted or prescribed. One participant described these ideas as 'another philosophy' which they worked from. Many participants found it difficult to fully articulate these ideas due to their complexity and the constraints of language.

Dylan: "The context of withness, the sort of between people, so what happens in a conversation where you don't leave your body but you're meeting in the middle somehow."

Jane: "The kind of models that I'm working from are about relational, dialogical, for want of a better word - within the dialogical sphere. It's a bit of a current theme at the moment in the systemic psychotherapy discipline and I'm interested more about the relational aspects of the therapeutic endeavour and more about how you can be present in a conversation, or even have a conversation that is more dialogical than monological."

Kate: "So it's very much about the dialogue, but the dialogue not just as in two people having a conversation, but the idea that that's where the meaning is generated. If two people have a conversation, how they negotiate what it is they both mean when they stay stuff."

Gwen: "I've got interested in the idea that you can be in space with other people in a sense that's more than being in your body and in your skin with someone, and there's this kind of idea of, I suppose things transcending the individual and the individual in relationship to the other. So there's that idea of 'we' I think is really important. That idea of 'we' is more than one individual and another individual, but I'm still grappling with that."

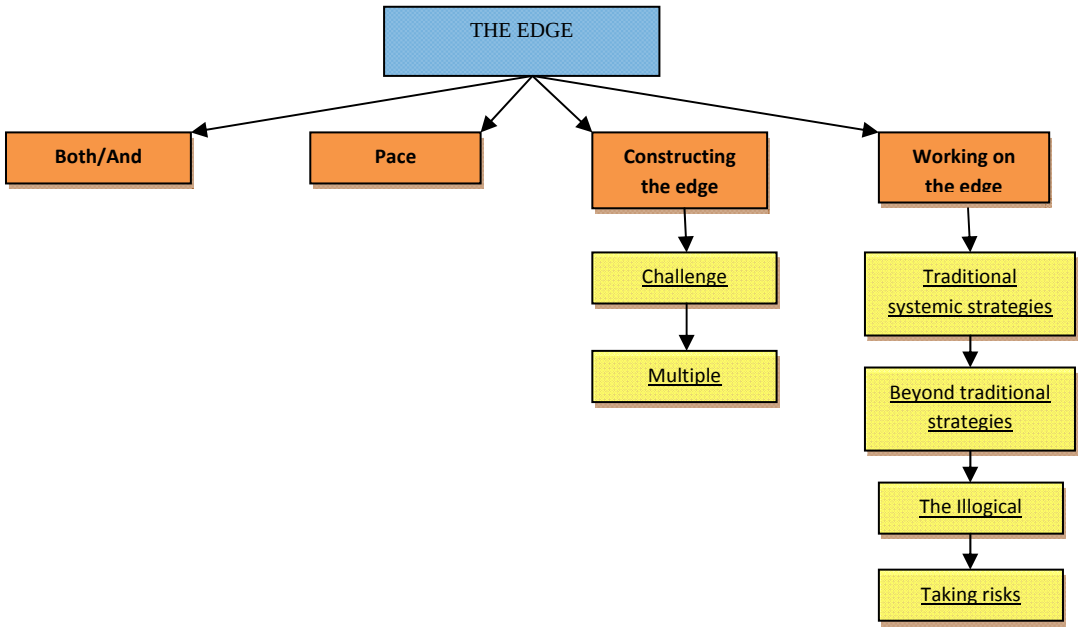
Kate: "It's kind of what you do with what's here, in that space between two people, and how you respond to somebody as a human being in the moment, and go with what's there."

Joining/connecting with clients was identified as fundamental part of creating a safe and meaningful context within which to work. However, in creating a context of *change*, an additional factor was understood to be needed, which was labelled as 'the edge'. Whilst this is presented as a distinct core category for the purposes of clarity and explanation, it was conceptualised as occurring not just *along with* the joining/connecting; but *interwoven* throughout the joining and connecting with an 'other'.

CORE CATEGORY TWO: THE EDGE

'The edge' was a term taken from participants' accounts directly, which was perceived to describe a distinctive 'approach' that was drawn on to create a context in which change opportunities could be maximised. This core category is composed of four categories: **Both/and**, **Pace, Constructions of the edge**, and **Working on the edge.** Within these categories, further sub-categories will be considered in turn.

Figure 5: Diagrammatic Summary of Core Category Two: 'The Edge'



Category One: Both/and

This category relates specifically to participants' account of *why* 'the edge' is felt to be an important aspect in creating a context of change for clients. Within this, participants identified the need for clients to experience *both* a joining/connection with the therapist *and* an element of 'challenge' or 'provocation', for a sense of difference to be introduced and change to be affected. Participants described the difficulties in managing the balance of both these positions when working with families, specifically the dangers of 'pushing too hard' versus 'not pushing enough' and the impact that it was felt to have on families.

Dylan: "You need both: you can't build up trust without pushing the boundaries; but you can't push without there being something there to, upon which to depend as it were."

Jane: "If you push too hard as a therapist, your client will back right off, if you don't push enough, if you don't challenge enough, you're client feels as though it's a waste of time, and so those are the interactional processes as a therapist you have to be mindful if all the time."

Blake: "If you're too immersed in the family, then the chances are, it's classic, you become part of the dance that the family have created for themselves. So you end up thinking, and doing stuff that's so familiar to them that no change, no difference to them has been generated. So the therapist's job is always to have an idea of tension somewhere, a kind of pull, it's not about stasis, it's about when motion is arrested … the family therapist has to really stay on the edge."

This identification of the complexity in maintaining a balance of both 'joining/connecting' and 'the edge' was explored further through the idea of pace within therapy sessions.

Category Two: Pace

This category considers participants views on when is the right time to work on the edge, and withdraw from the edge, in a continuously evolving process with clients. Whilst some participants valued taking time in building a trusting and safe relationship with clients, within which to connect, others grappled with the idea of working with the edge sooner, seeing this as the context for change occurring. Questions were raised by many participants regarding when the right time was, which was a continuously evolving fluid process, and recognised the need for further attention to feedback in judging this, which was understood to be a complex skill. One participant raised the idea that to delay working on this edge, where change opportunities are maximised, is to 'prejudice' against the client.

Emma: "We don't have to rush in and make the change straight away … actually I know I'm going to affect some change by going in very slowly and saying 'here I am again and I'm not giving up on you'."

Gwen: "There's lots of ... it is a careful negotiation ... and that can take some time."

Jane: "So I guess I'm wanting to work more on that edge, which are about pace,… seeing myself as somehow involved in helping people facilitate their change more than I was before … to be quicker … to pay more attention to detail and therefore to, to really kind of tweak that."

Dylan: "One of the things that I've become interested in is how quickly we do it. I think... we're working on an idea that to delay it is to prejudice against your client."

Jane: "I think the pace comes from paying closer attention, so going back to the dialogical stuff, being more aware, even more aware of what's going on, and picking up on the tiny little bits of communication that might be happening."

Moving beyond issues of why the edge is important and the complexity of pace within this, participants described how they understood the edge to be constructed, within therapy.

Category Three: Constructions of the edge

This category focused on participants descriptions of *how* they understood and conceptualised 'the edge'. Within this, two sub-categories were identified: Challenge and multiple edges.

Sub-Category One: Challenge

This sub-category captured participants' descriptions of the edge specifically as being a 'challenge' or 'provocation' of the therapist to the client, with the intention of 'loosening up' previously held ideas by the client, and creating an opportunity for *difference*, in this sense the 'status quo' of the family is agitated. The achieving of this was described drawing on some pre-existing theories, where a sense of 'agitation' and 'discomfort' within the client was sought by the therapist.

Blake: "The family therapist's job is both to join in that culture and then in some way, to begin to engage on the edges on where possibilities might lie for change. So to loosen up those ideas and behaviours that have become in the family's eyes, in the repetitive sequences are problematic."

Jane: "So away from the idea that if you just talk about something and you understand it better, change happens to something a little bit more proactive..."

Blake: "Within that expected ritualised interaction between therapist and clients, there needs to be challenge. There needs to be some degree of provocation, in my view, as well as support."

Dylan: "Vygotsky talks about the zone of proximal development for learning, that sort of idea that you're pushing out … your edge of discomfort, or the zone of discomfort, where you don't quite know where this is going to go."

In addition to 'the edge' being perceived as agitating a sense of challenge, there was an understanding that these edges were different for different clients.

Sub-Category One: Multiple edges

This sub-category relates to participants' descriptions of their being multiple edges. This considered not only the clients' 'edge' but members of the same family having differing edges, at differing times. In this way, an edge was understood to exist within relationships within a family. One participant also identified the edge of the therapist as well as the reflecting team, all of which are understood to be 'in motion' within a therapy session.

Blake: "For me though it's about finding the family's edge if you like, and very rarely is there a consensual family edge, … that edge might be just this far from his original idea, you can hit his edge very quickly, whereas other people in the family might want to push further … and almost inviting people to feel safe enough to kind of go to that edge and have a little look, and then keep an eye on the one who's lagging behind because they're waiting to see what these people think about the edge. "

Rhys: "My edge is going to be different as well, and the team's edge … It's not just about finding an edge in therapy, I think it's about being aware of lots of edges."

Given the perceived necessity of the edge in creating a context for change, and holding the complex issues of pace and multiplicity of edges, participants went on to describe ways in which they understood their working on 'the edge'.

Category Four: Working on 'the edge'

This category related to participants' descriptions of *how* they worked 'on the edge'. Four sub-categories are identified within this category: Traditional systemic strategies, beyond traditional strategies, the illogical and taking risks.

Sub-category One: Traditional systemic strategies

Participants described using a number of traditional systemic strategies in order to create this sense of 'challenge' and 'provocation'. Specifically, these techniques were understood to facilitate the development of a context or space in therapy, within which *difference* of thought, or meaning, or experience could be elicited, and hence change be affected. The traditional systemic techniques identified by the participants included: the use of circular questions, genograms, and the reflecting team.

Jane: "The questions are there to open up people's ideas and thinking … so we'll be asking somebody what they think about what else someone's said which means that people begin to understand that not everybody in the family thinks the same about the same issues."

Rhys: "You start off from something and then what you want to do is become more and more aware of the complexity and invite people into it in a way that's safe and hopefully useful for them. Saying, 'Your depression, oh there's a million and one ways of looking at this, or feeling about this, or sharing with other people."

Rhys: "So then … you kind of get in with dad and you say, 'Cor, where do you get this idea of fantastic from? I love that word fantastic, you use fantastic a lot, what's that all about?' So it gives the young person the opportunity to just have a break, … but also it gives the young person an opportunity to understand their dad a bit better … And then I might say, 'I noticed you were listening carefully there, what do you think about your dad saying you're fantastic?'"

Elisa: "As a team we use the screen and the space here as creatively as we can .... for instance, we might have a conversation with the mother in front, the young person behind the screen, ask the young person to run through, we might then swap over, thinking about how you deepen it, open it out."

Rhian: "Even genogram work, just looking back to a woman … where the change happened for her when we sat down with her genogram and she saw patterns in the wider family … and she said it was only when she actually saw that that she actually realised what was going on for her."

Participants identified that opportunities to work on the edge were not located within traditional systemic strategies alone, and instead drew on resources beyond these.

Sub-category Two: Beyond traditional strategies

In addition to traditional strategies, participants noticed occasions in therapy where they spoke or acted in ways which could not be framed in a formal approach, or accounted for by traditional models, or understood intellectually - *in the moment*. One participant described this as an 'innovative element', in which a sense of 'newness' was experienced by the therapist, in their relating with the client. In this sense, they were drawing on resources beyond that of traditional strategies to that of themselves and their 'being'. However this 'being' was more than making a connection; it was using their being through which to move beyond, or develop a sense of connection to introduce a sense of difference, or newness, in a way that was beyond the more explicit or established strategies. Participants described drawing on 'any aspect of their being' or 'life', to join with and more importantly work on this 'edge' in creating as sense of difference within the therapeutic space. In this way, one participant described therapy as 'art' and the need to balance both traditional strategies *and* the art of therapy, in a way that he described 'conscious naivety'.

Dylan: "That innovative element, when working with that edge, which is like, where I catch myself doing something or saying something and I go 'Why did I say that ?' 'Where did that come from?'… But it's not thought out, if I was to reflect on it afterwards I'd find a post-hoc rationalisation and if I read literature out there about what I've done. Or maybe literature to say, well what you did was risky or dangerous or... I don't know. What way that would go."

Blake: "And when there's that edge, the therapist has to draw in my view on any aspect of their being. I don't just mean how they sit and think and are but how they behave. And they can draw from any aspect of life … whether it's some resonance with a marital argument that I have had, or a story about one of my children, or an experience with one of my grandchild or experience of growing up in a housing estate."

Dylan: "And in that edge, it's about that moment, it's a momentous thing, it's in the moment and live. So, in that sense something new, some new expression, emerges. But that the understanding is not simply intellectual."

Blake: "Baranboy the conductor musician talks about 'conscious naivety'. You study and study and study, he's talking about playing music, but if you're playing music, just by reading

the notes, you're not going to do any art. To do art, you need to absorb all of that and then play it with 'conscious naivety'. Which is a wonderful expression."

Blake: "All of that [life experiences] is part of the painting of the therapist's gallery of work, because if you don't have that then what you're doing is you're really taking the paintings off the wall and putting up some kind of artificial imitation job. So the theorising is really important so that you don't just hit the client over the head with your pictures, 'here, have this one'... 'this reminds me of when I was a boy...' the art is how you refine those associations that come to mind in order that they find some, usually empathetic, but not always empathetic kind of connection with their client's experience."

In drawing on traditional strategies and also the self in working on the 'edge', participants described the importance of valuing the 'illogic'.

Sub-category Three: The illogic

The 'logic' of how a family have come to form particular ways of living was identified as an important part in understanding a family's culture. When working on the edge however, three participants placed emphasis on the need for the 'illogical' also, which was understood to create some space within the therapist so that they were not limited by the traditional strategies alone. This 'entertainment' of the illogic was felt to then allow them to work beyond traditional strategies and work from their 'being' to create this 'challenge' or 'provocation', which signifies the edge, in an authentic and 'meaningful' way for the client.

Ellen: "There's always some logic to what people do. I think that's something I really try and hold for the team, and I'm constantly kind of asking people to come back to that. How does this behaviour make sense, in this context, to that person, at this time. But there's also the illogic that needs paying attention to in creating a space for difference."

Blake: "I think that many therapists train themselves into thinking that reasonableness and the rational are the domains through which we can facilitate change. And sometimes that's so. But I think that in addition to that, not instead, therapists need to leave room for entertaining the irrational, the unreasonable, the exaggerated, the clowning, the silliness... and I think that one of the dangers of therapy, is that sense that if we can explain to people reasonable arguments as to why we should try this instead of that, and then get flummoxed because 'how come it doesn't work?'

Meg: "Not being logical all the time ... it's both and. And that illogic helps to create a space within me that I can move around in, and then work in a different way, to find the difference that is meaningful for the family."

In working with the 'illogic', or ways that were beyond that of traditional strategies or any obvious theoretical framework, participants identified that there was an element of risk involved, to which they gave much attention to.

Sub-category Four: Taking Risks

Participants described the need to 'take risks' when working on 'the edge'. Specifically they described a feeling of 'vulnerability' that was experienced in working more from their 'being' or the 'illogic' in relating with clients, as opposed to working from the safety of generalised models and 'protocol'. Acknowledging this risk, participants described an awareness of and real attention to the need to work within an overarching ethical frame at all times.

Dylan: "There's always a sense that they may be risky or dangerous because you move outside of the kind of perceived notions of what standard procedure is for sure or even what sits within a particular specific school of therapy".

Hannah: "I know there've been times when I've felt more willing to take the risk of saying something that might be completely unrelated to what the person's brought, so kind of almost using myself more."

Blake: "We don't break the rules of moral conduct with clients, we don't behave abusively towards people and so on there's a whole ethical frame that you and I enter into not just because we're professionals but because there's basic human values that we share. So those are kind of always operating at some level."

In summary, participants described the importance of both 'joining/connecting' with clients, and also working on 'the edge' in therapy, so that a space or context can be created in which change moments, or difference are most likely to occur. Whilst these themes have been presented separately and distinct from each other for the purpose of clarity, they are understood to be happening simultaneously throughout the process of therapy, or rather they are conceptualised as being *interwoven* together, in differing and unique ways for each

participant and a family. In attempting to understand *how* they are knitted together by the therapist, the author conceptualised a third theme of 'feedback processes' from participants' accounts, which was understood to mediate both 'joining/connecting' and 'the edge'.

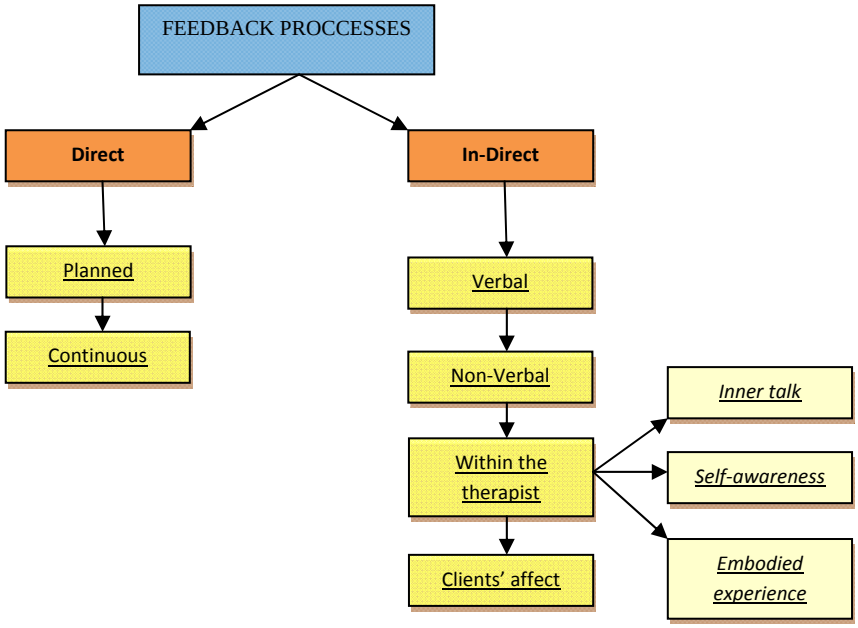
CORE CATEGORY THREE: FEEDBACK PROCESSES

This core category relates to participants' accounts of feedback processes that they identified as an integral component in knowing *how* to work with both connecting with a family and working on 'the edge', so to create a context of change. Specifically they referred to paying very close attention to '*minute* feedback' throughout a session. One participant likened the therapy space to that of the theatre, where interactions and meanings are amplified as they are with a play on stage, and 'such' attention can be paid, which then allows for possibilities to emerge and be worked with in that therapeutic space. This core category of feedback processes consisted of two categories: **Direct** and **indirect.** Within these categories further sub-categories are identified, which will be discussed in turn.

Category One: Direct

This category focused on direct feedback that participants reported drawing on during the course of therapy, which informed the ways in which they worked with both joining and the edge with families. Within this, two sub-categories are identified: Planned and continuous.

Figure 6: Diagrammatic Summary of Core Category Three: 'Feedback Processes'



Sub-Category One: Planned

This sub-category relates to planned and structured feedback that was reported by participants as being useful ways in which to illicit feedback both during and at the end of therapy. The structured feedback was seen as an opportunity for both the therapist and client to think through issues of 'stuckness' and also enabled a sense of space for clients to reflect on the process of therapy and change within this, which participants reported finding helpful in their balancing of connecting and creating an edge for difference, within the therapeutic work.

Emma: "That midway review was crucial because I think, that's when the change, that's when [the client] began to realise, 'actually, there are things that are influencing my parenting that are not really to do with me', I think it was at that review point it kind of clicked. And from then the [therapist] was able to work with her."

Hannah: "Those review points are a great place for us to think about if things aren't working, so maybe we need to think about doing things differently."

Jane: "[In gathering structured feedback].... it's about working collaboratively with the client – it's their process of change. Respect and collaboration are important in negotiating that, in a way that is safe."

In addition to planned feedback, continuous feedback was also highlighted as another way of accessing this more direct information.

Sub-category Two: Continuous

This sub-category refers to feedback that was sought continuously throughout the therapeutic process. Whilst still direct, this feedback was described as more informal and occurred naturally throughout the therapeutic process. This feedback was guided by the client's experiences of change and also the therapists own continuing working hypothesis. The reflective team was identified as an important part of providing continuous feedback for both the therapist and client throughout the course of therapy.

Jane: "So I'm asking throughout, 'What do you think?' 'Has enough change happened?' 'Has the right kind of change happened?' 'Do you think you've come enough to see us or would you like to keep coming?' So, in a way we're constantly reviewing that question with them."

Meg: "Sometimes you might think you've got a therapeutic agenda but you need to keep revisiting it because it feels like it's gone away or it's changed."

Rhys: "There's so much going on in the room that you're a part of. And that's why working with a team is useful, because you can't keep an eye on all that stuff at the same time. There's too much going on in the room for one person to keep a handle on."

In addition to planned and continuous direct feedback, participants described indirect feedback processes which appeared to mediate the ways in which they both connected and worked on the edge with clients, in creating a context of change in therapy.

Category Two: Indirect

This category focused more on indirect methods of feedback that participants identified as valuable. Within this, five sub–categories are identified: Verbal, non-verbal, within the therapist and clients' affect.

Sub-Category One: Verbal

This sub-category related to participants' descriptions of the verbal feedback that they received from clients, of a more indirect nature. Participants spoke of listening to not only what was said explicitly but attending to the tone and pace also in which something was said. The value of language was identified in providing important feedback during therapy, both overt and subtle. One participant described the power of language as being the 'biggest currency', and thus the best exchange in a therapy setting.

Gwen: "You get invited into the space to talk about those things and that's where the idea of the feedback loop is important. So, in any one session, you're waiting for those invitations. So if someone says 'oh well you know my ex-husband was violent ...' and then moves onto something else, well then there's that invitation."

Rhian: "I'm listening to what they're saying and watching them. So I'm observing way they are presenting themselves, what they're saying, how they're saying it."

Blake: "There are some fine fine details that therapists actually do pick up on, that promote that edge of change that you can amplify… So if somebody said, 'well, I haven't said this before but I'm saying this now', that's a rather obvious example."

Dylan: "Really all we have is language and it's the biggest currency in my view."

As well as indirect verbal feedback, participants' described drawing non-verbal feedback in navigate their way through connecting and working on the edge.

Sub-Category Two: Non-verbal

This category relates to participants accounts of more indirect non-verbal feedback that they identified as important in feedback processes. These included a broad description of clients' body language and the way they sit in the room, and also pauses and hesitations and what was *not* said which were equally valued as feedback. Two participants made reference to noticing the subtle smell of a client with a change of emotion, or the sound/pace of their breath as a session progressed, as an important form of feedback with which they worked. These processes however, whilst powerful, were identified as being more difficult to attend to. One participant also identified non-verbal feedback that we cannot 'knowingly discern'.

Blake: "And that goes for impressions that you get in all the non-verbal communicated behaviour that you witness and fits you. So you gain impressions as to where people sit in the room, or if you do home visits obviously the physical image that comes to mind when you see a family where everything's in pristine condition."

Hannah: "When I'm engaged with a family as a therapist I sense change occurs when I ask questions that make people pause before they answer. So very much in the micro moment of interaction with a family."

Rhian: "But then it's informed by the intuition of seeing what happens to people's body language, you know, what their feet are doing, what their eyes are doing, … just all those kind of nuances. So when I come into work I put on that way of thinking and looking."

Jane: "So to the smell of our clients to the way that they breathe in the room, you know, all those kind of very very small micro expressions and movements".

Dylan: "Obviously listening is always associated with the ears, we accept that that's the conventional way of thinking about it. But we began to think, well are we listening in other ways? And even things we can't knowingly discern."

In addition to verbal and non-verbal indirect feedback noticed in clients, participants identified their use of their inner selves as a source of accessing feedback during therapy.

Sub-Category Three: Within the therapist

This category refers to feedback as experienced within the therapists themselves. Three concepts emerged from the data forming this sub-category, namely: *inner talk*, *self-awareness*, and *embodied experience*. These will be discussed in turn.

Inner Talk

Participants described their 'inner talk' as a source of important feedback when relating with clients. This included reflection of: certain questions asked by the client; how it is that participants intended to react in response to whatever it was that a client brought; or what position they will take in their relating with a family.

Ellen: "It's constantly asking stuff: Why am I asking this question, at this time, in this way?"

Rhys: "I have a relationship with myself in the room, so while I'm listening I'm also talking to myself in my head about what it is that's going on in the room. It's about being very aware of what position am I taking. So for example, if a person says, 'Oh I really hate being in the same room with that person, I can't stand them,' you know, what's that all about? So I'm thinking, 'Well shall I take that position as well? Shall I hate this person?' What kind of position am I going to take before I kind of open my mouth and ask whatever it is I'm asking?"

Dylan: "Whether we like it or not, we're interpreting, we're doing something with it. It has an impact on us. So we become more interested in trying to notice where that is, tell ourselves, keep that internal dialogue open so that we're going 'I wonder, I wonder, I wonder...' Now sometimes it's articulated linguistically, you know like I have a stream of thought, like a dialogue, but other times it isn't it's just, so that when someone cries for example you know, there isn't a stock response to that, sometimes we will look for tissues, sometimes we won't. And then I'm thinking 'why did I do that today...why did I do...' you know so I'm interested in those things."

Self-awareness

In addition to 'inner talk', participants also identified their own self-awareness when working therapeutically with clients, as another important way to illicit feedback. This included examples regarding how a therapist was feeling independently of the client and the session, and also moods or feelings that are aroused within them by clients during therapy, such as feelings of 'stuckness'. Participants spoke about the value of noticing and having the option of responding to these subtle internal feedback processes during therapy, and the benefit this often had on sessions. One participant further identified an awareness of her own sense of identity, in relation to their client, for example being a woman, and the way that they then worked with those ways of relating during the session. Another described the importance of bringing his awareness to himself, so that he could ensure that there was space within him, to 'receive' subtle yet important feedback during a session that would otherwise be easy to miss.

Rhian: "What I'm noticing with quite a few clients ... is that there can be something going on for me which I'm aware of. So then maybe I make more effort to do something about that… and they then respond to that… that's feedback to me."

Emma: "Noticing where you're at on that day, in that moment. Because I might have come from, a really awful meeting and then going right into a session and then straight into another session. So I think that has an impact ..."

Rhys: "It's about becoming aware of what are you. Are you being genuine that day or are you not being genuine that day? Are you being sincere or, are you not being sincere that day? Are you interested or are you bored today? I can't do it the other way around, I can't come in and say, 'I'm going to be bored in the room today,' or, 'I'm going to be genuine,' or, 'I'm going to be sincere.' It's about noticing what I actually am in that moment."

Dylan: "[Talking about 'listening'] … we began to think, … are we receptive, are our receptors open in other ways?"

Jane: "There are lots of things that I'm drawing on, at different times, with different clients, some obvious things like I'm a woman, that's a very important thing … I'm a mother … I have a partner, so I draw on the experience of being with somebody."

Embodied experience

As well as 'inner talk' and self-awareness, participants identified responses evoked in their *bodies*, which they were able to use as important feedback. Examples of embodied experiences of feedback included tears in their eyes, or a 'sense of shuddering'. Participants also identified how difficult it could be to attend to this kind of feedback, which was understood partly be accounted for its lack of value in our culture more generally. The importance of feedback of this nature was identified as particularly valuable, and how the separation of intellect with embodied experience was often observed to close down the space within therapy, and with it possibilities for opportunities of change. One participant identified the experience of change in themselves in relation to the client, as an indicator of change within the session.

Rhys: "It's about becoming aware of what you're listening to through all your sense ... including touch ... somebody might say something and phrases like, 'Oh that made my skin crawl,' you know, so it will evoke some kind of feeling."

Dylan: "That fuller understanding of the pragmatics of communication, which is that it's much bigger than the word, it's how I say the word, the way the word sits in the room, it's the sound that's between words and so on. So in that sense you don't know what a word means until it's embodied. That idea that it's through the words embodied that you begin to make a relationship with the word. It sits with you and you then have to emotiate it."

Rhian: "If a clients' eyes fill up my eyes will fill up. And it might not be that I'm touched particularly by what they're saying, but it is about the relationship rather than the content of what they're saying."

*Blake: "And that goes for impressions that you get in all the non-verbal communicated behaviour that you witness and fits you intellectually and **fits you** in an embodied sense as well."*

Dylan: "Somehow by the end of that session it felt less sticky; it felt like there was some more space, more breath, who knows."

Blake: "When you're in conversation with another person, you're also changed… so in that sense the change process has to also take account for what's happening to the therapist… So I'm changing in relation to that family."

In addition to feedback that was drawn on from within the therapist, participants described clients' affect as another source of information, which they used in their endeavours to create a context of change.

Sub-category Three: Clients' affect

This sub-category refers to participants' descriptions of attending to the way a client appears affected in response to the therapist's continuing responses, as important feedback in knowing *how* and *when* to work in different ways; to find the balance between connecting and challenging with each individual client. One participant described how the affect of the therapist, as experienced by the client, is also valuable information within the processes of feedback. Furthermore, one participant proposed that it is in the clients' perception of the difference within the therapist's experience of them that can create a sense of *difference* within the client also.

Jane: "In terms of knowing how to, and when to, ask those questions, if I say something to you, I'm looking at the way you're responding and I'm thinking 'okay I've said something that was a bit jarring there, perhaps I need to soften up ...' So I'm using the way that people are speaking, the tone, the phrases they're using, the way they're sitting, all the kind of non-verbal information you get, and thinking about, about their context and how that's influencing the way they're experiencing what I'm saying."

Blake: "Well, first of all I have the view that the client sees in your nuanced responses to them that you have been moved or altered in your perception of them so, the idea that you see yourself in the eyes of the other. So if the client sees the therapist as being moved or changed in some way, the client takes that image as further confirmation that what they present themselves as, is seen differently in the light of the other, which means it's seen differently in

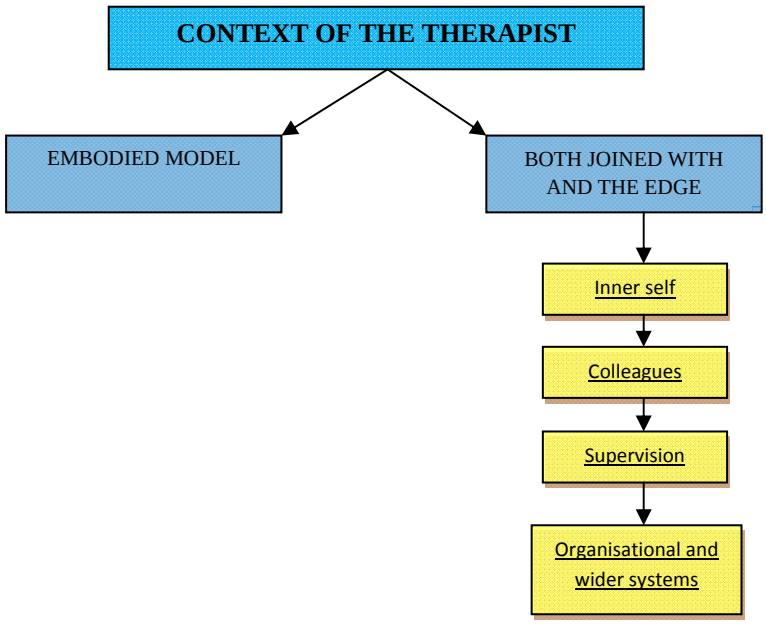
their light and so it's a feedback mechanism. And that can be very subtle or it can be very bold."

The participants understood their work as creating a context within which difference could be elicited in a meaningful way for clients. As such, change is understood to occur within a specific context. In order for therapists to be able to create a 'context of change', they described drawing on a number of factors that were understood as necessary in supporting them. These factors were drawn together into the final theme of the 'context of the therapist', which was conceptualised as underpinning and sustaining the work that they do, and therefore formed an important part of the change process.

3.2.2 THEME THREE: CONTEXT OF THERAPIST

Working from the premise of 'change as a context', this theme captured two core categories: 'Embodied model', and 'being joined with and the edge'. Each core category will be considered in turn in the following sections.

Figure 7: Diagrammatic Summary of Theme Three: 'Context of Therapist'



CORE CATEGORY ONE: EMBODIED APPROACH

This core category captures participants' descriptions of embodying systemic therapy approaches. Specifically, participants referred to systemic therapy being more than a model or approach, but rather an identity, or 'a way of life', and even 'philosophy', which they worked from. This way of being, both within and external to the therapy session was described by participants as allowing them to work in way that was genuine and created a sense of trust in the client, and thus enabling the therapist to develop a connection and also work on 'the edge'.

Gwen: "I think the fact that the therapist has a ...again I think it's more than model, maybe philosophy does that justice, the fact that the therapist has the philosophy that they feel attuned to, I think that then helps to create that trust and the person with that therapist then gets a sense that this therapist is an embodied person, so I'm not just going in with a theory, an idea, but that this person is living these kind of ideas."

Kate: "Actually this isn't just something that impacts on the way I think about the work I do in the room with another person, it impacts on my relationship with the entire world, and it's coming from that and bringing all that. And so when you come into a room you privilege all of that".

Hannah: "I run a family therapy clinic once a week. But I practice family therapy wherever I am, as it were."

Kate: "one of the things that the systemic psychotherapy has offered me is an approach to come from, kind of like a philosophy of working."

Hannah: "The skills that I have developed they're more than just a skill or a tool, they are a way of seeing. So it sort of does become a part of my way of seeing and thinking."

Gwen: "I 'am' systemic. I don't 'do' systemic, it's part of who I am."

As well as the importance of the therapists' embodiment of the systemic model, were *their own* experiences of being both 'joined/connected with' and 'provoked/challenged', in order to be able to create a context in which clients could experience the same.

CORE CATEGORY TWO: BEING JOINED WITH AND THE EDGE

This core category focuses on participants' *experiences themselves* of being *both* joined/connected with *and* challenged/provoked, which were conceptualised to be key factors in creating a context of change for clients. Participants described these experiences as necessary to enable them to work in this way with families and sustain their practice. This core-category was conceptualised to be a 'mirror image' of the core-categories from the previous theme, however distinct nonetheless: participants *themselves* needed to be both joined with and challenged, in order to evoke this within their clients. In this way the 'context' was conceptualised by the author as occurring within differing levels, beyond that of the therapy session. This core category comprises four categories: **Inner self, colleagues, supervision,** and **organisational and wider systems**.

Category One: Inner self

This category related to the importance of experiencing a sense of connection or unity with one's self, and also the need for personal challenge, which was understood to sustain participants in their work with clients. In this way, the context for change was conceptualised at a micro level. Participants described a number of ways in which they maintained their own sense of connection and also personal challenge and stimulation, for example through exploring poetry or listening to music.

Blake: "I think that the overlap between how one lives one's life outside of work is very very important to the idea of what I can look forward to in terms of developing practice in the future. So when you've got many many worries in your life it's very difficult to be creative about your work because you're in survival mode, what is needed is life circumstances that allow you to explore."

Dylan: "I pursue that challenge in all kinds of ways. Like I read a lot of poetry for instance, because I think for me, often in therapy we're using poetic language rather than more pros, or people use refrains almost like a chorus in an old song or something, they say something and use a word in that way. So I've become very interested in that so I read a lot of poetry to help me tune into that and help me stay on that edge."

Moving beyond the inner self of the therapist to the professional sphere, colleagues were identified as providing participants with a sense of being joined with, and also as providing a sense of challenge which was valued by participants.

Category Two: Colleagues

This category specifically relates to participants descriptions of the importance of having colleagues who join with them in their systemic thinking and approaches. This was particularly pertinent for colleagues who worked with colleagues who did not share the same values or approaches, where participants often found themselves in the minority. In these instances, they described how this made it more difficult to hold onto a different way of understanding and working, where the dominant story prevailed. In feeling connected with, participants also described the value of being 'challenged' in constructive ways. Specifically this allowed for other ways of understanding, or 'difference', and a sense of 'playfulness' in adopting different positions at different times.

Blake: "If we understand change as creating a context for difference, rather than something that is an individual characteristic, then clearly where one works and who one works with as a therapist are first and foremost the most impressionable and likely influences."

Kate: "Knowing that there are other people that you can have conversations with that think similarly, that leaves you feeling more confident, more enthused, more, more validated I suppose that this is a good way of thinking."

Blake: "So I'm fortunate to have colleagues that I really respect here, colleagues that are really open and positive and kind of curious about what it is that we do and ... that really is conducive to feeling that you can experiment and explore and do different things."

Hannah: "One of the richest ways that I have had to develop that is working in teams of other therapists. So it's not just my ideas that I'm holding in my head, I'm thinking 'oh, I wonder if so and so was here what they would be... what would they do? If I acquired a bit of that person's style today, how would I be then?' So I don't feel wedded... I try not to feel wedded to my beliefs or to my hypotheses but I also try not to be too wedded to self, to myself."

Rhys: "I think in many ways if I wasn't working in an environment with a colleague who didn't have a similar type of training or ideas, I think it would be a lot harder to hold on to, you know? The dominant discourse is very different, very, very different, and has very different implications to your practice and everything else, to this type of discourse."

In addition to colleagues, supervisors were identified as important in creating a space or context through supervision, within which participants could experience being joined with and challenged.

Category Three: Supervision

This category related to the importance of supervision in creating a more formal space or context for both joining and challenge to be experienced by participants, which they felt was an important part of maintaining their practice with families. A supervisor that shared a systemic way of working was identified as important within this, where feelings of safety and value were highlighted.

Ellen: "I think you have to have regular supervision with someone that is likeminded and challenges you. I would find it very unsatisfying to have clinical supervision with someone who didn't have the same systemic … and also somebody who's going to be able to take you beyond what you think."

Meg: "Having the space then to reflect in supervision…it almost mirrors my relationship with the client, so I think I've built up, hopefully that relationship where we trust."

Emma: "We get drawn into it and we get organised by the system and that's the great thing about supervision … we're able to discuss cases, do reflecting teams so there's lots of discussion that goes on and open things out."

*Gwen: "I'll be talking with *** about it in supervision and that will create something, another energy and then I'll talk with someone else and then another energy so it's always developing, that evolution of ideas."*

In consideration of the different levels of systems, organisational structures and wider systems were also identified as important spheres in which to experience both/and for participants.

Category Four: Organisations and wider systems

This category specifically refers to more organisational structures that provide opportunities for therapists to experience being both joined with and challenged in the ways described, which participants identified as being equally valued. Specifically they identified the importance of working in contexts and organisation that provides support for systemic approaches. Examples included organisations that valued and protected structures that allowed for space for therapists to develop, such as regular supervision and reflection. Specifically, 'the edge' was identified as important in challenging the traditions and

approaches of systemic family therapy itself. This involved initially experiencing and holding a sense of discomfort, which then allowed for challenge and potential change. Participants however also expressed a sense of tension in their experiences of how much 'challenge' was conducive to affecting a context of 'change'. Specifically this related to their motivation to challenging the 'dominant story', particularly within organisations where practices were perceived as being 'objectifying' and 'dehumanising' in their treatment of clients. In this sense their experience of being joined with needed to be strong enough to enable them to work with the challenge that they had identified in the dominant culture, or to hold these 'oppositional features'. For some participants this balance was not yet achieved in their context of work, and as such little change was felt to be effected in this wider context.

Gwen: "That's a really value of working here is that, there's lots of supervision and structure in place and there's all those formal arrangements that exists but there's also that space to reflect and that is valued … space for the ideas to evolve, space for people and practice to evolve."

Meg: "I constantly feel that I might be losing some of those skills … so I suppose, where I'm at now is questioning … how well do you maintain your position as a therapist in a particular model, if you don't get a lot of support, feedback, supervision and training around that?"

Blake: "The mirror thing is a very good example because Tom Anderson associated very much with the idea that the mysterious team behind should be challenged as part of that, and his idea, is that he sat with the discomfort for a long time before he did something to change it. So I think going back to the question on how we view change in systemic family therapy, the question overlaps for me a lot with process of change <u>outside</u> family therapy. For example, Tom needed to feel such a degree of discomfort that he decided to do something very very different. And I think we need to tune into that with ourselves and our clients."

Ellen: "You know, for me part of the pleasure of this job is being able to constantly ask questions about those things. 'Why do we do it like this? Why do we?'"

Rhys: "I've been motivated by ideas about the clients resourcefulness and how that can be shut down also colleagues resourcefulness, how that can shut down also opposition to all sorts of protocols and ways that lead to people feeling objectified. So one of the main motivators for me about change in psychotherapy is an objection to practices are dehumanising instead of humanising … and the older I get, and the more I do this job, the more convinced I am that we need to find ways to be in organisations, that allow us to maintain and develop those kinds of oppositional features."

Blake: "Unless we can somehow create a negotiation, some context where change is more likely to happen, those people who are shoved and dropped, or too readily lost, that's where we need to be creatively oppositional, otherwise we just comply with the status quo. So what's the point in that? The big question is, what arena do you create in order to argue it?"

3.3 SUMMARY

The aim of this study was to explore systemic family therapists' understandings and experiences of the process of change in family therapy. The study was conducted with the expectation that findings could support the development of theory of processes of change in systemic family therapy, the development of training programmes, as well as individuals' own developing practice, by increasing understanding of family therapists' experiences of processes of change in current practice. The study yielded a large amount of rich data from the individual interviews, and a Constructivist Grounded Theory was used to understand the experiences of participants. The analysis identified three themes: 'Conceptualisations of Change', 'Creating a Context of Change', and 'Context of the Therapist'.

The theme of 'Conceptualisations of Change' captured participants' definitions of change and how they understood change to come about. The theme of 'Creating a Context of Change' encapsulated factors that were understood to be integral to the processes of change: 'joining/connecting' and 'working on the edge' and also the ways in which these were mediated through 'feedback processes'. The 'Context of the Therapist' focused on elements that were understood to support therapists in their abilities to create a context in which change could occur.

Within this chapter, the core categories, categories and sub-categories captured within each of the three themes have been outlined. The next chapter will consider these findings in relation to relevant research findings and the clinical implications will be discussed.

CHAPTER FOUR

DISCUSSION

4.1 OVERVIEW

This chapter will provide a summary of the results of this study and a discussion of the main issues in relation to the existing literature. The clinical and service implications will be discussed, along with the methodological strengths and limitations of the study. Recommendations for future research will also be outlined.

4.2 RESEARCH FINDINGS AND THE EXISTING LITERATURE

The principle aim of this study was to explore systemic family therapists' understanding and experiences of the process of change in family therapy. To the author's knowledge, this was the first study to investigate systemic family therapists' understandings and experiences of processes of change in the UK, and the analysis of the data yielded an overview of themes relevant to the change processes in family therapy currently practiced.

Three key themes were identified from the analysis: 'Conceptualisations of change'; 'Creating a context of change'; and 'Context of the therapist'. In the sections outlined below, the main findings of the study will be presented in relation to the available literature on processes of change in family therapy and the role of the therapist within this. While all of the findings will be outlined, specific results will be linked to the available literature. For ease of reading, **THEMES** will be highlighted in capital and bold lettering, CORE CATEGORIES in capital lettering, **categories** in lower case and bold lettering, and <u>sub-categories</u> in lower case and underlined lettering.

4.2.1 THEME ONE: CONCEPTUALISATIONS OF CHANGE

The theme **'CONCEPTUALISATIONS OF CHANGE'** related to the ways in which participants understood and conceptualised change in their work with clients. The key

findings relevant to the three core categories: 1) 'DEFINITIONS OF CHANGE', 2) 'POSITION OF THE THERAPIST IN RELATION TO CHANGE' and 3) 'HOW CHANGE IS ACHIEVED', will be reviewed in the following section.

1) Within the core category: 'DEFINITIONS OF CHANGE', participants described a number of ways in which they defined 'change', incorporated under the categories: **'change as difference'**; '**multiple ideas of change'**; and '**change happening all the time'**. For most participants, the term change was understood as limiting; within mental health services it was often associated with behavioural changes only, or those that can only be captured as an 'outcome measure'. Instead participants' deconstructed 'change' as it is understood in the therapeutic context, and opened out other ways to understand it, this included questioning the word itself, with participants feeling a more appropriate word would be 'difference'. Participants located the definition of difference or change in others, and as such understood change to be multiple, and continuously evolving. These ideas of change can be located within the postmodern perspectives that knowledge is socially constructed (Gergen & McNamee, 1991; Gergen, 1985; Anderson & Goolishan, 1988; Jones, 1993) and the importance of questioning metanarratives (Sanders, 1998; Foucault, 1965). Participants demonstrated an awareness of the dominant discourse of change as constructed within mental health settings, and the pressures within services to evidence change using specific outcome measures. These measures were felt to be inadequate to faithfully capture the work undertaken in therapy. This echoes criticisms more broadly of the inadequacy of traditional research methodologies used to examine family therapy effectiveness, and the privileging of certain measures over others (Larner, 2004; Roy-Chowdhury, 2003).

2) 'POSITION OF THE THERAPIST IN RELATION TO CHANGE': This core category included participants' accounts of their position in relation to change, and how these had developed over time. Participants' described locating the responsibility of change initially with themselves, as 'instigator', at the start of their careers. This resembles the early family therapy approaches such as strategic or structural, informed by the more directive first-order perspectives, which understood the therapist as instrumental in the process of therapy (Dallos & Draper, 2010; Jones, 2003; Rivett & Street, 2003). This positioning may also be reflective of more traditional forms of psychotherapy, which position the therapist as the 'expert' that

'does to' the client (Larner, 2004). This has been identified in research as unhelpful in affecting change (Wark, 1994). The development of positions described by participants as 'facilitator' reflects the influences of postmodernism which challenged the 'metanarratives' of dominant knowledge, where instead 'local knowledges' of clients' voices and stories become privileged (Sanders, 1998; Foucault, 1965). Finally, the positioning of 'co-constructor' reflects the social constructionist (Gergen & McNamee, 1991; Anderson & Goolishan, 1988; Gergen, 1985) and narrative influences (White & Epston, 1990) on the positioning of the therapist. In this way, the position of the therapist is observed to have moved from a central 'expert' position, to a more peripheral role of 'facilitator' or 'mediator', as described by Sexton (2007), then back to the centre again, as 'co-constructor', or 'moderator' of the change process (*ibid*).

3) In the core-category, 'HOW CHANGE IS ACHIEVED', two categories were identified: '**creating a context'**, and '**the role of the therapist in creating a context'.** Participants understood change to be achieved through creating a context, which encouraged space for different kinds of conversations to occur, thus allowing for a 're-authoring of self' and 'other'. It was in this sense of *difference* created through this kind of conversation that change was understood to occur. These understandings are reflective of postmodernist approaches, in which difficulties are understood to be constructed within language systems (Anderson & Goolishan, 1992; Gergen & McNamee, 1991; Gergen, 1988), and thus the therapists' primary contribution to the process of change is in the construction of a particular style of conversation (*ibid*). These findings mirror those of Davis and Piercy (2007a) who identified making space within therapy as an important component for change. Narrative approaches were also drawn on in their descriptions of the 'story' and the 're-authoring' that occurred within this space, as a way to effect change (White & Epston, 1990). In summary, participants' understandings of change as a context appear to be consistent with postmodernist and social constructionist ideas of language and narratives (Dallos & Draper, 2010; Rivett & Street, 2003; Anderson & Goolishan, 1992; Gergen, 1988; White & Epston, 1990).

In addition to the construction of a context of change, participants demonstrated a deconstruction of the metanarrative of the 'therapeutic context'. Specifically, participants

positioned the 'therapeutic context' as something that was *outside*, as well as *inside* the traditional 'therapy session'. This is acknowledged in the review undertaken by Carr, where he concludes that '*systemic interventions may be offered by a range of professionals'* (Carr, 2009b, p. 29); a view reflected also in recent guidelines (NICE, 2002, 2004a, 2004b, 2005 & 2006). However, whilst this acknowledges the importance and value of systemic interventions at all levels of work, there is a danger that the complexities of the differing types of systemic approaches and interventions required in delivering these interventions, become lost (Eisler, 2005). In this respect the therapist was felt to have two areas of influence: in consultation, and in supervision. Within consultation they were well placed to both identify and enhance resources within a system that might create a therapeutic context in which change was most likely to occur for a client, and within supervision they were able to support other professionals to work systemically with clients. In this way therefore, 'creating a context of change' occurs at differing levels, within differing systems. This echoes the perspective of Bateson (1979) that therapy occurs in the context of relationships, between individuals, and between systems.

4.2.2 THEME TWO: CREATING A CONTEXT FOR CHANGE

This theme explored how participants worked to create a context of change. It was conceptualised as including three core categories: 1) 'JOINING/CONNECTING' 2) 'THE EDGE' and 3) 'FEEDBACK PROCESSES', which will be discussed in turn.

1) The core category 'JOINING/CONNECTING' captured participants' motivations to join and connect with families during therapy, which they understood as significant in creating a 'context of change'. At a broad level, this core category maps onto the generic terms used in the literature of 'engagement' and 'therapeutic relationship'. This concept has been identified as an important variable in research in psychotherapy broadly (Wampold, 2001) and within family therapy specifically in the form of 'therapeutic alliance' (Blow *et al.*, 2009; Davis & Piercy, 2007b; Wark, 1994; Jackson, 1986). Participants spoke of a range of issues, incorporated under the categories, **'Position of therapist', 'power',** and **'encountering the client'.**

The category **'position of therapist'** referred to the position that the therapists assumed, in order to enable a sense of joining/connecting of them with families. It included the sub-categories of: Joining the family's culture; curiosity; irreverence; and humility. Rober *et al.,* (2008) similarly reported therapists attempted to be in tune with the client's expectations, preferences and vulnerabilities: for example wanting to be in contact with the client's personal process, and make room for their story. In the current study, participants described a motivation to join or connect with families' lives, experiences and culture, which they understood as an important position to take in building a relationship within the space of therapy. This is consistent with previous research which identified therapists' efforts to understand and know more about what a family's experience was like for them (Wark, 1994), and recognised the importance of affirming the families' own account of their experiences (Burck *et al.,* 1998). Similarities to the Milan Team's approach of 'curiosity' (Selvini-Palazzoli *et al.,* 1980), and Anderson and Goolishan's work on the importance of 'not knowing' (1992), can be seen in participants' attempts to join with clients. Participants also identified a sense of 'irreverence' as being important, particularly with regard to their own theories and hypotheses. Postmodern ideas about valuing 'local knowledge' can be identified in this positioning in which therapists continue to work at balancing their own hypothesis, to ensure the clients' story does not become marginalised (Jones, 2003).

The category of **'power'** referred to issues of power that were described not only in the relationship between the therapist and client, but also between the client and mental health system more broadly. These issues were understood to have an important impact on opportunities to join and connect with families. There were five sub-categories identified within this category: 'Clients' experiences of services', 'resilience', 'engaging with what the client brings', and 'collaboration and co-construction'.

Participants considered an awareness of, and sensitivity to clients' experiences of services prior to attending therapy as important, and in doing so attempted to contextualise both the client and the therapy service within which they are attempting to create a space. Clients were reported to have experienced psychiatric interventions as unhelpful and dehumanising; as

such participants intended to position themselves differently to this. This reflects current concern of abuses of power within mental healthcare systems more broadly (Bentall, 2009; Johnstone, 2000) and reflects the critique of Anderson and Goolishan (1988), of the 'problem saturated' ways of talking about difficulties, as well as the critique of Hoffman on the wider system's role in maintaining discourses of 'pathology' (1993). Instead, participants reposition and redefine clients as 'resilient', the importance of which is consistent with much of the research reviewed (Burck *et al.,* 1998; Wark, 1994; Jackson, 1986). Simon (2006) proposes that a fit of the approach/model with the therapist's own worldview is fundamental to effective therapy. In line with previous criticisms made (Eilser, 2006; Sexton *et al.,* 2004), these findings suggest that the fit between the approach/model used and the worldview of the *client*, is also a crucial factor, particular in the early stages of making connections with families. Participants described the re-locating of power back to clients, through drawing on a collaborative approach in which the therapeutic space and agenda were negotiated. This echoes findings from the research discussed (Davis & Piercy, 2007b), and also reflects postmodernist informed approaches of 'collaborative' working (Hoffman, 1993).

Finally, participants identified the importance of **'encountering the client'** in attempting to join and connect with them. Within this, the following sub-categories were identified: 'being present', 'beyond language', and 'the space-in-between'. Specifically, participants referred to the need for a 'humanised interaction', and the importance of being fully present when relating with clients, which aligns with the call for 'authentic relating' (Simon 2006). Although not explored directly, Blow *et al.,* (2009) identified in their study the importance of interaction between the therapist and client being grounded in 'authentic relating' in the forming a 'therapeutic alliance'. Participants' descriptions of 'the space in-between' can be identified in the work of Bakhtin (1981) and Shotter (2011, 2005), and their description of 'dialogism' and 'withness', in which change is understood to occur in the space between people. In this approach, therapist and client are understood as interconnected and working together to understand something in a new way, which can never be predicted or prescribed, but can only occur organically in each new situation and in 'therapeutic moments' (*ibid*). Whilst difficult to articulate, participants demonstrated a conviction to work in these ways. The experiencing of this connection with clients was described by participants as something extending beyond that of language alone, and in a more embodied way. These findings support the critique of Sanders (1998), who identifies the importance of the pre-linguistic,

and non-verbal elements of therapy; factors that are at risk of neglect within postmodern approaches of family therapy. Rober (2005, 2011) further supports this argument in his identification of the importance of the experienc*ing* of the therapist, and its role in the process of therapy.

2) In addition to joining/connecting, participants identified 'THE EDGE', as a crucial factor in creating a context of change. This construction of 'the edge' was taken directly from the data and appeared to be a useful way for participants to describe their work. There is no literature to date that identifies this 'edge', however it can be understood within the theories of second order cybernetics more broadly. It included four categories, including: '**both/and'**, '**pace'**, **'constructing the edge'** and '**working on the edge**'. Specifically this theme referred to participant's descriptions of needing *both* to join/connect with clients *and* to work on the edge. This 'edge' was described as a 'challenge' or 'provocation' of the therapist to the client, from which a sense of *difference* could be agitated. Whilst the importance of the therapist becoming directly challenging through the course of therapy, has been identified in the research of Burke *et al.* (1998), what is less clear is knowing *when* to work in this way. In the current study a participant drew on Vygotsky's 'zone of proximal development' theory to guide this way of working. Whilst Helmenke and Sprenkle (2000), identified the importance of 'challenge' occurring early in therapy in their study, for example in helping clients feel a sense of hope to stabilize the future direction of the work, Davis and Piercy (2007b), identified the need for therapists to be patient with clients and follow their pace. The findings of this study however would align with Helmenke and Sprenkle (2000) and suggest that to delay challenge might be detrimental to processes of change.

Participants described a number of ways in which they worked on the edge. Four sub-categories were constructed to explore this: Traditional systemic strategies, beyond traditional strategies, the illogic and takings risks. A number of traditional systemic techniques and approaches were drawn on when working on the edge including: circular questions, genograms, and the reflecting team. This mirrors findings of Wark (1994) and Jackson (1986) who identified these strategies as important in processes of change in family therapy. Participants also described moving beyond traditional strategies when working on the edge; where they would work 'in the moment', in a way that was authentic and

innovative, in which a sense of 'newness' could be created. This appears to relate to the literature of Shotter (2011, 2005) and Baktin (1981), in which change is understood to occur in the space in-between two people. These living moments are understood to be intertwining creating new possibilities for experiences and meanings to emerge that differ from the original meanings of both the client and therapist (Rober, 2005). This study found that working in this way involved the therapist taking risks; both in the use of the self and in their authentic ways of relating. As such, participants demonstrated a regard for working within an overarching ethical framework, in accordance with their professional codes of conduct (e.g. Association of Family Therapy, 2011; and British Psychological Society, 2009).

The core categories of 'joining/connecting' and 'the edge' can be seen as providing a description of participants' accounts of how they understand their work in creating a context for change. Whilst they were presented separately, they were conceptualised as being interconnected and occurring simultaneously throughout the process of therapy. Congruent with early systems theory (Bateson 1976), these core categories were understood to be responsive to a range of feedback processes, in which a third core category of 'feedback processes' was conceptualised. While drawing on aspects of systems theory, this category is positioned with the second order perspectives, with a focus on the complexity of the layers of cybernetic processes, or 'processes of feedback' that occurs throughout therapy (Jones, 1993). Whilst the first two core categories can be seen as descriptions of the *what*, this core category responds to the *how*; *how therapists work with processes of change in family therapy*. The feedback processes identified were understood to mediate and navigate the weaving of both 'joining/connecting' and 'the edge', in a way that was recursive and live, in which experiences of newness could be found (Baktin, 1979; Shotter, 2005, 2011).

3) The core category 'FEEDBACK PROCESSES' captured participants descriptions of the importance of attending to the minute feedback that occurred during a session, and was constructed upon two categories: **'direct'** and **'indirect'**. Larner (2004), and Chowdhury (2011, 2003) identify the need for audit and gathering of 'practice-based evidence' within family therapy, as an important part of developing an evidence-base that is grounded in real life clinical work. Participants' descriptions of direct and planned feedback appears to

respond to this gathering of structured feedback that was used in audit, as well as informing the development of their work with clients as sessions progressed.

Indirect feedback was identified by participants as being a significant part of the process throughout therapy. This category included four sub-categories: 'Verbal', 'non-verbal', 'within the therapist' and 'clients' affect'. The work of and Anderson and Goolishan (1988) can be seen to be influential in participants' descriptions of the value of verbal feedback. In line with social constructionist approaches (Gergen & McNamee, 1991; Gergen, 1985), language was identified as the most valuable means to construct and also dissolve meanings. The findings in this study mirror those of Helmenke and Sprenkle (2000), who also identified language as an important in change. However, participants in the current study also drew attention to what was 'unsaid', which can be interpreted through postmodern ideas of 'alternative' knowledges that have until now been silenced by the metanarratives of a family and/or culture (Sanders, 1998; Foucault, 1965). This aspect of 'active listening' has also been addressed by Andersen (1991) who focused in his clinical work on the client's spontaneously occurring bodily activity and the manifestation of these in the intonation, not only of words but pauses, the client's breathing, and so on.

The sub-category of 'within the therapist' included: '*Inner talk'*, '*self-awareness'* and '*embodied experiences'*. Participants identified the importance of their own awareness, in enabling them to attend to valuable feedback within themselves. This 'attending to' was also felt to create a sense of space within the self, which then allowed for movement and newness (Bakhtin, 1981). Specifically, participants identified '*inner talk'* as an important part of this self-awareness, which involved their own reflexivity about what was unfolding during the session with a client/family, and their own position and actions in relation to this. Burck *et al.,* (1998), similarly identified the reflections of the therapists during sessions as important, where they were described as addressing their own position in the discourses of the family. Several authors have suggested that the therapist's inner conversation is important in understanding the practice of family therapy (e.g. Flaskas, 2005; Lowe, 2004; Rober, 2002, 2005; Andersen, 1995). This 'inner talk' is also understood as a dialogical process that occurs *within* the therapist, as well as *between* therapist and client (Bakhtin, 1981), and refers to the private dialogues therapists have with themselves whilst talking with family members (Rober,

2005a). Bakhtin (1981) describes this as the 'polyphony' of inner voices that populate the self, which are brought into an internal dialogic space. Whilst the therapist's inner conversations have mainly been discussed conceptually in the literature (Shotter, 2005; Rober, 2005), Rober and his colleagues (2011, 2008) studied it empirically, and identified a broad range of thoughts, feelings and ideas on the therapist's mind, which had significant effects on the continuously evolving processes of therapy.

In addition to 'inner-talk', participants identified their 'embodied experiences' as providing important feedback during sessions with families. This extended beyond linguistic reflections to the awareness of their own embodied and emotional responses, for example tears in their eyes, or a shudder. To close off from this type of feedback was felt to close down space within the therapeutic relationship, and reduced opportunities for clients to tell their stories, and make room for other stories. Linked closely with research and literature on 'inner talk', the value of the therapist's 'experiencing' within a session is identified by a number of authors (Rober, 2005; 2011; Shotter, 2005; Sanders, 1988; Bakhtin, 1981). Bakhtin (1984), refers to this minutia of 'noticing' in which an individual draws on and participates '*throughout his whole life*: *with his eyes, lips, hands, soul, spirit, with his whole body'*, when in dialogue with another (cited in Rober, 2005). In line with this, therapists have been found to welcome information from within that is reported through their own 'intuitions, feelings, passing images and phantasies' (Bolas, 1987, cited in Rober, 2005). This focus on the therapist's own experiencing refers to the therapist as an embodied human being in the here-and-now of the session. The therapist's attention is on his/her own experiencing and in this sense, the therapist is listening to the story the client *invites him to experience* (Shotter, 2011). The therapist therefore is presented in session as '*a complete human being, in relation to the client and not just as an information-processing/hypothesis-testing expert'* (Rober, 2011, p. 237).

Rober (2005, 2011) sees this 'inner talk' as an important tool that may be used to further the therapeutic process, rather than an 'obstacle' to so-called 'real' understanding and subsequent change (*ibid).* As such, he proposed that therapists be sensitive to their own experiencing during sessions (Rober, 2011, 2005; Flaskas, 2005; Larner, 2004; Elkaim, 1997). Elkaim (1997) also highlights the importance of the context in which the therapist's feelings arise,

arguing that what is experienced during sessions comes not only from their personal history, but is amplified and maintained by the dialogical context (Shotter, 2011). In this way the therapist can explore the dialogical opportunities to use his/her experiencing to proceed with the session in new and constructive ways (*ibid*; Rober, 2011). In working with both traditional strategies and with the therapist's self, therapy can be understood as both *art* and *science* (Larner, 2004; Wilson, 2007).

Finally, participants identified 'clients' affect' as an important source of feedback; specifically the visible affect of the client, in response to the therapists' own responses. Research similarly locates the 'impact' on clients as an important part of feedback (Casement, 1991, cited in Rober, 2011). Rober *et al.*, (2008), reported that, being in tune with the client was accomplished by the therapist's continuous monitoring and evaluation the clients' reactions. One participant proposed that it was the client's perception of the *different* way in which they were being *experienced* by the therapist, which affected a sense of difference in them. It could be further argued that it is impossible to locate the instigator of *difference*, as processes are interwoven and interdependent (Bakhtin, 1981; Shotter, 2005).

It is argued that whilst the family therapy field propose some general principles about how the therapist should position themselves in the session with the family, such as 'neutrality', 'curiosity', and 'not-knowing', they insufficiently value the therapist's *here-and-now experiencing* during the session (Rober, 2011). Furthermore, they fall short of meaningfully addressing the full complexity of the relational processes within a family therapy session (*ibid*). Feminist critiques draw attention to the cultural context within which particular theories of change are privileged (Sanders, 1988), and suggest that 'action' and 'doing' are descriptions of experience that are more familiar to men, whereas 'thinking' and 'feeling' are more salient in the experience of women (Jones, 2007). In this way, theories of change can be seen to systematically privilege the experience of men, reflecting the dominant cultural position. As such, theories and research about change are called for that recognise and validate *both* experiences (Knudson-Martin, 1997; Sanders, 1988). The findings within this core category of 'feedback processes' demonstrates that both the 'doing' and the 'experiencing' are seen as important in processes of change.

4.2.2 THEME THREE: CONTEXT OF THE THERAPIST

The theme '**CONTEXT OF THE THERAPIST'** relates to the context within which the participants are embedded. It was this context that enabled them to work in the manner outlined above. Two core-categories emerged: 'EMBODIED MODEL' and 'BEING BOTH JOINED WITH AND THE EDGE'.

1) The core category of 'EMBODIED MODEL' referred to participants' accounts of the importance they placed on being able to work from a model/approach, which they embodied, both within and outside of the therapy session. In this way it became a way of life and a philosophy from within which they lived their lives. This supports the theory proposed by Simon (2006), of the importance of fit between a therapist's approach and their worldview. However, echoing the critique of Sexton *et al.,* (2004), whilst this fit is an important part of the therapeutic process, it cannot alone account for change: the fit of the model with the client's own worldview is also identified as an important component (Davis & Piercy, 2007b).

2) The core category of 'BEING BOTH JOINED WITH AND THE EDGE', referred to participants *experiences themselves* of being both joined with and challenged, in order for them to work effectively with clients. It included four sub-categories: 'Inner self', 'colleagues', 'supervision', and 'organisational and wider systems'. These sub-categories were conceptualised as differing levels within which participants' experiences of being 'joined/connected' with and 'the edge' were identified. In this way, the 'context of change' was understood to be occurring at differing levels, within and around the therapist. This conceptualisation is influenced by Bateson's (1976) ideas of interconnectivity, in which he argues that natural forces, behaviours or patterns tended to hold true on a micro and also macrocosmic level (Huxley, 2004). It also appears reflective of the Co-ordinated Management Meaning (CMM) model of Cronen and Pearce (1985), in which each level is contextualised by adjacent levels, with 'implicative' and 'contextual' forces acting through the differing levels. This way of conceptualising reflects the development and application of 'non-linear' models within psychotherapy and processes of change specifically (Bloom, 2000).

Bateson (1979) argued that there were ways of 'knowing' other than by scientific methods, and as such felt that the artist's or the poet's vision of reality was as profound as the scientist's, even though it might not be wholly conscious or have a demonstrable chain of logic (see also Huxby, 2007). This thinking can be demonstrated by participants, not only in their identification of other modes of therapies, but within their own personal lives, where they described exploring for example, music and poetry, as a way to extend their 'knowing' (Bateson, 1979), and experience 'newness' and 'difference' within themselves (Shotter, 2011).

Similarly within their work with clients, participants described a sense of *tension* in balancing the position of being 'joined with' and 'challenged' at the differing levels, or contexts, particularly at the 'organisational and wider system' level. Pare and Lysack (2004) argue that it is the therapist's ethical responsibility to ask questions that bring into the open suppressed stories that contradict, deconstruct and disempower the dominant view. Dallos and Draper (2010) further identified the importance of resisting the pathological tendencies of orthodox psychiatry and the individualistic stance assumed as dominant in Western cultures. They observed that family therapy started from a radical and critical position and questioned whether therapists want to maintain this: the alternative stance being to collude with and maintain the dominant discourses of mental health and family life. Within this, participants described the difficulties with challenging dominant discourses within services, where they often felt outside of a context of safety themselves. This lack of safety was observed in participants who worked as the only systemic therapist within mental health services within the NHS; i.e. those that were located firmly within a medical model. Participants who described a strong sense of being 'joined with' appeared to feel better able to challenge and effect change in the broader system within which they worked. The lack of safety that participants experienced might be related to the political, economic and social context within which they work, where funding for psychotherapists are being cut, and those that remain are under pressure to demonstrate accountability using more traditional measures of outcome (Larner, 2004; Roy-Chowdhury, 2003). Regardless to context, participants demonstrated a self-reflexivity on their continuing practice, which is consistent with postmodern thinking itself (Jones, 2007).

In summary, the data gathered in this study reflects an exploration into processes of change in family therapy, co-constructed with systemic family therapists, and authored by the researcher. Participants defined how they understood 'change', before then describing the ways in which they worked to create a context of change when working with families. These included 'joining/connecting' with families, *and* working on 'the edge', which occurred in a simultaneous and recursive way, and were understood to be mediated by a range of intricate and subtle 'feedback processes'. Finally, the 'context of the therapist' was identified as important in enabling participants to continue to work in the ways outlined. These processes are understood to occur in a circular, rather than linear way, informed by the thinking that things cannot be understood by their separate parts but rather as an interconnected whole (Bateson, 1979; Bakhtin, 1981). As such, the focus on change in therapy is on the movement *in-between*.

A number of concepts did not appear through this analysis which might have otherwise been anticipated. These included ideas around: how safety is established within therapy; how the process of pursuing change is enacted across the phases of the clinical cycle and; how therapists recognise when 'enough' difference has been prompted to allow preparation for ending therapy. Whilst these ideas were identified to varying degrees by individual participants, the concepts were not prominent enough to form specific categories or sub-categories, and so were potentially 'lost' amongst stronger categories. Working from with a social constructionist epistemology, it is acknowledged that this does not necessarily reflect a lack of significance of such concepts within family therapy work, but instead a lack of prominence in the way in which both the researcher and participants constructed the data, at this time.

4.3 CLINICAL AND SERVICE IMPLICATIONS

The clinical and service implications of the results of this research will now be outlined, in relation to implications for systemic family therapists, clinical psychologists and other

therapists working systemically with clients. These will include recommendations for practice, training, and the development of the role of therapists working systemically within mental health services. The recommendations will aim to facilitate the provision of effective systemic intervention for clients, by contributing to the understanding of processes of change within family therapy, as experienced by systemic therapists.

4.3.1 EXPERIENCING OF THE THERAPIST

The experiencing of the systemic therapist emerged as a significant theme throughout this study and requires further attention. Indeed, Elkaim (1997) states that the therapist should not try to avoid experiencing, but rather place it at the heart of therapy (see also Rober, 2011; Flaskas, 2005; Larner, 2004). Rober notes that *'it is the bodily nature of the relevant processes and what occurs in the meetings between them that have not, I think, been sufficiently emphasized'* (p. 99, 2011). In line with the literature and research relevant to the experiencing of the therapist, the findings in this study identify the importance of integrating this way of working within clinical practice. It is proposed that within clinical psychology, the experiencing of the therapist be integrated into the clinical cycle of assessment, formulation, intervention, and evaluation, which through a systemic approach are understood to occur in a continuously evolving process. The findings indicate that each stage of the cycle could be enriched with attention to the experiencing of the therapist in relating with a client and creating a context within which change opportunities are most likely to occur. In agreement with Rober (2011), it is proposed that therapists: *'i) be sensitive to their own experiencing during the session; including their thoughts, intentions, affect, prejudices, physical responses, hypothesis and so on; ii) considers the implicit invitations to join the family members in potentially destructive relational scenarios, and reflect on the possible negative and perpetuating effects of new interactions with the family, and then: iii) explore dialogical opportunities to use his/her experiencing to proceed with the session in new and constructive ways'* (p. 251). It is also acknowledged that becoming aware of and tolerating these experiences can be challenging, therefore issues of safety are important.

Furthermore, it is proposed that training of both systemic psychotherapists and clinical psychologists could be enhanced by an increased focus on the 'self' of the therapist;

specifically how their experiencing affects the processes of change with clients during therapy (Rober, 2011; Davis & Piercy, 2007b; Asay & Lambert, 1999). It is therefore argued that the 'reflective-practitioner model' within clinical psychology be repositioned, not as an adjunct to, but as central to their role in working systemically with clients (Lavender, 2003).

4.3.2 DIALOGISM

In consideration of the work of Bakhtin (1981) and Shotter (2011), together with these findings, it is recommended that therapists working systemically consider the dialogic nature of their interactions with clients; specifically their capacity to engage in a humanised interaction, which allows for dialogue, and the possibilities of newness to be created in the space *in-between*. As such, it is proposed that systemic training at varying levels would be enhanced with attention to the dialogic, in an attempt to better understanding processes of change that occur between therapist and client. Jones (2007) however highlights the limitations of traditional ways in which theories of change are transmitted (such as books, journals, and dyadic teaching) which tend to privilege *language*-based descriptions, and are somewhat monologic. In this way, both the therapeutic and learning process can be understood as isomorphic in their attempts to create a context of change. As in the therapeutic context, monologic approaches within training are understood to shut down possibilities of change or newness. Therefore a dialogic, rather than monologic approach to teaching is needed, which draws on alternative ways to explore therapists' experiencing and relating. Examples might include drawing on the medium of: art, music, movement and poetry, which are suggested as providing equally useful ways to explore dialogic processes that can develop beyond the confines of language alone.

4.3.3 EVALUATION

The current era is characterised by high levels of accountability within mental health services, which requires family therapy to demonstrate measurable outcomes (Dallos & Draper, 2010). In addition, the current economic difficulties require those 'treatments' to be cost-effective (Stratton, 2010; Crane, 2008). Whilst the evidence for the efficacy of family therapy interventions is growing, it continues to struggle to become 'evidence-based' (Larner, 2004). The review of literature and findings in this study identified the importance of an evidence-

base that is developed from *real life* clinical practice. This highlights the importance of auditing systemic work undertaken with families. The challenge is for therapists to select measures that are meaningful and sophisticated enough to capture the work that is being undertaken. Whilst psychometric measures are being developed to respond to this specifically (Systemic Therapy Inventory of Change, Pinsof *et al.,* 2009), qualitative brief measures, that allow for the personal nature of change for each client is recommended, so to contribute to the development of *practice-based* evidence.

Clinical psychologists and family therapists often work in collaboration with other colleagues, and therapy is often combined with other interventions. This highlights the need to consider a wider range of change outcomes and processes to inform an evidence base (Stratton, 2010; Crane, 2008). Auditing is therefore needed not only for therapeutic work, but also in other fields of activity, for example consultation. In this way, clinical psychologists draw on both the 'science-practitioner model', and also the 'reflective-practitioner model' (BPS, 2006), as a way to adapt traditional methodologies so that they are better able to meaningfully capture processes of change. This would mark a shift from a limited positivist, empirical approach, to a more inductive exploration of the construction of meaning and knowledge within families, within the epistemic networks of the professions responsible for delivering psychotherapies.

4.3.4 CONSULTATION, SUPERVISION AND TRAINING

Throughout the study, participants deconstructed the concept of a 'therapeutic context'. In identifying 'possibilities' both inside and outside of the traditional therapy session, the role of systemic therapist shifts to working increasingly with systems around the family. Through the development of the role of applied psychologists in New Ways of Working (BPS, 2007) and the current economic climate, which demands cost-effective delivery of services, the role of consultation and supervision of systemic therapists and clinical psychologists becomes more crucial in mental health settings. As such, they are identified as an invaluable part of multi-agency teams for their expertise in systemic thinking and practice (Dallos & Draper, 2010). In his review, Carr concluded that systemic interventions '*may be offered by a range of professionals*' (2009b, p. 29), a view reflected in recent NICE guidelines (2002, 2004a,

2004b, 2005, 2006). Whilst this acknowledges the importance and value of systemic interventions at all levels of work, the complexities of the differing types of systemic approaches and interventions, and the role of the therapist in delivering these interventions, are in danger of becoming lost (Eisler, 2006). This risk highlights the importance of the supervisory and consultancy roles of qualified systemic therapists, in ensuring that clinical governance is adhered to in the delivery systemic interventions by other professionals. In agreement with Stratton (2010), it is recommended that therapists who are systemically trained, provide training and support for professionals applying family interventions, such as Expressed Emotion and Brief Solution Focused approaches, and where appropriate engage with training of other professionals working with families.

4.3.5 CONTEXT OF THE THERAPIST

This study identified the importance of support systems and protected structures when working systemically with families. Specifically this includes: colleagues and wider peer systems; structured quality supervision; and a protected space within which to reflect with others and develop practice. Participants who lacked these systems described struggling to maintain their systemic practice with families. Therefore, it is recommended that therapists working systemically seek out where ever possible structures that are supportive and enable them to develop professionally, for example accessing wider network groups. If change is understood as a context, then the context of the therapist should be a paramount concern, rather than an optional 'add-on'. Rober (2011) argues that having time to reflect after sessions with colleagues and supervisors is not a 'luxury' but a 'necessity'. In this way the systemic paradigm needs to focus out not only past the first-order cybernetic lens to include the therapist, but out again *beyond* second-order perspectives, to include the therapist *in their context.*

Whilst outcome studies have highlighted the importance of the therapeutic relationship and the role of the therapist, the family therapy literature does not offer many conceptual resources to enable practitioners to reflect about the complexity of processes of change (Rober, 2011). Whilst it is acknowledged that this study offers *an* interpretation of processes of change, it is intended to 'provoke' further thought and exploration of change processes, as

understood and experienced by family therapists in their day to day practice. Whilst communicating agreement with the overall findings, participants in the focus group each expressed differing preferences for pieces of language used and the categories privileged. This indicates the individual and unique way that therapists understand different components of the process of change, which will be more or less meaningful to differing therapists, at differing times and highlights the need for therapists to process, integrate, and deconstruct the conceptualisations offered in this study.

4.3.6 THEORY DEVELOPMENT

Like any system, that of family therapy is constantly changing. Alexander *et al.*, (2002) reflect that within the profession of systemic family therapy, new information is always entering the system requiring revisions, and so its knowledge bases or conceptual foundations, like any meaning system are open to change and modification (cited in Sexton, *et al.*, 2004). The findings presented here are consistent with the development of theory outlined at the beginning of this work, and might encourage a consideration of the trajectory of systemic theory development. Inherent in the movement to second-order cybernetics was an important shift in the perceived role of the therapist, and an acknowledgment of the complexity of the layers of cybernetic processes, or 'processes of feedback'. The findings presented here suggest that this is continuing to develop, with an *increased* focus on the subtle and intricate feedback processes that are occurring when two people are in dialogue. From the position of 'observer' of the system in first-order cybernetics, to becoming part of that which is being observed in the second-order, the findings here suggest that that the *reflexivity* of the therapist, have come into particular focus, with the valuing of the experiencing of the therapist in processes of change. Flaskas (2005) comments that family therapy has increasingly moved towards a self-reflexive approach, in that, *'an essential part of the analysis moves from 'out there'- an analysis of the family – to a more internal analysis 'in here' – in which the focus is on how the therapist and the family are experiencing each other'* (p.99, 2005). It is also acknowledged however, from a postmodernist stance, that favouring one narrative risks silencing others, and so these reflections are offered *alongside* the existing narratives within family therapy. What is attempted is an unearthing of *other* narratives that have until now become silenced within a particular culture, at a particular time. In his *paramodern* position Larner advocates that the focus, rather than being on an

either/or, should be on the *movement between positions* (2004), which is reflective of the dialogical approach also (Shotter, 2011).

4.4 STRENGTHS AND LIMITATIONS OF THE STUDY

Overall, the current study explored processes of change in family therapy, from the perspectives of the therapists themselves. The literature demonstrated that there is a lack of quality research exploring the role of therapists in processes of change in family therapy, in particular regarding how change occurs. This gap was considered and addressed in the current study, which was intended to generate information to facilitate further studies.

Participants in this study were recruited from a range of mental health settings across South Wales and the South West of England (including private, public, and third sector, adult, child and learning disabilities services) and worked with a range of client groups (including rural and urban populations, with diverse ethnicity, age, and socio-economic status) therefore it is considered that the sample is generally representative of family therapist practitioners and grounded in 'real life' clinical work. This diversity also responds to the gap in current research where homogeneity in the sample of therapists has been highlighted. Given the diversity of the sample identified in this study, the findings were understood to reflect a rich understanding of the experiences of family therapists practicing at present. Limitations include the possible overrepresentation of female (n=8) to male (n=3) participants; although the gender demographics of those practising in this region are unclear. In addition, a majority of the participants trained in the same institute and also attended similar training events; it was therefore possible that their ideas were influenced by a particular orientation, for example dialogism (Shotter, 2005, 2011). Participants were also recruited to the study on a voluntary basis and therefore may have had a greater interest in the research due to personal interest.

This study benefited from the use of triangulation from a number of sources, where the emergent analysis was brought back and reviewed with a supervisor and a sample of the

participants themselves, the latter of which had been found to be lacking in previous research (Davis & Piercy, 2007a; 2007b; Burck *et al.,* 1998; Wark, 1994; Jackson, 1986). This was understood to conform to the principles of good qualitative research as described by Elliott *et al.,* (1999), and thus was felt to add validity, with the emergent analysis being *grounded* in the data at different points of the research process. Issues of validity of the research findings could have been improved through the use of a focus group of all participants during the stages of analysis. This may have provided additional data and means to validate the interpretations made by the author. However it was not possible to conduct this in the time frame available. The participants who provided feedback on the emergent analysis noted that the findings reflected their experiences, and additional comments made by participants were responded to by the author through the development of her final analysis (see Appendix IV).

The application of a constructivist grounded theory approach (Charmaz, 2006) is a strength of this study. This methodology provided an epistemological fit with both the phenomenon under investigation, and also the style of the author. This method of investigation allowed for exploration of the subject matter, and involved a high level of reflexivity and transparency throughout the process of co-construction with each participant, and in the authoring of that co-construction in the analysis. Memo and journal writing formed an important part of this process for the author, as well as regular supervision. Limitations of the use of this approach included the difficulties that were experienced by the researcher in constructing knowledge with participants. Working from a postmodernist approach, participants' descriptions and language were at times difficult for the researcher to construct and deconstruct, as she had relatively little experience of such approaches. Attention to reflexivity was increased by the researcher at these times, and regular supervision was accessed in an attempt to maintain validity through the research process.

A thorough review of the relevant literature exploring the role of the therapist in processes of change was conducted in this study. The review was targeted at mainstream English language journals over the last three decades, with an aim to gather up-to-date and good quality information. However, such an approach undoubtedly reflects a particular *culture* and within a particular *context* and as such should be seen as a potential shortcoming (Jones, 2007). It is observed that journals which reflect a predominately American perspective of systemic

psychotherapy (which composed the large majority of this review), tend to publish articles that focus on the technical aspects of therapy, compared to European journals which reflect an interest in theory and liberal philosophy, or Asian/Pacific journals, with a focus on holistic approaches and cultural sensitivity (*ibid*). Models of change can therefore be seen as embedded and understood within their culture of origin. This study can be seen as founded upon a product of a European/American culture, and so other viewpoints, for example those with a focus on cultural sensitivity, have perhaps been neglected. In addition, this study identified a lack of representation of the more language-based postmodern approaches, which since the 1980s appear to have been silenced amongst a surge in use of the privileged quantitative methodologies. Therefore this study might have benefited from extending the search criteria beyond 1980, so to capture a wider movement of systemic thinking.

4.5 RECOMMENDATION FOR FURTHER RESEARCH

This study offers a preliminary investigation into processes of change in family therapy, as experienced by therapists themselves. Therefore, a number of recommendations for further research are identified from this study.

Particular aspects of this study have been identified as important to explore further. Whilst the experienc*ing* of the therapist emerged as a significant part of the process of change within these findings, as well as in the literature, there is surprisingly little understood about this (Rober, 2005, 2011). Rober (2008) notes that the experiencing of the therapist in sessions have for a long time been ignored in the family therapy field. This is accounted partly to the impact of postmodern and narrative approaches that emerged in the 1980s, with an emphasis on language (Anderson & Goolishian, 1992; Boscolo *et al.,* 1994) and the *client's* expertise (Anderson & Goolishian, 1988). At this time, a focus on the *therapist's* contribution to the therapeutic dialogue became suspect, as it had the potential for 'colonizing' clients and 'robbing them of their own voice' (Rober & Seltzer, 2010). Sanders (1988) argues however, that rather than an either/or discourse, it is the privileging of any *one* idea that is problematic; as it consequently silences others. Specifically she draws attention to the construction of theory that is argued to have been developed through the privileging of the male experience

and reflects the dominant cultural position. Sanders instead warns against the 'untheorising' of emotions and argues that it 'impedes' our understanding of processes of change in family therapy (*ibid*). Despite this critique being made over 20 years ago, not one empirical study was located in this extensive review that explored the family therapist's experiencing directly on processes of change. Therefore the need for research in this area is identified, not only to develop a better understanding of processes of change in family therapy, but also to deconstruct the dominant and subjugating discourse of the engendered 'male' experience that define theories of change.

Whilst this study provided an in-depth focus on the therapist's understanding of processes of change in family therapy, it is recognised that in doing so, neglected the position of the client. As with family therapists, research on clients' experiences of processes of change are also neglected and future research in this area is highlighted (Sprenkle *et al.,* 2007; Duncan & Miller, 2000). Furthermore, theories of change have been suggested to reflect a bias towards the idea that the therapist is more important in the process of change than the client (Duncan & Miller, 2000); Sprenkle and Blow (2004) refer to this as 'professional centricism'. As such, participants in therapy are rarely consulted on how research into change might be defined or measured (Jones, 2007). It is possible therefore that this study has resulted in an exaggerated sense of the importance of the explanatory framework which has unintentionally sought out confirming evidence (*ibid*). Conducting research within the context of the client's *own* theory of change, therefore offers a way of integrating *multiple* therapy perspectives (Duncan & Millar, 2000). On the other hand, it is argued that research conducted with *either* the therapist *or* the client, serves to perpetuate a monologue, rather than create a dialogue between both (Shotter, 2011). What is called for therefore in future research are methodologies that are able to explore the dialogue between *both* therapist *and* client in their co-construction of the process of change within their *specific relational context.*

Finally, in response to the identified absence of research published in the UK on the role of the therapist in processes of change in family therapy, it is recommended that further research on this topic be conducted within the UK. If change is understood within a context, as identified through this study in support of existing theories, *where* research is conducted is then important to attend to. Stratton (2010) similarly argues that effective systemic

interventions for families delivered in the UK needs to be developed through research on practice *in the UK*, rather than relying on methods developed by practitioners in the US and elsewhere.

4.5 CONCLUSIONS

Therapists have been identified as having a significant effect on outcomes of both psychotherapies broadly and family therapy specifically. Despite this, little research has been conducted on the role of therapists on processes of change. Running parallel to this is a prevailing lack of understanding about *how* systemic family therapy approaches work to bring about change for families. As such, this study serves as an important piece of research to address this deficit.

The current study aimed to explore the understandings and experiences of systemic family therapists' of processes of change in family therapy. The research explored participants' experiences by means of individual semi-structured interviews with 11 qualified systemic family therapists working in a variety of mental health settings across South Wales and South West England. The method of Constructivist Grounded Theory was used to analyse the data.

The study identified current definitions of change as understood by participants, and their attempts to work with change through creating a context within which change opportunities were maximised. This included a motivation of participants to *both* join/connect with families, *and* also to challenge them through working on the edge. These conceptions were understood to be occurring simultaneously, in motion, and mediated through a complex and intricate process of feedback. The context of the therapist was understood to be fundamental to the sustaining and development of their practice. Some of these findings can be linked to previous findings and literature relevant to the role of therapist in processes of change in psychotherapies broadly and also family therapy specifically.

The study provided a detailed overview of family therapists' understandings and experiences of processes of change in family therapy in the UK. These findings may help to facilitate the development of systemic interventions used with families and contribute to the developing evidence-base and wider discourse of theories of change within family therapy. Further research is needed to develop these understandings with attention to: the experiencing of therapist, the client's perspective, and the dialogic nature of therapy, contextualised within the diverse mental health settings of the UK.

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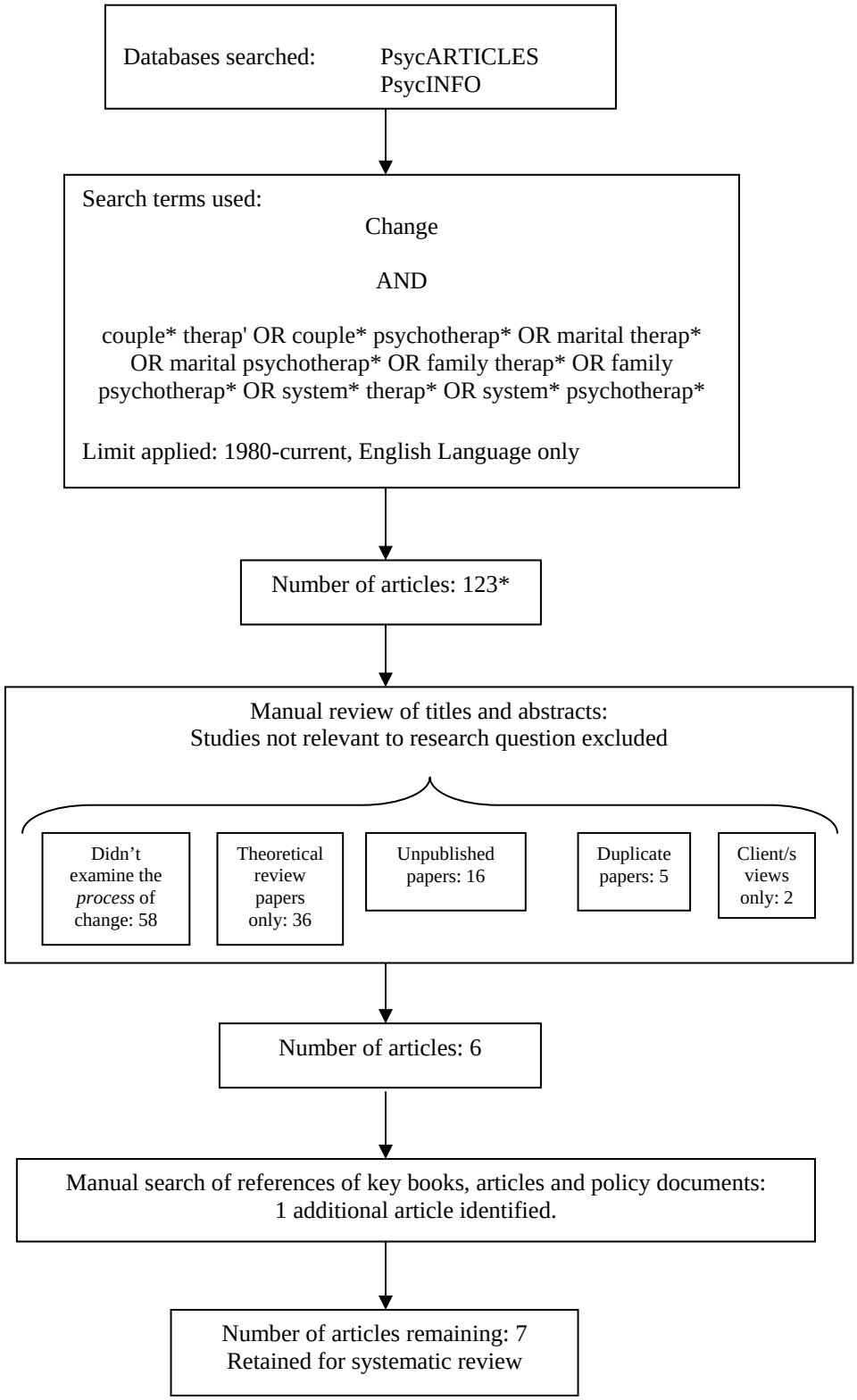
Appendix I:

Summary of Systematic Literature Review Process

SUMMARY OF SYSTEMATIC LITERATURE REVIEW PROCESS



**Search conducted on 19th March, 2012.*

Appendix II:

Development of Researcher's Position of Change

Development of Researcher's Position of Change

May, 2011: ***Beginning of research process***

'At the beginning of the research process I am noticing that I am feeling very unsure and overwhelmed about the different theories of change. I seem to be drawn to the common factors debate as it appears to organise factors into a way that I can understand, however at the same time having to be careful that I don't get organised around this way of thinking. At this stage I'm just trying to hold all the conflicting and new ideas in tension, as well as my anxiety of my relative lack of experience in family therapy.'

November, 2011: ***Middle of data collection***

'I am finding myself drawn to participants' description of narrative and story, with its focus on the 'unsaid' or 'untold', and the creativity drawn on in language and stories. Together with the literature I am reading following the interviews, I've noticing that I'm becoming quite 'fixed' on these postmodern theories of change, which is important for me to attend to in my developing interviews, where I need to be sure that I listen out for 'other' explanations also. I'm feeling very frustrated with the common factors debate/papers now. Not only does it feel inadequate but unhelpful as it distracts me from the opening out of participants' experiences.'

January, 2012: ***End of data collection/beginning of write-up***

'I've begun to be influenced by the feminist critique of postmodernist approaches, particularly that of the 'untheorised emotion'. The more that my ideas change, the more I wonder about what it is that I am missing in the way that I approach the acquisition of 'knowledge' or meaning. So, rather than working very hard to find the 'answer' to the process of change, or the 'correct variables', instead to be able to find a way of seeing that can be robust enough to hold more than one gaze; so to be able to hold both the modern and postmodern, as Larner (2004) talks about. In addition I am beginning to be really influenced by the work of Shotter (2011) and then right back to Bateson's ideas of feedback processes within an *interconnected* system, and the focus on the movement *in-between* the different positions.'

Appendix III:

Extract of Interview Transcriptions

Extract of Interview Transcriptions

EXTRACT 1:

Victoria: How do you understand what it is that you do?

Blake: I think there're two bits: what I do and how I do it.... I think it's about understanding the art or craft of therapy, and there's an important distinction there. And I understand, if you like, a form of psychotherapy that tries as far as possible to create the conditions for change by setting a context in which the possibilities for change are more likely to emerge. The assumption is that change process in family therapy is a relational, takes a relational form, so that individual change within a child or an adult is understood in part of a context in which relational change becomes interactional change occurs so the family therapist is geared from the word go to try and understand those interactional sequences that contribute to ideas that people have about why they're stuck, or why they've got problems, as well as what's going well. So you're focusing very much from the word go on the setting, the context and the relational features of the family and into which you step as a therapist. And the therapist at that point is to be very mindful of both the logic of how the family have come to form these ways of living, in these lives, having these problems, having these resources, holding the values they hold and so on and so forth. So you step into that culture as a family therapist. And the family therapist's job at that point is both to join in that culture and then in some way, to begin to engage on the edges on where possibilities might lie, for change. So to loosen up those ideas and behaviours that have become in the family's eyes, in the repetitive sequences are problematic. So ... the theories are all there, you've probably read all the theoretical stuff so we probably don't need to go into that in such great detail. But there are some basic things that I think that the family therapist has to be mindful of. One of them is the focus on pattern. Patterns of beliefs, patterns of relationships, patterns of interactions, those characterise your kind of antennae, you're looking to see, what, so called problematic patterns, or stuck patterns continue to repeat themselves in ways that families are stuck. So at a very simple level you're helping people to begin to push or nudge themselves towards a more reflexive process where they're beginning to, maybe not identify those patterns, because that in itself doesn't lead to change, which is the focus of your work, but it's an important element for the therapist to be mindful of. Because the therapist has to join, to some extent that culture before you can possibly help you to shift forward. Yeah. So that's how I understand how I try to do, in a nut shell really.

Victoria: Thank you ... and when you describe the being outside and also being part of that family, and learning to understand the meanings, the patterns ... what are you drawing on to do that?

Blake: Well, certainly the tools are useful, I mean systemic questions are very important. Circular questions and so and tracking questions, and all those technical things can be very important. But in addition to that you enter, you simply immerse yourself in the culture of the family. So you enter into it and they will perform how life is. And you'll pick up impressions and associations and stories will come to your mind, or maybe previously families that seem to be in the same atmospheric ... So you're ... yes you are in some senses you're investigating with your questions, but I think, while you're doing that, or more importantly that doing that, your simply absorbing how the family functions and talks to one another, performs their lives in front of you. And that goes for impressions that you get in all the non-verbal

communicated behaviour that you witness and fits you, intellectually and it fits you in an embodied sense as well. So you gain impressions as to where people sit in the room, or if you do home visits obviously the physical image that comes to mind when you see a family where everything's in pristine condition, or families that seem to be chaotic ... or it's more a case of ... it's not so much a case of making an investigation, through questions, although that is part of it. It's more a noticing, and a absorption of aspects of their lives that then trigger things in the therapist. So for example there was a girl who I saw recently, and of course this is all impressionistic, this isn't scientific, I mean, and this is where, it needs people like you to write your stuff up. But I saw a girl here a couple of months ago and the first couple of sessions she hardly said a word, and then it somehow became apparent to me, she wasn't silent and dismissive or walking or obstructive towards me being present, she was silent and watching. So, even though she didn't say anything the impressions I got from the way she sat silently and the occasional things she did say, led me to gain in the second or third session a strong sense that the questions I was asking her Mother and Father about family life were kind of by osmosis transferred questions from her. So I could see when I was asking the questions, for example the mother's depression and obsessive behaviour, I had theories about the daughter's identification with her mother for example, and father being optimistic and so on. These were the things the parents were talking about their life, about loss in their life, and the sense I had from the silent girl was that I was raising words that she wanted to have raised. Now that was an impressionistic response, that wasn't something I discovered... maybe if I would have said "do you think that the questions I'm asking you are the questions your daughter would like me to ask you". But I felt that in the climate of that family session, that would have been stating something too directly. It was best to be left implicit. So those are the kinds of tool qualities that a therapist has to take account of, those atmospheric, in that sense of, what can you do that's possible?

Victoria: And it sounds like, creating that culture or understanding of the family's culture, stepping into that, immersing yourself, can you help me understand how you can be outside, where you're noticing and the feedback, the wondering... and also at the same time, being in that conversation with them ...

Blake: That's exactly it. Peter Rober writes about this in some of his articles about the therapist. I don't know if they're relevant for your research but he wrote a paper about 10 years ago now. He's the professor of family therapy, and Peter's written quite extensively over the last number of years about what he calls the therapists' 'inner talks' and about the processes of interaction and the fine detail between therapist and clients. So he's written a paper on hesitations for example, when somebody changes they're mind or when somebody, you know... there are some fine fine details that therapists actually do pick up on, that promote that edge of change that you can amplify. So if somebody said, "well, I haven't said this before but I'm saying this now", that's a rather obvious example. And the family therapist would then have this idea that when families come and they're feeling, I mean I know people argue and there's the post-modernist view that things are changing all the time... Yes. But... the experience of people when they come to a therapist is that it's not changing all the time, it's like waiting for Godot, it's the same damn thing over and over again, and they're frustrated and angry and feel betrayed. So all lots of types of negativity so while we could argue philosophically that things are changing all the time, I think that's a neat idea, I think we need to utilise those change moments, special moments, but the experience of families is that they're routinised. And we need routines, so Rober is one among contemporary therapists that are clearly looking at the nuance details of what happens between a therapist. And you need to all the time be in both your, be aware of your personal

style, or your personal qualities, and at the same time you're professional role. And it's that that helps you stay on the edge. If you too immersed in the, become so immersed in the family that you can't take that kind of ... borderline stance, then the chances are, you know, it's classic, you become part of the dance that the family have created for themselves. So you end up thinking, and doing stuff that's so familiar to them that no change, no difference to them has been generated. So the therapist's job is always to have an idea of tension somewhere, a kind of pull, it's not about stasis, it's about when motion is arrested, the family members are stuck, the girl won't speak, or there's a shutting down, the family therapist needs to be appreciative of the reasons and the logic of that and at the same time has to have some sense that there are alternatives so you have to really stay on the edge.

EXTRACT 2:

Victoria: Okay. I wanted to ask you a bit more about how you help them perceive things differently, or how you help them to hold that temporary reality that you talked about. How do you get to that point? Because I appreciate that and that's something that's familiar theme through what people have talked about so far. And I was wondering how you were able to do that, because I still struggle with understanding that.

Jane: I'm not surprised you struggle with understanding it because it's hard to describe. Umm I think the basic basis is having a conversation like you are with me now. And you used the word curious with me earlier. I would use the word curious so when someone's telling me something I would be curious about what that means for them and I would be curious about what kinds of assumptions or beliefs they were holding that lie underneath that statement. So in a sort of gently challenging, sort of questioning way, so I would say that one of the big differences in systemic psychotherapy from say Rogerian counselling is we use questions more, rather than empathic just listening and the questions are there to open up people's ideas and thinking. So again in the traditional notion of working with families we use, what we call circular questioning, which will be reflexive questions, so we'll be asking somebody what they think about what else someone's said which means that people begin to understand that not everybody in the family thinks the same about the same issues. And if you're hearing your husband give a view on you, it kind of makes you think 'ooh, that wasn't what I thought about myself', or if you hear your Mother describe something about you, that has 'oh I didn't realise you thought that when I said that'. It kind of helps people get an understanding of how other people are relating to them and the world. So you're not kind of locked in this, your own vision of it, in your own understanding.

Victoria: And you talked a bit about the models you draw on, or the tools you draw on, the specific kind of questioning, and I was wondering about, are there other things that you draw on other than the model, the tools, or when do you know it's okay to ask those questions and how do you gauge how gentle to be?

Jane: Ooh those are good questions ... okay... ummm ... the other tool is me. That's what I use, my colleagues. We use ourselves. So all that we are is part of how we are with our clients. In terms of knowing what question to as when and how... challenging to be with that. I mean it's got to be a lot, it's got to be partly experienced, partly intuition, sense, feeling but

I think the, if you were to strip back the years of experience and think about that question if you ask that question to somebody new in training, then I'd be talking about things like feedback, communication theory would be really important, as a tool for using, in terms of knowing how to, and when to, ask those questions. So we talk about feedback loops, if I say something to you, I'm looking at the way you're responding and I'm thinking 'okay I've said something that was a bit jarring there, perhaps I need to soften up ...' So I'm using the way that people are speaking, the tone, the phrases they're using, the way they're sitting, all the kind of non-verbal information you get, and thinking about, about their context and how that's influencing the way they're experiencing what I'm saying. Erm so there's a, there's an awful lot I think. When I call it intuition, it's learnt intuition, it's not… it's instinctive but it's also developed through training, if that makes sense.

Victoria: And that's something that's coming through more in each interview. There's the tools and the models and then the experience, and then this other stuff, this intuition, and people have used different words to describe it, and that sense that you have. And it's interesting to hear you talk about feedback generally, about how you've found ways to kind of learn or work with that - which might have just felt like instinct before or something. You began to describe some of the things there that you've drawn on from communication through your different kinds of approaches, is there anything left over that that can't account for?

Jane: That's a good question. Erm, yes and no I think is the answer to that. I'm thinking about some of the more recent theory that's been writing about it within the sort of dialogical sphere, because that's, it's a bit of a current theme at the moment in the systemic psychotherapy discipline and people are talking more about the relational aspects of er the therapeutic endeavour and more about how you can be present in a conversation, or even have a conversation that is more dialogical than monological. And again in my mind I'm thinking back to working in an statutory sector organisation where I think conversations of necessity by the context become more monological, because there's assessment forms that people have to go through and there's all of that. Erm so… but coming back to this context, so people are, so people in the field are thinking and working out how to begin to describe some of those things that haven't yet been described within the intuition phrase, so the things that you were asking me about. Am I… are you still with me?

Victoria: Yes I am, yes.

Jane: So people talk about, for instance, the context concept of withness, the sort of between people, so what happens in a conversation where you kind of, you don't leave your body but you're meeting in the middle somehow. And then Tom Anderson, before he died, he was talking a lot about the physical responses that you have in your body when you're having a conversation. So I think in some ways people are beginning to try to articulate some of those things that haven't yet been described. I'm not sure we're there yet, I'm not sure we ever will be there, because I'm not convinced that we really have the language to describe everything that happens between people when they're in a dialogical conversation., and I'm not sure I'd want that really, because then it becomes too much of a mechanisation of human beings. So I think I'd like to keep a little bit that perhaps we can't describe.

Appendix IV:

Focus group notes with participants regarding Constructed Grounded Theory

TRIANGULATION PROCESS

RATIONALE

The process of triangulation was drawn on to ensure that the developing theory was valid and credible, and grounded in the *participants'* experiences, rather than the authors. A focus group was deemed to be the most useful method of gathering this feedback, given the resources available.

PROCEDURE

Given the limited time available within which to gather this data, participants who worked in the same department with either the researcher and/or the clinical supervisor were approached to participate in the focus group (n=4). Invitations were made where possible in person, or otherwise via e-mail. Of the four invited participants, three were able to attend. The focus group was scheduled to be held over one hour.

At the start of the focus group participants were informed of the rationale and procedure and given an opportunity to ask any clarifying questions. The researcher then presented an overview of the analysis to date, and asked the participants to comment on ideas that 'fit' or didn't 'fit' with their experiences, as well as any thoughts they had on concepts/experiences that were absent in the analysis. Having presented the initial analysis the researcher left the room and observed the participants from behind a one-way screen. The conversation was then recorded using audio equipment. It was hoped that this structure would provide the participants with more of a 'space' for their own thoughts to develop, with as little disruption from the researcher as possible. It was also felt to provide the researcher with a 'space' from which to observe participants 'construct' the emerging theory together, rather than being part of the 'constructing' process themselves. This approach was felt to be congruent with systemic ideas of exploring 'different perspectives' and working in 'reflective teams' (Selvini-Palazzoli *et al.,* 1980).

At the end of the focus group the researcher re-entered the room and reflected with participants on some the main themes that were fed back regarding the initial analysis. Participants were thanked for their time and contribution to this stage of analysis.

The audio recording was listened to by the researcher and the following stages were completed:

- key comments/observations were noted;
- each identified concept was 'taken back' and where possible located within the data, so as to check whether it was a shared phenomenon or held by one participant only;
- each concept was then explored further in supervision and;

- prominent concepts/comments that were also identified within the original data were integrated into the complete analysis.

RESULTS

General Feedback:

Participants commented on how rich and detailed the analysis was, which was felt to faithfully capture the complex ways in which they worked.

One participant commented on how well the researcher had 'listened' to the descriptions that participants had offered which had been captured by the model presented.

Whilst feeling somewhat overwhelmed with the articulation of all that they did within their work with families, participants communicated that the model was able to capture the work in a clear and articulate way.

Participants described privileging different parts of the model, for example one participant felt that for her, at this time, 'being present' was a focus of her work, and would therefore fit more into a core category rather than a sub-category. Whereas another participant felt that its positioning fitted with their experiences of working in this way. Participants acknowledged that different concepts would be privileged by different therapists at different times.

POINTS TO TAKE FORWARD:

The above information allowed for the researcher to identify parts of the analysis in which their own bias had influenced the construction of the data. This also allowed for the terminology used to be clarified and developing theory validated. The following changes were made to the initial analysis following the stages outlined above:

- 'Feedback *mechanisms*' to be changed to 'feedback *processes*' **(THEME 3, Core-Category 2)**
- Make clear the idea of *interconnectivity* and *fluidity* between different parts of the model
- The category of 'time' to be changed to 'pace' **(THEME 2, Core-Category 2)**
- Draw out the isomorphic nature of the process of learning and the process of therapy **(THEME 3, Core-Category 2, category 1)**
- Draw out ideas more explicitly on story and narrative **(THEME 2, Core-Category 3)**
- Discuss the *irreverence* of family therapy itself, and the way in which is can be understood as self-referential **(THEME 3, Core-Category 2, category 4).**

Appendix V:

Interview Schedule (Version Three)

Version 3 – 23/6/11

Interview schedule

An exploration of the process of change in systemic family therapists' perspective

Tasks for facilitator

1. Introduce self and project
2. Check if there were any outstanding questions from the information sheet and consent form.
3. Check that the consent form has been completed, and make sure that the participant has agreed to the interview being recorded.
4. Remind participants that everything discussed should remain confidential, and that client confidentiality should be maintained throughout the discussion. Also remind participants of the limits to confidentiality when discussing professional issues.
5. Intervene to keep the discussion focused on the broad topic, but do not seek to control the content of the discussion.
6. Keep the overall interview length to between one and one and a half hours.

Questions for the facilitator to ask

Stem questions are in bold, *and prompts are in italics*.

1) **Tell me a bit about what you do**.

Where do you work? What is the Service/Department?
Who are the clients that you work with?
What are the kinds of presentations?
How do you understand the work that you do?
What are you trying to do?
How do you get referrals? Discharge?

How do you know that change has happened?...

2) What does 'change' mean to you?

What does it look like?

How do you understand when it is occurring?
Can you give me a clinical example?

What do you think are the barriers for this?
Can you give me a clinical example?

3) **How has your understanding of change developed throughout your experiences working systemically with families?**

What did it used to be like?

Who have you been influenced by?
What key authors/ideas have influenced your understanding of change?

How do you see this developing?

[What role do you think the client has in the process of change?]

4) **Is there anything I haven't asked you that you'd like me to ask?**

What else do you think I should ask in the next interviews?

Thank you very much

<u>Interview schedule changes 1</u> *(following participants no. 1,2,3 & 4)*

***For purpose of clarity amendments have been highlighted in dark, bold text.**

An exploration of the process of change in systemic family therapists' perspective

Tasks for facilitator

7. Introduce self and project
8. Check if there were any outstanding questions from the information sheet and consent form.
9. Check that the consent form has been completed, and make sure that the participant has agreed to the interview being recorded.
10. Remind participants that everything discussed should remain confidential, and that client confidentiality should be maintained throughout the discussion. Also remind participants of the limits to confidentiality when discussing professional issues.
11. Intervene to keep the discussion focused on the broad topic, but do not seek to control the content of the discussion.
12. Keep the overall interview length to between one and one and a half hours.

Questions for the facilitator to ask

Stem questions are in bold, *and prompts are in italics*.

5) **Tell me a bit about what you do**.

Where do you work? What is the Service/Department?
Who are the clients that you work with?
What are the kinds of presentations?
How do you understand the work that you do?
What are you trying to do?
How do you get referrals? Discharge?

How do you know that change has happened?...

***ADDITIONAL CONSIDERATIONS**:*

- ***No need to go into too much detail here, just enough to contextualise work/setting.***

6) **What does 'change' mean to you?**

What does it look like?

How do you understand when it is occurring?
Can you give me a clinical example?

What do you think are the barriers for this?
Can you give me a clinical example?

ADDITIONAL QUESTION:

- ***'What are the main ideas/theories that are influencing your ideas of change in your work presently?'***
- ***'Can you help me to understand what you mean by ... ('engagement', 'withness', ...)'.***

ADDITIONAL CONSIDERATIONS:

- ***Explore/open out/question the language that participants offer more.***
- ***Notice similarities of themes or ideas that have emerged in previous interviews and explore ideas of difference.***

7) **How has your understanding of change developed throughout your experiences working systemically with families?**

What did it used to be like?

Who have you been influenced by?
What key authors/ideas have influenced your understanding of change?

How do you see this developing?

[What role do you think the client has in the process of change?]

ADDITIONAL QUESTION:

- ***When talking about a 'change' moment: 'How do think the client experienced this?'/ 'what sense' do you think the client made of this moment?'***

8) **Is there anything I haven't asked you that you'd like me to ask?**

What else do you think I should ask in the next interviews?

Thank you very much

<u>Interview schedule changes 2</u> *(following participants 5,6 & 7)*

An exploration of the process of change in systemic family therapists' perspective

Tasks for facilitator

13. Introduce self and project
14. Check if there were any outstanding questions from the information sheet and consent form.
15. Check that the consent form has been completed, and make sure that the participant has agreed to the interview being recorded.
16. Remind participants that everything discussed should remain confidential, and that client confidentiality should be maintained throughout the discussion. Also remind participants of the limits to confidentiality when discussing professional issues.
17. Intervene to keep the discussion focused on the broad topic, but do not seek to control the content of the discussion.
18. Keep the overall interview length to between one and one and a half hours.

Questions for the facilitator to ask

Stem questions are in bold, *and prompts are in italics*.

1. **Tell me a bit about what you do**.

   Where do you work? What is the Service/Department?
   Who are the clients that you work with?
   What are the kinds of presentations?
   How do you understand the work that you do?
   What are you trying to do?
   How do you get referrals? Discharge?

   How do you know that change has happened?...

***ADDITIONAL CONSIDERATIONS**:*

- *No need to go into too much detail here, just enough to contextualise work/setting.*

2. **What does 'change' mean to you?**

   What does it look like?

   How do you understand when it is occurring?
   Can you give me a clinical example?

   What do you think are the barriers for this?

Can you give me a clinical example?

ADDITIONAL QUESTION:

- *'What are the main ideas/theories that are influencing your ideas of change in your work presently?'*
- *'Can you help me to understand what you mean by ... ('engagement', 'withness', ...)'.*

- ***Offer back key themes from previous interviews for exploration (e.g. some participants have described a sense of 'withness'... 'is that something that is part of your thinking'... 'in what way' ... 'how might it differ?'***

ADDITIONAL CONSIDERATIONS*:*

- *Explore/open out/question the language that participants offer more.*
- *Notice similarities of themes or ideas that have emerged in previous interviews and explore ideas of difference.*

- ***Notice 'change moments' experienced through the interview.***
- ***Spend more time being guided by the participant's interest/'story' that they bring to the forefront.***

3. **How has your understanding of change developed throughout your experiences working systemically with families?**

   What did it used to be like?

   Who have you been influenced by?
   What key authors/ideas have influenced your understanding of change?

   How do you see this developing?

   [What role do you think the client has in the process of change?]

ADDITIONAL QUESTION:

- *When talking about a 'change' moment: 'How do think the client experienced this?'/ 'what sense' do you think the client made of this moment?'*

4. **Is there anything I haven't asked you that you'd like me to ask?**

   What else do you think I should ask in the next interviews?

ADDITIONAL QUESTION:

- ***'What has surprised you about all we have talked about?'***
- ***'What has felt particularly prominent for you in what we have discussed?'***
- ***'What do you think has been 'untold' in this interview that needs consideration?'***

Thank you very much

Appendix VI:

Cardiff and Vale Local Health Board Research and Development Approval

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Ysbyty Athrofaol Cymru
University Hospital of Wales

Heath Park,
Cardiff, CF14 4XW
Phone 029 2074 7747
Fax 029 2074 3838
Minicom 029 2074 3632

Parc Y Mynydd Bychan,
Caerdydd, CF14 4XW
Ffôn 029 2074 7747
Ffacs 029 2074 3838
Minicom 029 2074 3632

Eich cyf/Your ref
Ein cyf/Our ref
Welsh Health Telephone Network 1872
Direct line/Llinell uniongyrchol

Tel: 029 20746986
Fax: 029 20745311
CAV_Research.Development@wales.nhs.uk

From: Professor JI Bisson
R&D Director
R&D Office, 2nd floor TB2
University Hospital of Wales
Cardiff
CF14 4XW

18 February 2011

Ms Victoria James
Trainee Psychologist
South Wales Doctoral Programme
Clinical Psychology
Archway House
77 Ty Glas Avenue
Cardiff
Cf14 5dx

Dear Ms James

Project ID : 11/MEH/5049 : An Exploration Of The Process Of Change in Systematic Family Therapy: The Therapists Prospective

Thank you for your recent communication regarding the above project, which was reviewed on 18 February 2011 by the Chair of the Cardiff and Vale Research Review Service (CaRRS).

Documents submitted for review were:

Document	Version/Serial number	Date
NHS RD Form	3.1	Received 31 January 2011
SSI Form	3.1	Received 31 January 2011
Protocol	2.0	10 January 2011
Patient Information Sheet	2.0	21 December 2010
Patient Consent Form	1.0	22 November 2010
Invitation Letter to Focus Group	2.0	21 December 2010
Interview Schedule	2.0	10 January 2011

I am pleased to inform you that the Chair had no objection to your proposal.

You may now contact the R&D Office to obtain the sponsor signature needed for your submission to the NHS Research Ethics Committee.

R&D approval and final acceptance of sponsorship by Cardiff and Vale UHB is now subject to the following:

- Evidence of favourable opinion from the relevant NHS Research Ethics Committee
- Evidence of completion of appropriate online Informed Consent training by the PI.

Once the above are in place, an R&D approval letter will be issued. You should not begin your project before receiving this written confirmation from the R&D Office.

Please ensure that you notify R&D if any changes to your protocol or study documents are required in order to obtain a favourable opinion from the Research Ethics Committee.

If you require any further information or assistance, please do not hesitate to contact the staff in the R&D Office.

Yours sincerely,

Professor Jonathan I Bisson
Chair of the Cardiff and Vale Research Review Service (CaRRS)

CC R&D Lead Prof Nick Craddock
CC Dr Andrew Vidgen, Academic Supervisor

[ENCS] Obtaining a sponsorship signature - guidelines

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Ysbyty Athrofaol Cymru
University Hospital of Wales

Heath Park,
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Minicom 029 2074 3632

Parc Y Mynydd Bychan,
Caerdydd, CF14 4XW
Ffôn 029 2074 7747
Ffacs 029 2074 3838
Minicom 029 2074 3632

Eich cyf/Your ref
Ein cyf/Our ref
Welsh Health Telephone Network 1872
Direct line/Llinell uniongyrchol

Tel: 029 20746986
Fax: 029 20745311
CAV_Research.Development@wales.nhs.uk

From: Lee Hathaway
R&D Facilitator
R&D Office, 2nd Floor TB2
University Hospital of Wales
Cardiff
CF14 4XW

13 May 2011

Ms Victoria James
Trainee Psychologist
South Wales Doctoral Programme
Clinical Psychology
Archway House
77 Ty Glas Avenue
Cardiff
CF14 5DX

Dear Ms James

Project ID : 11/MEH/5049 : An Exploration Of The Process Of Change in Systemic Family Therapy: The Therapists Perspective

REC Reference: 11/WA/0051

Thank you for submitting revised documents as evidence of compliance with the ethics committee approval conditions.

The documents reviewed were:-

Document	Version	Date
Acknowledgement letter from SEWREC		05/04/11
Participant Information Sheet	3	01/04/11
Participant Consent Form	2	01/04/11

I can confirm that the above support documentation has been favourably reviewed and that you may continue with this study accordingly.

Please ensure that the appropriate Research Ethics Committee have a copy of this letter.

May I take this opportunity to wish you success with the project and remind you that as Principal Investigator you are required to:

- Inform the R&D Office if any external or additional funding is awarded for this project in the future.
- Inform the R&D Office of any further amendments relating to the protocol, including personnel changes and amendments to the actual or anticipated start / end dates.
- Complete any documentation sent to you by the R&D Office regarding this project.
- Adhere to the protocol as approved by the Research Ethics Committee.
- Ensure the research complies with the Data Protection Act 1998.

Yours sincerely,

Lee Hathaway
R&D Facilitator

CC **R&D Lead Prof Nick Craddock**
Victoria James

Appendix VII:

South East Wales Research Ethics Committee Approval

GIG CYMRU NHS WALES
Canolfan Gwasanaethau Busnes
Business Services Centre

South East Wales Research Ethics Committee Panel C
Direct Line: 02920 376823/376822
Facsimile: 02920 376835
Email: Carl.phillips@wales.nhs.uk

Ms Victoria James
Trainee Clinical Psychologist
Cardiff and Vale UHB
South Wales Doctoral Programme in
Clinical Psychology, Archway House,
77 Ty Glas Avenue, Cardiff.
CF14 5DX

21 March 2011

Dear Ms James

Study Title: **An exploration of the process of change in systemic family therapy: the therapists' perspective.**

REC reference number: **11/WA/0051**

The Research Ethics Committee reviewed the above application at the meeting held on the 18 March 2011.

Thank you for attending to discuss the study. The additional information and clarification that you were able to provide was most helpful and much appreciated.

Ethical opinion

The Committee noted that this was a single site study involving qualitative methods which aimed to explore systemic family therapists' understanding and experiences of the processes of change during family therapy.

The Committee in noting that the study was sponsored by the Cardiff & Vale University Health Board and that therefore NHS indemnity applied. Members noted that the sponsor's representative had declared that an appropriate process of scientific critique had demonstrated that this research proposal was worthwhile and of high scientific quality, and that the study had been approved by the Cardiff & Vale Research Review Service (CaRRS).

The Committee noted that the study was being undertaken as part of an educational project, namely a Doctorate in Clinical Psychology and members further noted that the '*Declaration for student projects by academic supervisor'* had been signed.

The Committee noted that the study would involve a total of between 8 and 12 participants who would be qualified systemic family therapists with a minimum of 2 years experience working therapeutically with families.

The Committee noted that the study would involve face to face semi structured interviews followed by a focus group and that the initial approach to potential participants would be through the Academic Supervisor and the Senior Lecturer at the Family Institute of Glamorgan University.

The Committee noted that potential participants would be provided with written information about the purpose of the study, why they had been invited to participate, who was conducting the research, how the data would be used and what participation would be required of them. They would also be given the opportunity to ask any questions about the study. Written consent would be obtained prior to participation in the study and it was made clear that participation was entirely voluntary and that those taking part could withdraw at any point for any reason.

The Committee was grateful for the confirmation provided that the telephone provided in the *Invitation Letter* was a work number and not a mobile telephone number.

The Committee noted that participants would have 2 weeks in which to decide whether or not to take part in the study.

The Committee noted that if a participant, who had given informed consent, lost capacity to consent during the study then that participant and all identifiable data would be withdrawn from the study. Data not identifiable to the research team might be retained.

The Committee noted that translation services would be sought if necessary and that the proposed *Information Sheet* and *Consent Form* would be translated into Welsh if required.

The Committee noted that both the interviews and focus group would be video-recorded and that potential participants were informed of this within the proposed *Information Sheet*. Members also noted that participants were advised how the tapes would then be stored and what would eventually happen to them.

The Committee noted that the study would involve the publication of direct quotations from respondents and that this information had not been included within the proposed *Information Sheet,* although it had been referred to in the *Invitation Letter to Focus Group*

The Committee noted from *section A43* of the *application form* that personal data would be stored for less than 3 months after the study had ended. The Committee pointed out that it was the responsibility of the Chief Investigator to be up to date and to comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer.

The members of the Committee present gave a favourable ethical opinion of 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.

These include a number of additional conditions which you are asked to pay particular attention to.

- 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 (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

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

- The Committee raised a number of issues with the proposed *information sheet,* which need to be addressed in a revised document. The issues raised were as follows:-

- The Committee noted that the study would involve the use of direct quotations and participants must be advised of this within revised *information sheet.*

- The *consent form* must be resubmitted to include an updated version number and date of the associated *information sheet.* The revised *consent form* must themselves include both a revised version number and date.

- 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).

- You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

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.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Protocol	2	10 January 2011
Letter of invitation to participant	2	21 December 2010
REC application	3.1	04 January 2011
Participant Information Sheet	2	21 December 2010
Participant Consent Form	1	22 November 2010
Interview Schedules/Topic Guides	2	10 January 2011
CV	V James	10 January 2011
Investigator CV	Dr AM Vidgen	19 January 2011
Letter from Sponsor	Cardiff & Vale UHB	18 February 2011
Personal Details Form	2	21 December 2010

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.

11/WA/0051 **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Mrs J Jenkins
Chair, Panel C
South East Wales Research Ethics Committees

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

"After ethical review – guidance for researchers" SL-AR2

Copy to: R&D office for Cardiff & Vale University Health Board

Andrew.Vidgen@wales.nhs.uk

NISCHR

Uned Cydlynu Caniatâd | PCU | Permissions Co-ordinating Unit

South East Wales Research Ethics Committee
Sixth Floor, Churchill House
17 Churchill Way
Cardiff CF10 2TW

Telephone : 029 2037 6823

Ms Victoria James
Trainee Clinical Psychologist
Cardiff and Vale UHB
South Wales Doctoral Programme in
Clinical Psychology, Archway House,
77 Ty Glas Avenue, Cardiff.
CF14 5DX

5 April 2011

Dear Ms James

Full title of study: **An exploration of the process of change in systemic family therapy: the therapists' perspective.**

REC reference number: **11/WA/0051**

Thank you for your letter of the 1 April 2011. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated the 18 March 2011. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	Version	Date
Covering Letter	V James	01 April 2011
Participant Information Sheet	3	01 April 2011
Participant Consent Form	2	01 April 2011

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

11/WA/0051 **Please quote this number on all correspondence**

Yours sincerely

Carl Phillips
Executive Officer
South East Wales Research Ethics Committees
E-mail: Carl.phillips@wales.nhs.uk

Copy to: R&D office for Cardiff & Vale University Health Board

Appendix VIII:

Participant Information Sheet (Version Three)

SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

VERSION 3: 1/4/11

Participant Information Sheet

An exploration of the process of change in systemic family therapy: the therapists' perspective.

I would like to invite you to take part in a research study which is being carried out by myself Victoria James (Trainee Clinical Psychologist), under the supervision of Dr Andrew Vidgen (Consultant Clinical Psychologist and Principle Lead, South Wales Doctoral Programme in Clinical Psychology) and Billy Hardy (Senior Lecturer and Systemic Family Therapist, The Family Institute, University of Glamorgan). The results of the research will be written up as a dissertation and submitted as part of my examinations towards a Doctorate in Clinical Psychology.

Before you decide whether to take part it is important for you to understand why the research is being done, and what it would involve for you. Please take time to read the following information carefully. Please feel free to ask any questions if there is anything that is unclear or if you would like more information.

What is the purpose of the study?

The research project aims to focus on systemic family therapists' understanding and experiences of the process of change during therapy.

Whilst family therapy has been established as effective in a wide range of child, adolescent and adult mental health difficulties, little research has looked beyond outcome measures to explore *how* systemic therapy works. In order to better understand this, studies that reveal more about the nature of the therapeutic process are needed; currently there is a lack of research literature investigating this.

This study aims to explore systemic family therapists' experiences of change during therapy with families, in order to gain a deeper understanding of the processes involved. It is hoped that this will generate a theory that can contribute to the development of a shared understanding of how change is achieved in systemic family therapy. This has implications for the development of models, future research agendas, training and practice.

It is hoped that the study will be published in an academic journal and be presented at national conferences and thereby inform clinical practice.

Why have I been invited?

You have been invited to take part because you are a Systemic Family Therapist with a minimum of 2 years experience working with families.

Do I have to take part?

It is up to you to decide whether or not to take part, as taking part in this research study is entirely voluntary. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason. If you do decide to withdraw, the data provided up to the point of withdrawal will be used within the study.

What is involved if I do agree to take part?

If you decide to take part you will be invited to attend an interview, followed by a focus group. These will be facilitated by the researcher, Victoria James (Trainee Clinical Psychologist).

You will also be asked to complete a brief personal details questionnaire. It is anticipated that each interview and focus group will last between 60 – 90 minutes, and will take place during the working day. Arrangements will be made for these to take place at a time and place convenient to you.

The interview and group discussion will be video recorded so that the researcher can transcribe the information in order to analyse it.

What are the possible advantages of taking part?

I hope that you will welcome the opportunity to talk about your experiences, and in light of the limited available literature on the process of change in family therapy, it is hoped that the information provided will shape future research development.

What are the possible disadvantages of taking part?

This study is a psychological study and there are no known risks involved in taking part. However, if at any point during the interview or focus group you feel that you would like to withdraw from the study you will be free to do so.

Will my taking part in this study be confidential?

All data gathered will remain strictly confidential, and you will not be able to be identified by anyone other than the interviewer. The data will be stored in a locked cabinet within the host University Health Board, and the researcher alone will have access to the data. When the data is transcribed all names will be changed and so you will not be identifiable from the transcripts. Following transcription, the data will be destroyed.

.

What will happen to the results of the study?

The results of the research will be written up as a dissertation and submitted as part fulfilment of my Doctorate in Clinical Psychology. Transcribed interview data will be anonymised as will the identity of the participants. Direct quotations will be used in the write up of the dissertation. If you would like a copy of the final report you can ask for this when the project is concluded – you will not be identified in this.

What if I have a problem with the study?

If you have concerns about any aspect of this study, please contact the researcher (contact details below) – I will do our best to answer your questions. If you remain unhappy and wish to complain formally we will give you contact details of other people who may be able to respond to your concerns.

Who has reviewed the study?

All research in the NHS is looked at by independent group, a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the South East Wales Research Ethics Committee.

Further information

If you have any further questions about taking part in the study or require any more information please do not hesitate to contact me (Victoria James) at the Psychology Department on **02920 206464**, email me on **jamessv@cardiff.ac.uk** or contact me at the address above, and I will get back to you as soon as possible.

Thank you very much for taking the time to read this

Your help is greatly appreciated

1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX

Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106

Email/Ebost deborah.robinson2@wales.nhs.uk

Appendix IX:

Participant Consent Form (Version Two)

SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

VERSION 2: 1/4/11

PARTICIPANT CONSENT FORM

Study Title: An exploration of the process of change in systemic family therapy: the therapists' perspective.

Name of Researcher: Victoria James

	Please initial the boxes below if you agree
1. I confirm that I have received, read and understood the information sheet, version 3, dated 1/4/11 for the above research study. I have had the opportunity to consider the information provided and to ask questions, which have been answered adequately.	☐
2. I understand that participation is entirely voluntary and that I can withdraw from the study at any time, without giving any explanation.	☐
3. I understand how my confidentiality will be ensured.	☐
4. I understand that any data for which I provide my consent will be used within the study. If I decide to withdraw from the study, I will not provide any further information and my existing data will not be used for analysis.	☐
5. I agree to participate in the above research study.	☐
6. I would like a summary of the research findings on completion of the study.	Please circle YES NO

If you have indicated 'yes' to the above question please provide details of where you would like the summary sent (i.e. email or address). Contact details: _____

Name of participant Signature Date

Copies: x1 to participant; x1 to researcher

1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX

Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106

Email/Ebost deborah.robinson2@wales.nhs.uk

Appendix X:

Personal Details Form (Version Two)

SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

VERSION 2: 21/12/10

Personal Details Form

These questions just give me some background information about you:

Name…….....…….....……

Professional background…….....…

Current place of work…….....…….....….

Number of years since qualification (as systemic therapist).....…….

Gender: Male ☐ Female ☐

Age 18-30 ☐ 31-45 ☐ 46-60 ☐ 61+ ☐

Thank you very much

1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX

Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106

Email/Ebost deborah.robinson2@wales.nhs.uk

Appendix XI:

E-mail Invitation to Participants

From: Victoria James To: [redacted] Date: Monday - May 30, 2011 11:10 AM Subject: Invitation to participate in research project

Hi [redacted],

My name is Victoria and I'm writing with regards to a research project that I am conducting; looking at family therapists' experiences and ideas about change in family therapy. Billy (Hardy) is also involved in this project and has let me know that you may be interested in participating. I'm therefore writing with some more information about the project and to ask, if you are still happy to participate, for a possible time and place for us to meet to conduct the interview. In short, it will be a chat about an hour long, about your thoughts on change during family therapy. Attached is a more detailed explanation of what will be involved.

I am happy to meet at a place convenient to you, I understand from Billy that you are based in [redacted] in [redacted] so this might be easier for you? I will need some DVD recording equipment which I hope won't be a problem. Or otherwise we could meet at [redacted]. Let me know whatever is best for you.

If you have any queries about any part of this project please don't hesitate to ask- I will attempt to answer them as best as I can! I will also reiterate the information enclosed and provide an opportunity for you to ask any questions when we meet, prior to conducting the interview.

Thank you for your support and looking forward to meeting with you soon.

Kind regards

Victoria

Trainee Clinical Psychologist

Appendix XII:

Extracts from Reflective Journal

Extracts from Reflective Journal

November, 2011: ***The methodology***

'The more I read and understand about social constructionism and family therapy the more I feel the tension within this research process: trying hard to faithfully capture processes using a methodology that is flexible enough to do so, yet also robust enough to be considered 'valid'. And all of this against the backdrop of meeting the thesis requirements, which is ultimately what is privileged in this process. Having a supervisor within each of these different fields to guide the process however, helps me to feel as though these difficulties are being balanced, although I continue to attend to them as it feels like a very *fine* balance.'

February, 2012: ***The use of self***

'I've been wondering about the function of this reflection, in particular the 'spotting' of how my own personal thinking is 'influencing' the process of research. Whilst I have been vigilant to notice my biases, I am now inclined to think that they only appear to be 'biases' because they are not the 'dominant discourse'. Instead they can be constructed as the 'minority', 'silenced' voice, and are deserving of attention and processing, like any discourse, rather than being 'tempered' so to not 'pollute' the positivistic scientific endeavour. Rather, I am more curious about the strength behind the emotion and the deconstruction of this in the context of the culture within which I am writing. That is proving more fruitful to opening out meaning at this time.'

March, 2012: ***Analysing of results***

'I have noticed that I am privileging the accounts of some participants over others and am wondering why. Is it simply because they are particularly poetic, and articulate? Or is it because their words have touched something inside of me through our interrelating in the construction of meaning? I'm not sure. I suspect both, however I am also nervous of missing other important voices, therefore have revisited the principles of grounded theory and re-

viewed the interviews to ensure that I am not excluding other equally important voices in my authoring of the co-construction.'

April, 2012: *Processing of dialogism*

'After spending a long time processing ideas of dialogism, I think I understand its principles. In doing so I have re-visited the ideas of Bateson (1979) and his ideas of interconnectivity and feedback, which extends beyond therapy, to that of humanity itself. Together with the work of Shotter (2011), it has made a significant impression on me and I have become more interested in ideas of dialogism. In particular I have reflected on the interviews in which I experienced my own 'change' and the ways in which this might have occurred. I have wondered throughout if, when describing to me processes or techniques of change, participants were in fact practicing those very techniques/processes *with* me, in a live and authentic way, where my meaning, met their meaning in the space *in-between*, where a new difference or experience could emerge for both. I cannot know if participants experienced this also, however, according to the theory, if I felt changed, then they did too, as it happened *in-between* us. In this way the process of research is isomorphic with the process of therapy, which prompts me to 'check-out' my emerging theory not only with the participants in the focus group but within my lived/embodied experiences of them.'

May, 2012: *The 'both/and' position*

Having noticed a lot of movement in my position throughout this research process I have drawn more on the 'paramodern', or 'both/and' position of Larner (2004), and attempted to focus on the movement between the/any two opposing positions. This draws me right back to the original theory of Bateson (1979), and in this way the beginning and end are one and the same. I have noticed that this takes the 'heat' out of my need to take *a* position or find *the* answer, and instead to be free to observe the movement, and the context, and the ways in which everything is interconnected.

Appendix XIII:

Examples of Memo Writing

Examples of Memo Writing

EXTRACT 1

Interview Date: 24/06/11 **Todays Date:** 24/06/11

Interview Number: Two (Gwen)

Themes Generated from Interview:

- How to manage change, working with different agendas agencies. Expectations of others.
- Change as difference, first and foremost... whose difference?
- Focusing on the strengths and resilience of the families and working from that foundation. All the time returning to this and validating families' experiences and resources and resilience.
- Systems linking in and the negotiation of this. Systems of family/professionals. Systems being organised around behavioural changes.
- Change being a 'felt experience' instead.
- Small change versus big change.
- Ideas of the feedback loop...
- Reflecting and developing hypothesis through the process of feedback throughout the session.
- Co-creating something that's different between therapist and family, so that a new story is created.
- Issues of power and the importance of empowering the client.
- Paying attention to the context within which they are in.
- Working from the philosophy of systemic therapy- forming part of the identity of the therapist. More than just an approach from which to work.
- Throughout the process of therapy drawing on theories, professional experiences and training.
- Always pulling on the therapeutic relationship. Being understood as a fluid and continuously changing thing. Never static.
- Paying attention to the possibilities in the room and within the interactions. Both of the family members and also the therapist relating with the family.
- The use of 'self' in the room with clients.
- The importance of being 'attuned' to families and their experiencing.
- The importance of being an embodied person in the room, relating with others.
- Noticing development from the past to the present to the future.
- Ideas of 'withness'.... difficult to explain. New ideas developing.

Other information or observations:

During this interview I noticed the expected nervousness and real attention to all that the participants was saying, as well as the questions I wanted to ask, however half way through I noticed myself relating into the conversation and feeling more or a connection with the participant or what they were saying. I'm not sure of the difference. Towards the end of the interview they begun to talk about ideas of interconnectivity and 'withness' and I experienced a real sense of being connected with the environment around us. At the time I was struck by this and also noticed that I tried to 'figure' out what was happening. Was it merely an intellectual idea that stimulated me? I also begun to be aware of my own embodiment, and some breath inside me that felt different. I'm not sure if this is relevant at this stage, my own personal experience of the interviews, but it was powerful enough to note. And to be open to should it happen again.

Information to pursue in further interviews:

- Feedback loop.... what is this? How are therapists understanding/ working with this.
- Explore ideas between change and difference
- Ideas about context
- The importance of the positioning of the client as resilient
- Ideas of withness/interconnectivity
- The authoring of the client's story
- Noticing of own emotions in relation to the participant

EXTRACT 2

Concepts generated following first five interviews

Context of therapist

Space around and within the therapist

Formal and informal

Challenging safe space

Joining family culture

Irreverence of theories and ideas of change

Teams dominant story and about a family

Families' ownership of their stories and meanings

Parallel of culture of family and culture of team

Role of consultation

'What is this' (withness)

The edge

Holding both personal and professional

Appreciation of clients' experiences

Much more than language

Logic AND illogic

Openness to re-see, re-think, re-learn.

How to be more present in dialogue versus monologue (withness?)

Change is a context

Change generated in a context...

Therefore where and who one works with is most influential

Reviews (in relation to change)

Feedback/inner talk... to promote edge of cha nge?

Expert position (resisting and working with)

Curiosity in order to challenge the status quo

How to sustain curiosity in self?

Feedback mechanisms

Clients' experience of the therapists' experience of change/being moved, something becoming different. ... change point.

Importance of tension (not stasis?)

Organisational context/change and the client's change

Position of therapist, both within family culture AND holding the edge

Support AND provocation

Ethical/professional considerations/framework

Dominant story (for family, for therapist)

Isomorphic (therapy/learning and therapists' space and clients' space)

Personal and professional development

Support of the therapist (peers/colleagues)

Creating a space (context?) within which change can happen, for client- for 'difference', to learn?

Listening to client, self-talk/experiences/actions

Listening and connecting ('therapeutic relationship', 'engagement')

Feedback (use of language to do this)

Pace/timing

Moment by moment change

Different levels of relationships

Creating new stories

Holding an appreciation for the unknown

Creating intimacy of relationship

Helping teams to open out understandings in he same way (parallel processes with clients)

Challenging status quo

Innate skills of noticing (of client, of therapist)

Providing opportunity for difference (for family, for therapist also)

Learning to ignore your responses

Withness (in relationship with)

Appendix XIV:

Participant Invitation Letter To Focus Group (Version Two)

SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Version 2 – 21/12/10

INVITATION LETTER TO FOCUS GROUP

Date:

Dear [participant]

I am writing to inform you on my progress with the research study that you participated in regarding therapists' experiences of the process of change in systemic family therapy. I am pleased to tell you that all of the interviews have now been completed and analysed. Everyone's contribution was very valuable and has provided interesting insights into the process of change during systemic family therapy.

You may remember that at the interview I informed you that I would contact you with an invitation to take part in a focus group with the other participants who took part in the study. The purpose of this group is to feedback the main themes that emerged during the interviews and discuss how these findings fit with your experiences of the process of change in systemic family therapy. This is to ensure the findings are accurate and that I have not missed anything important out of the analysis. Anything you said during the interview will be anonymised and therefore any quotes used will not identify you.

The focus group will be held on [DATE] at [VENUE].

Please could you complete the attached slip to indicate whether you would like to attend the focus group and if you are available on the suggested date. Please return the slip in pre-paid envelope provided.

Please do not hesitate to contact me if you have any queries about the group: **07917 402608.**

I look forward to hearing from you.

Kind regards

Victoria James
Trainee Clinical Psychologist

Dr Andrew Vidgen
Consultant Clinical Psychologist and Principle Lead, South Wales Doctoral Programme in Clinical Psychology.

Billy Hardy
Senior Lecturer and Systemic Family Therapist, The Family Institute.

RETURN SLIP

Name:_____

a) I would like to attend the focus group on [DATE]

b) I would like to attend the focus group but am unable to make [DATE].

c) I do not wish to attend the focus group.

Thank you

Victoria