

What makes a difference in family therapy? Exploring
the links between theory and practice using qualitative
interviews and interpersonal process recall.

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RESEARCH PAPER

The following paper is intended for submission in the Journal of Marital and Family Therapy. The journal publishes articles on research, theory, clinical practice and training. It was chosen because it is committed to moving the field of family and marital therapy forward through disseminating the best in family therapy research, theory and practice. It was also targeted because it has the largest circulation of any family therapy journal in the world.

The journal publication guidelines state that the total manuscript length, including references, tables, and figures, should not ordinarily exceed 30 pages using a 12-pt. font. The manuscript should include an abstract which should not exceed 120 words. Citations and references should follow APA style. The paper below follows those guidelines.

Applying Interpersonal Process Recall to change process research in family therapy

Abstract

This article describes how Interpersonal Process Recall (IPR), a qualitative process-orientated methodology, can be applied to change process research in family therapy. To date, this approach has mostly been used to study individual therapies. The paper examines the theoretical evidence base and rationale for this approach and demonstrates the process of using IPR with families, using a case example. Methodological and conceptual issues are also addressed, and opportunities for further research are discussed.

Introduction

In the last 40 years, family therapy research has generated substantial evidence that supports the efficacy of systemic treatment approaches for a wide range of problems (Carr, 2014a, 2014b). However, in recent reviews family therapy researchers have called for a greater focus on change process research (Heatherington, Friedlander, & Greenberg, 2005; Sexton & Datchi, 2014). Change process research examines particular processes in therapy and attempts to link them to theories of change (Heatherington et al., 2005; Llewelyn & Hardy, 2001). It attempts to uncover *what* is significant, for *whom* and *when*, in order to examine *how* change occurs. Change process research is increasingly recognised as essential for several reasons. It helps us understand what works for whom and in which setting, so that we can match clients to interventions and programmes (Kazdin, 2009). It helps bridge the gap between academic researchers and practitioners, in that an understanding of the detail of change processes allows clinicians to improve or modify therapy models and determine core competencies (Dattilio, Piercy, & Davis, 2014; Sexton & Datchi, 2014). It also strengthens the overall evidence base for psychotherapy, because without a plausible explanation that links cause and effect, the case for therapy is reduced (Kazdin, 2009).

Despite the acknowledged importance of change process research, it is a neglected area in family therapy (Heatherington et al., 2005; Sexton & Datchi, 2014). Not only

is there limited research into the change process in family therapy, but what research there is focuses on manualised, empirically supported treatments for specific presenting problems (Sexton & Datchi, 2014). For example; Multisystemic Therapy (Deković, Asscher, Manders, Prins, & van der Laan, 2012; Schoenwald, Carter, Chapman, & Sheidow, 2008), Functional Family Therapy (Sexton, 2011) and Emotionally Focused Therapy (Greenberg, Ford, Alden, & Johnson, 1993; McRae, Dalglish, Johnson, Burgess-Moser, & Killian, 2014; Stavrianopoulos, Faller, & Furrow, 2014). However, in real-world family therapy practice there is a move towards integration and using skills and techniques in a flexible manner (Dickerson, 2010; Lebow, 2013). This would suggest that the current limited literature on change process research does not reflect family therapy as practised on the ground.

One suggested reason given for the lack of focus on change process research in family therapy is the difficulty of studying complex and multifactorial processes (Sexton, Kinser, & Hanes, 2008). A proposed solution to this problem is that family therapy researchers have access to a range of appropriate methodological approaches (Sexton et al., 2008). This article presents an adapted version of Interpersonal Process Research (IPR) (Larsen, Flesaker, & Stege, 2008). IPR is a methodological approach which has considerable potential to provide finely grained descriptions of change process in family therapy. As such, IPR is a valuable tool for family therapy researchers interested in investigating how change occurs. The methodology will be described in detail using a case example from the authors' own research. The relative advantages and disadvantages will also be examined. Prior to this, a brief review of family therapy change process research and a history of IPR is presented.

Change process research

In a recent review, Sexton et al (2014) highlighted how little of the family therapy research literature focused on researching change processes. This is despite a previous review by Heatherington et al (2005) which explicitly challenged researchers in the field of family therapy to move beyond research which looks at the overall efficacy of family therapy and into a more detailed exploration of the processes that can or should (according to theory) instigate change. The authors highlight the lack of what they call 'mid-range theories' which link theoretical ideas of

how overall change might happen to defined therapy tasks/therapeutic interventions to specific moments in therapy. These links between theory, process and outcome are important in order to build a complete, evidence and practice-based model of family therapy (Heatherington et al., 2005). They are also key in determining what should be taught in family therapy training programmes and what the stated competencies of a family therapist practitioner should be (Nelson et al., 2007; Northey Jr, 2011; Stratton, Reibstein, Lask, Singh, & Asen, 2011).

Existing methodological approaches have contributed to our understanding of the change process of family therapy at several levels. Several recent reviews summarise the depth and breadth of these findings (Heatherington et al., 2005; Sexton & Datchi, 2014). Much of the research falls within three specific areas: 1. Research into the therapeutic relationship, 2. Micro-analysis of specific moments in therapy, and 3. Studies which ask questions about the helpful factors of therapy. The following summary is intended to illustrate the most common methodologies used and is not intended as an exhaustive overview of change process research.

There is a long history of exploring the therapeutic relationship as a factor in therapeutic change (Norcross, 2011). Within family therapy, it has been investigated using a number of questionnaires and psychometric measures, such as the Working Alliance Inventory-Observer (Pereira, 2006) and the Vanderbilt Therapeutic Alliance Scale (Hogue, 2006). The literature has consistently shown that this is an important factor in therapeutic outcomes (Friedlander, Escudero, Heatherington & Diamond, 2011). Moreover, the extensive work of Friedlander et al on the development and validation of the System for Observing Family Therapy Alliances or SOFTA (Friedlander, Escudero, Heatherington, & Diamond, 2011; Friedlander, Escudero, & Heatherington, 2006b) means that there is now an empirically validated research tool designed to explore the complex nature of therapeutic alliances in family therapy.

Another approach to change process research is to focus on the micro-analysis of specific moments in therapy. This approach looks in detail (turn by turn) at therapist/client interactions and responses. It has tended to be most widely used in research into well-specified evidence-based interventions. For example, research into emotion focused therapy for couples has focused on softening events and has evidenced that specific therapist interventions contribute to these events which have

an impact on outcomes (Greenman & Johnson, 2013). Attachment-based family therapy, a well-articulated approach for treating depressed adolescents (Diamond, Siqueland, & Diamond, 2003; Diamond, 2014) has also been the focus of micro-analytic methods. A series of studies by Diamond et al (2003) looked at how therapists have used relational reframes to encourage disclosure and non-defensive acknowledgement between parents and adolescents (Diamond et al., 2003; Diamond, Diamond, & Hogue, 2007). The methodological approach most commonly used in these studies was task analysis: a detailed analytic process which focuses on turn by turn speech acts between therapist and clients (Greenberg, 2007; Greenberg & Foerster, 1996). Task analysis is a useful methodology to look at the fine-grained detail of moments in therapy. However, it requires a well conceptualised model of change as a starting point for exploration (Greenberg, 2007). Thus, it is most suited as a methodological tool for the examination of clearly defined models of therapy.

The third approach most often employed in family process research is what might be termed a helpful factors approach (Elliott, 2010). Much of this research uses semi-structured interview approaches, often asking families to comment on their therapy after sessions have ended (Allen, Burbach, & Reibstein, 2013; Bischoff & McBride, 1996; Bowman & Fine, 2000; Campbell, 2004; Sheridan, Peterson, & Rosen, 2010). The helpful factors approach has yielded a great deal of qualitative data as to what clients find helpful. This includes reformulating and giving feedback, a collaborative relationship, gaining insight, being treated as an expert on their experiences, developing new perspectives and problem solving, and therapist empathy and warmth (Laszloffy, 2000; O'Connor, Meakes, Pickering, & Schuman, 1997; Stanbridge, Burbach, Lucas, & Carter, 2003; Sundet, 2011). As a methodological approach, it has limited utility for investigating detailed processes. Asking broad questions about overall process cannot determine exactly how therapists promote insight, what are the important factors in reformulating and how best might a therapist convey empathy to all family members. The examination of these mid-level change processes (and others) will be key to advancing the understanding of family therapy. It is proposed that, as a methodology, Interpersonal Process Recall could provide an option to be exploratory in approach, yet provide an opportunity to focus on detailed interpersonal processes.

Overview of IPR

Interpersonal Process Recall is a video elicitation research method designed to access participants' thought processes and subjective experiences of a specified interpersonal interaction (Elliott & Shapiro, 1988; Hill et al., 1994; Larsen et al., 2008). It is a flexible methodology that can utilise "a number of different strategies ... depending on the interests and methodological predispositions of the researcher" (Elliott, personal communication, August 2012). The method involves videotaping a complete therapy session. The participants are then interviewed shortly after the therapy session and asked specific cuing questions about the pre-recorded therapy session whilst being able to watch and control the video tape. The recording acts as a cue to memory and also slows down the interview process, giving time for participants to reflect on and differentiate their experience (Elliott, 1986). IPR has been shown to have the potential to both identify significant events and explore conscious yet unspoken experiences, so that participants can recall their perceptions and subjective impressions of therapy at a detailed level (Larsen et al., 2008).

IPR was first developed as a means of studying the thought processes of college students (Bloom, 1954) and was subsequently developed as part of a training programme for counsellors (Kagan, Krathwohl, & Miller, 1963). The approach taken by Kagan and colleagues saw the development of IPR as a specialist interview technique in which the videotapes of caregiving situations were played back to trainees. During the playback sessions, interviewers focused on asking exploratory questions designed to draw out emotional reactions, experiences and the stated intent of participants as they occurred in the caregiving episode (Kagan, et al., 1963). In this way, IPR became a methodology for accessing the subjective and detailed internal processes of participants. It has since been adapted for psychotherapy process research (Elliott, 1985; Elliott & Shapiro, 1988; Timulak, 2007; Watson & Rennie, 1994). It has been widely used in process research in individual therapy (Balmforth & Elliott, 2011; Elliott et al., 1994; Hardy et al., 1998) and an increasing number of studies in family therapy research mention the use of similar forms of video recall technique (Bowen, Madill, & Stratton, 2002; Lloyd & Dallos, 2008; Strickland-Clark, Campbell, & Dallos, 2000).

IPR was considered as a useful methodological approach to change process research because of its open ended nature. By allowing participants to pause the recording when they wish, it privileges the participant's subjective understanding. It allows the participants to dictate when they are having a salient thought or feeling related to the research question. The current approach for using IPR with families came from research which was designed to begin to build a description of the change process in family therapy as practised on the ground - an account of what factors contribute to change, how they interact and how they unfold. It was thought that obtaining this description would be best achieved through an exploratory approach. Open-ended qualitative research interviews were considered, but it was felt that they might not provide enough salient detail. Research strategies that relied on pre-prescribed quantified tools (surveys, psychometric measures, etc.) were also considered. They appeared to have limited usefulness in investigating processes that were not yet clearly operationalised. IPR allowed the possibility of moving from a description of what might be helpful to a more finely grained description that begins to unveil the how and why of change processes.

A case example: Using IPR with families and family therapy teams

In the current research study, IPR was employed to investigate families' and family therapy teams' experiences of important moments in a therapy session. Prior research seems to suggest that these in session processes have an impact on the overall process of change for families (Heatherington et al., 2005). Since the research was interested in investigating what family therapists do (or don't do) that might be contributing to change in families at the level of an individual session, IPR seemed a plausible methodology, as it allowed the ability to look in detail at interactions between families and family therapy teams. Evaluating both clients' and therapists' perspectives of a therapy session is important, because the literature suggests that there is often a mismatch between what a therapist feels is important or useful in a session and how clients experience the same session (Bachelor, 1991; Pekarik & Guidry, 1999; Rosenblatt & Rosenblatt, 2002; Thompson & Hill, 1991). Group interviews were chosen over individual interviews as the aim of the research was to investigate the interactional processes of family therapy and it was hoped that

group interviews would encourage greater interaction between participants. Joint interviews also have the ability for participants to stimulate one another into discussing issues that might not otherwise be recalled or salient. Morgan (2010) suggests that the interactional advantage of group interviewing is due to the process of sharing and comparing. Kitzinger (1994) also discusses the importance of interaction in focus groups and illustrates how this can be utilised when interviewing natural groups (for example family groups, work groups) as a way of highlighting implicit knowledge.

Preparing for IPR with families

Deciding on the scope of the data collection and determining what/whom to sample is the first step in implementing an IPR methodology. Whom to interview, when, and why will depend on the research question. It is important to be clear about the rationale for your sampling strategy. The demands of the IPR interview should be considered as they are often longer and more involved than other interview techniques. So, for example, a method that involved multiple IPR interviews of a single participant might be considered very taxing. In the research used as the current case example it was decided to take a comparative stance, which meant interviewing pairings of families and family therapy teams sequentially about a therapy session that they had both taken part in. Selective and snowball sampling, was used in which qualified or part-qualified family therapist from local clinics were initially contacted and then recruiting families from the caseload of those therapists.

Researcher preparation is key to the success of IPR. It is recommended that researchers are familiar with the IPR methodology and have experience in conducting process-orientated interviews. It is also recommended that researchers have some experience of conducting interviews with groups, families or couples and are aware of the group or family dynamics that can occur during these types of interviews. Researcher One (who conducted the interviews) had received doctoral level training in qualitative research methods and had prior experience of conducting process-focused qualitative group interviews. Researcher One is also a systemically trained and qualified couple's therapist and has worked as part of a family therapy team. For researchers unfamiliar with IPR, training may involve studying the

literature on IPR and conducting a trial simulated interview prior to interviewing participants (Larsen et al., 2008).

A simulated interview also gives the benefit of allowing familiarity with the necessary equipment. To prepare for the recording and interviews Researcher One filmed a dummy interaction with the equipment and set up a playback session. This allowed changes to be made to the technology selection. There are several details to take into account when considering the equipment needed for IPR with families. To capture the full range of verbal and non-verbal communication during a session, all participants must be both audible and visible on the recording. As families and their family therapy teams can vary in number, this requires a camera that has a wide angle lens setting and either a high quality omni-directional microphone or the ability to have multiple audio inputs and a suitable number of external microphones. The camera must also be able to be mounted onto a tripod which fits easily into a therapy room. There are a number of semi-professional video cameras that meet this requirement. The camera selected for the current project provided adequate coverage and had the additional benefit of recording to a HDMI memory card allowing the direct transfer of material to the playback screen.

The complexities of establishing trust and gaining informed consent bring additional demands in IPR interviews. In the current research, therapist's consent was sought before any of their clients were approached. Potential families were informed of the research via a poster and information sheet. If families expressed an interest in taking part, the researcher would arrange a telephone call with each member of the family individually to explain the study and obtain verbal consent to schedule a filming session. This individual contact was maintained to minimise the risk of coercion. If family members agreed to take part, they were asked to arrange to meet with the researcher fifteen minutes before the recording session. This was to ensure that formal informed consent was obtained and was also helpful in beginning to build the trust necessary for the interview. Care was taken to make it clear to both family and family therapists that the interview remained confidential. This was particularly stressed to families so that they were aware that any feedback they gave regarding the session was not shared with the family therapy team. It was hoped that this would encourage families to discuss any negative aspects of their therapy.

Conducting the interview

Consideration should be given to the timings of recordings and interviews. In the current research, the focus was on the content of one session. Choosing which session to film was dictated partly by pragmatics and partly by research question. As the study was not looking at the establishment of the therapeutic relationship, it was decided to exclude the first three sessions of therapy. After this, families had to be accommodated and this required liaison with family therapy teams and researcher schedules. Sessions for video recording were scheduled so that IPR interviews with both families and therapists could be conducted as soon after the session as possible (as recommended in the literature (Larsen et al., 2008)). It is common to stipulate a forty-eight hour window between session and interview (Larsen et al., 2008), but in practice, this is not always possible, and some therapist interviews were conducted up to five days later. It would be advisable not to conduct an IPR interview on the same day as a therapy session, as IPR interviews can be quite demanding on participants. Both sets of participants (families and family therapists) were informed that interviews would be between an hour and an hour and a half. In practice, several of the interviews were slightly longer than this.

Staging the IPR interview is important. Interviews should take place somewhere where the participants feel comfortable and that is quiet and private. In the current study, families were given the option of coming back into the clinic or being interviewed at home. All the families interviewed opted to be interviewed at home. The system for playback of the video should ensure that both the interviewer and all the participants can see the screen. If using a laptop as a playback device, the screen should be of sufficient size and an external speaker should be used to maximise the sound quality. The playback machine should have the capacity to play, pause, forward and rewind with ease and the participants should have the ability to control this.

Managing the interview consists of two stages: initial preparation and interview skills. Establishing the focus of IPR interviews is important. Prior to playing back the family therapy session, the researcher made it clear to participants that they were being asked to explore their unspoken experiences. It was stressed that the focus of interest was in the participants' experiences and participants were encouraged to

take an observer position with regard to the material (Elliot, 1986; Kagan, 1984). In order for IPR interviews to have a successful focus on process, it is suggested that researchers discuss the detail of the observer role prior to the interview (Larsen et al., 2008). For example, it might be helpful to remind participants that they are not being asked to comment on how they feel now looking back at the session, but that it would be helpful to recall their thoughts, experiences and emotions that occurred in the session itself. In the case of the current study, the focus of the interview was the moments identified as important. So, the families were asked to stop the video at any point when they felt there was something significant or important that occurred. They then had the opportunity to playback this section of the video, rewinding it and playing it back again if necessary. Most participants required little prompting to locate significant moments, but it is important to regularly check if the video needs to be paused to encourage any participants whom may be less forthcoming.

Although each IPR interview may have a different foci (according to the research question), all IPR interviews share a common process. To facilitate high quality IPR interviews, researchers need to use skills that enable this process. In addition to standard qualitative interviewing skills, interviewees must be able to keep participants focused on the contents of the video playback. As participants may wish to discuss how they feel in the present moment, it is the job of the interviewer to help them focus on their thoughts, feelings and emotions at the time of the recording. This can be helped by framing questions in the past tense and using particular prompts. For example, Larsen et al suggest the following phrases may be helpful:

“As you reflect on that moment in therapy”, “taking a step back from that moment”, (Larsen et al., 2008).

Table 1 displays some examples of questions that the researcher found helpful in maintaining the process focus of the interview.

Table One: Example Questions

What was that like for you in the session?

What do you remember thinking at that point in the session?

What are your memories of how you were thinking/feeling at that time?

Can you tell me what you felt at this point?

What was important about what your therapist said or did?

What's the most important thought or feeling that occurred to you at this moment?

What makes this moment important for you?

Although it is helpful to have process-orientated questions noted down prior to the interview, it is important to note that IPR requires a degree of flexibility in framing questions. For example, our study was focused on what might be important in facilitating change. This meant that questions had to incorporate a reference to the moment being discussed, a focus on process and on possible impact. This can be seen in the following example taken from an interview transcript:

“Was there anything in particular about, when you say ‘talk about it like that’, was there anything significant or important about the way in which you were talking about it? Or the way that the situation was set up?”

Managing the interview session also requires attending to the emotional and interactional processes that are likely to occur. Qualitative interviews with couples or families can be challenging, as one member of the group may try to dominate the interview (Hertz, 1995). The interviewer also needs to acknowledge that issues of power, family stories (for example about gender or intelligence) and patterns of family interaction may affect the interview. Care must be taken to ensure that all participants' opinions are sought. Researcher One found following the principles of good focus group interviewing useful in establishing an interview style for families and family therapist groups (Krueger & Casey, 2009; Morgan, 1993). The researcher must be able to guide participants away from using the IPR interview as a continuation of the family therapy session. Likewise in interviewing family therapy teams it is important to keep the focus of the interview on the process of therapy rather than allowing the family therapy team to use the interview as an opportunity to reflect on the family and 're-therapize' them. Whilst it is helpful to acknowledge families or family therapists feelings, it is also important to redirect them to what they remember about how they felt in the session. In addition, because of the focus on process, IPR interview may lead to heightened emotions in interviewees.

Interviewers need to have the skills to work with emotional content and feel confident

that they have a planned response should participants become distressed. In the current study interviews were closed with a short debrief to ascertain if there were any issues that needed addressing. Participants were also offered the option of a separate debrief with the research team as well as access to a senior family therapist (not a member of their existing family therapy team) should the interview raise any issues that they wanted to discuss further.

Advantages and Disadvantages

The main advantage IPR has over other qualitative interviewing techniques is that participants can focus on the process, not recall, of events. This gives the researcher an opportunity to access rich and detailed accounts of therapeutic processes. Some examples of the process focused qualitative data are given below:

From Families (being interviewed about the change process in family therapy):

Male interviewee: But in each of those three moments what she is really doing is just tying back what you're saying to a previous moment and what you felt and thought then. And then saying, 'so right is there change, or if there is what sort of change?' So that is kind of the common thread that she is stitching back through time, and then you can compare and contrast things in a way in which you might not otherwise do. It's kind of, while they are my experiences why do I need to compare what I am now with what I was then, and I'm not good at doing that anyway, so that's the common thread. It's sort of what she's getting asked to do, or that's the bit that was useful for us.

Interviewer: And what in particular is useful about that compare and contrast?

Woman interviewee: well it makes you realise what you can do now that you couldn't do before you started to therapy. And it gives you a measure of how you are progressing and what's good about now what was really bad about then.

From Family Therapists:

Family therapist (discussing the intention behind an intervention): *It's all about trying to open up different perspectives. It's kind of responding to what he said, it's, it's (pauses). I'm kind of thinking of this triangle of trying to, trying to draw out what it is*

that she wants to say in the face of him going 'What?', 'I didn't know, it looks different from where I sit'.

Family therapist (describing the process behind a moment in the session): *That was me being transparent with attention that I felt from me. But also very aware the more I say, am I missing anything or is there anything else? They will always come up with something. I always want to check that I'm not cutting off ...*

As well as being reflected in the data resulting from our study this has also been reported by other researchers using IPR (Gale, 1995). The complex, interpersonal processes that often occur in therapy can be slowed down and explored in a far more focused way than in a post-hoc qualitative interview. This means that very specific aspects of therapy can be explored, giving new perspectives and information. In fact, in one study, Gale, Odell, and Nagireddy (1995) reported that participants found the IPR interview to be actively therapeutic.

The disadvantages are mainly practical in nature. IPR can be time consuming, and technically demanding. For example, transcribing the recall audio-interviews is even more time consuming than transcribing similar qualitative interviews, as the transcriber has to differentiate between multiple participants, both in the here and now of the interview and in the audio of the videoed therapy session. The nature of the interviews requires several different skills from researcher (technical competence, group interviewing skills and an ability to focus on and manage process). There are some limitations to video recall procedures that may be seen as disadvantageous. Participants' mood during the playback interview session may well affect how they recall their thoughts and feelings regarding the therapy session. This is particularly pertinent in families. Family members may wish to reconstruct their thoughts and feelings in a session in order to present a particular perspective to their significant others (or indeed the researcher). Researchers should thus consider interviewing each family member individually.

Summary and future directions:

The IPR methodology is a unique research approach which lends itself to accessing complex interactions such as those between family therapists and families. It provides an opportunity to study aspects of therapy that are difficult to investigate via other research methods (for example, previously undisclosed thoughts, feelings, perceptions, intentions and reactions). It has been a somewhat overlooked methodology in family therapy process research, yet it holds considerable promise as methodological tool.

Within the field of family therapy process research, it has particular relevance in two main areas. Firstly, it is an approach that can examine detailed therapist client interactions or sequences of interactions. Secondly, it is a tool for scrutinising specific therapist behaviours or interventions during sessions. Because of its flexibility, IPR can be used on its own or in conjunction with other methodologies (for example, rating scales or outcomes measures), so that both therapist-client interactions and therapist interventions can be tracked to micro and macro therapy outcomes.

IPR offers the opportunity to explore the complex interactional patterns of family therapy. Its use as a research tool could help family therapy researchers determine what exactly works for whom and why, thus strengthening the case for family therapies effectiveness.

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ABSTRACT

There is now good evidence to show that family therapy is effective in helping families with a wide range of presenting problems (Carr, 2014a; Shadish & Baldwin, 2003; Stratton, 2011). Although family therapy has a strong evidence base, much of the focus in the research literature has been on outcomes; far fewer studies have attempted to investigate the process of change in family therapy, and there has been a call for greater research in this area (Heatherington et al., 2005; Sexton & Datchi, 2014; Vilaça, Margarida, & Ana Paula, 2014). The inability to evidence how the process of family therapy works leaves it open to criticisms concerning credibility. Since family therapy is one of the few alternatives to one-to-one talking therapies (such as cognitive behavioural therapy) (Stratton & Lask, 2013), its devaluing would limit client choice. In order to justify its position as an alternative to one-to-one ways of working, family therapy needs to be able to evidence the link between theories of change, the process of change and outcomes.

The present study attempts to address some of the above concerns by exploring how family therapists in the U.K understand the change process in family therapy both in theory, and in their practice. In addition, it explores how the rationale that therapists' provide for their interventions in specific therapy sessions relates to how families conceptualise and experience change in the same sessions. A multi-modal triangulation methodology was used, whereby eight family therapists were interviewed in prospective qualitative interviews, and then two families and two family therapy teams were interviewed while they reviewed therapy sessions using the process methodology of Inter-personal process recall (IPR). The two methodologies revealed several themes. Three super-ordinate themes emerged from the prospective interviews: 'safe-space', 'perspective taking' and 'privileging the change'. The IPR interviews yielded four super-ordinate themes: two from family therapy teams; 'expressing a clear rationale' and 'linking theory and process is difficult' and two from families 'things we found helpful' and 'things that we didn't like'.

Convergence and divergence between the data sets are discussed as well as implication for further research and limitations of the current study.

LITERATURE REVIEW

The following literature review gives an overview of the theoretical underpinnings and approaches of family therapy, and its evidence base, with particular attention paid to what we understand about the process of change in family therapy as it is practised in the UK today. The review starts with an introduction to family therapy, including an overview of its history with a focus on how change has been conceptualised in differing family therapy approaches. The current practice of family therapy is then reviewed, followed by an account of the evidence base of outcome studies for family therapy. The literature review concludes with a more detailed review of research which explores the process of change within family therapy. The presentation and critique of this research concludes with the rationale for the current study.

Definitions: what is family therapy?

Historical overview

Family therapy as practised in the UK today is an integration of theory and research encompassing many different therapeutic perspectives and traditions from the last 60 years. In order to understand the theoretical underpinnings of how change is conceptualised in family therapy, and how the process of change is encouraged, it is necessary to explore a little of the history of how family therapy came into being. A number of authors have explored the history of family therapy, each taking a slightly different focus and approach. The author is guided by the accounts of Carr (2006) and Dallos and Draper (2010), who conceptualise the development of family therapy in three distinct phases. What follows is a brief outline of those phases with an emphasis on their associated theories of change.

The first phase (1950s–1970s): emerging ideas and research

The origins of family therapy can be traced back to the 1950s, when several theorists and researchers began to challenge the accepted wisdom that psychological and behavioural problems were located entirely within the individual (intrapersonal). This was in part a response to the limitations of existing individual treatment approaches, but it was also driven by new ideas such as systems theory and cybernetics (Dallos & Draper, 2010). A number of theorists from varying professions played a role in the

development of early family therapy theory (e.g. Gregory Bateson, Jay Haley and Salvador Minuchin), but all shared a common perspective in which problems were seen as interactional and resulting from interpersonal processes. Individuals within a family were seen as interdependent and engaged in repetitive (or circular) patterns with one another. Treatment focused on understanding the function of patterns of behaviour in the family and working on disrupting these unhelpful patterns and changing dysfunctional styles of communicating (Asen, 2002; Dallos & Draper, 2010). Different clinicians began to write about these approaches, and as theories and clinical experience were disseminated, the discipline of 'family therapy' emerged. 'structural' and 'strategic' approaches were the first named approaches, with distinct ideas about how change could be promoted (see Table 1. The differing approaches to family therapy).

The second phase (1960s–1980s): the development of distinct schools

The development of different schools of family therapy began as researchers and clinicians began to test out and refine new theories. Although the emerging schools shared a common belief in the interactional and systemic nature of psychological problems, they began to differ in how they approached such problems. The idea of constructivism was particularly influential. Constructivists argue that there is no objective 'real' truth, merely a view of the world that is constructed through our own lens (Hoffman, 1990; Watzlawick, 1976). This led to a shift in which family therapists focused less on the structure of family systems and more on the ways in which families conceptualised their difficulties. This shift coincided with an emerging debate about the nature of change, and ideas about second-order change became influential. Broadly speaking, this led to more exploration of beliefs, meanings and stories (as opposed to merely a functional analysis of behaviour). Therapists also increasingly moved from an expert stance to being more collaborative. These changes were epitomised by the emergence of the Milan school of family therapy, in which change was facilitated by encouraging family members to think about beliefs and reciprocal patterns through circular questions (see table 1. The differing approaches to family therapy).

The third phase (1980s to present day)

In the last 30 years there have been several key developments in systemic family therapy, the first being the influence of social constructionist theories and the second a move towards integration and an acceptance of plurality (Dallos & Draper, 2010). At its heart, social constructionist theory posits that a family's perceived reality is in fact constructed and influenced by wider societal factors. Families are influenced by the culture in which they live and construct meaning from this, but this meaning is not 'reality'. Thus, the wider culture and context shape family life, from the structure of a family to the language it uses, as well as roles, responsibilities, beliefs and behaviour (Anderson, 1997; Anderson & Goolishian, 1992). Practising family therapy in a way that incorporates these ideas has become known as post-modern practice (Boston, 2000). Post-modern therapy approaches consider how culture and dominant narratives (for example about class or gender) may be influencing the family. Therapists pay attention to the use of language and the assumptions that they may bring as therapists (because of their own cultural influences), and the therapy is co-constructed with the family. Change is promoted by inviting the family to uncover meanings and encourage new ways of seeing problems (for example via reflecting teams, or by focusing on solutions not problems).

The second development in recent times has been a move towards integration. Family therapy has moved away from rigid schools of therapy towards conceptualising itself as an approach that utilises a number of key concepts that are linked to a set of specific techniques (Lebow, 1997; Stanton & Welsh, 2012). In addition, several multi-component treatment programmes (such as multi-systemic family therapy (Henggeler, 2009) and functional family therapy (Alexander, 2013)) have explicitly integrated skills, techniques and strategies from several schools of family therapy in manualised treatment programmes (Alexander & Parsons, 1982; Henggeler, 2009; Huey Jr., 2000). Family therapy has also begun to explicitly integrate ideas from other areas of psychotherapy, such as the importance of working with attachment processes (attachment narrative therapy (Dallos & Vetere, 2009, 2014)) and the need to attend to the emotional states of family members (emotion-focused therapy (Greenberg, 2006; Paivio, 2013)). Whilst many practitioners see integration as beneficial (McNamee, 2004), there is also a concern that integration may lead to poorly defined practice and a lack of rigour in therapeutic

models (Asen, 2004). It may also make it more difficult to identify what is facilitating change (Sexton & Datchi, 2014). In fact, it seems apparent that the move towards unification has indeed brought with it problems of definitional uncertainty, as outlined in the following discussion.

Table 1. The differing approaches to family therapy

Therapy school and leading figures	Focus of concern	Theories of how change occurs	Techniques used to encourage change
Strategic Hayley (1973, 1976)	Behavioural	Patterns which have built up over time may have originated in trying to solve a problem, but often become part of the problem or a problem in their own right. This can be seen in 'triangulation', in which a child becomes involved in a conflict between parents. The role of the therapist is to interrupt these patterns.	Changing parental roles. Disrupting patterns of behaviours. Reframing, the use of paradox (a contradictory statement, for example predicting the problem will get worse). Reframing through asking questions that pose alternatives.
Structural Minuchin (1974)	Behavioural	Conceptualises family's problems as structural and focuses on roles and boundaries. Also looks at problems of cohesion (emotional closeness), adaptability and power struggles. These lead to dysfunctional family structures. Change is attempted through focusing on changing structures across these domains, predominantly by asking families to change their usual ways of behaving in the therapy room.	Change is focused on altering family structure. Enactment (playing out a typical interaction in the therapy room, but trying to find an alternative solution). Active techniques, such as moving between family members to block certain types of communication or altering where family members sit. Unbalancing: taking the side of one family member in order to force change. Also uses reframing.
Milan school Palazzoli, Cecchin, Boscolo and Prata (1978)	Beliefs	Families have a unique set of beliefs about the family that guide behaviour; problems arise when these are inflexible.	Hypothesising and neutrality (not taking sides and having several ideas as to what might be the problem patterns). Circularity: circular questions designed to shift families away from linear thinking into thinking about interdependence and reciprocity. Reframing.
Solution focused deShazer (1982)	Beliefs	Solution-focused therapy is underpinned by the theory that families should focus on what works well and include more of this in their interactions with one another. Therapists help change occur by encouraging tangible descriptions of change. This gives the family insight into how to make things better.	The miracle question. Exploring exceptions to the problem (perhaps using scaling: what was different between the time when the problem scored a five and the time it scored a two). Setting modest positive goals to move towards an overall goal.
Narrative therapy White and Epston (1989)	Beliefs	Problems arise because families choose a family script or story (often because of culture or context) that is unhelpful. The therapist encourages change by exploring the problem in depth and giving it an identity, and then exploring alternatives to this narrative.	Therapists strive not to judge, but to make sense of the problem. They use questions to examine assumptions, externalise conversations by asking 'How does the problem affect you?' and reconceptualise <i>the problem</i> as the problem.

<p>Attachment-based therapies</p> <p>Johnson (emotionally focused therapy, 1988), Dallos (attachment narrative therapy, 2004)</p>	<p>Contextual</p>	<p>Families come to their current positions within a family with a series of unconscious constraints (based on their own family of origin and attachment patterns). Change is focused on freeing families from these constraints so that family members can be individuated and in relationship.</p>	<p>Listening and exploring patterns (in particular across generations). Using circular questions to explore not just beliefs, but underlying feelings. Exploring emotional reactions and their possible context. Offering interpretations.</p>
<p>Multi-systemic therapy (MST)</p> <p>Henggeler (1990)</p>	<p>Contextual</p>	<p>MST posits that anti-social adolescents are often unsupported and poorly parented and form unhelpful peer relationships. Interventions are focused at changing interactions at every level of the system (family, school, peers, etc.).</p>	<p>Interventions target specific problems-maintaining interactions and are based on empirically-validated therapeutic techniques (for example parent training, CBT to enhance social skills and structural and strategic family therapy interventions to improve family functioning). The therapy is offered as an intensive intervention with 24-hour support.</p>

Current definitions of practice and process

The above review has outlined how various schools of family therapy have conceptualised the change process. However, it is important to note that family therapy as practised in the UK today incorporates elements of many of those schools and developments. In fact, the issue of integration is made explicit in the Association for Family Therapy's (AFT) framework for accreditation of family therapy training courses. In their requirements for qualification-level training, they state that courses should be able to demonstrate the following learning outcomes: "*an ability to compare and contrast different approaches in systemic therapy and their relationship with other therapies and theories of change ... an ability to use a range of techniques to help clients to make changes in their lives*" (AFT, 2011 p.8). Yet, whilst AFT makes integration an explicit goal, no further details of exactly what models of change might be presented and which techniques might relate to this change are provided. Nor is there any rationale or meta-model for integration. So whilst it is increasingly accepted that family therapy as it is practised on the ground is not model-specific but in fact a synthesis of ideas and techniques from several schools (Rivett, 2008), there has been very little research that operationalises how family therapy is integrated and practised by family therapists in the UK.

There are two major exceptions to this. The first was a project to 'manualise' family therapy, undertaken by a team of researchers and family therapists at the University of Leeds (Pote, Stratton, Cottrell, Shapiro, & Boston, 2003). The aims of the research were to generate a manual that reflected current practice and that incorporated both traditional and post-modern systemic frameworks (Pote et al., 2003). The research involved interviewing therapists, videotaping family therapy sessions and making explicit the links between family activating events, therapists' interventions and therapists' intentions and theoretical rationale. The resulting manual offers a clear exposition of an integrated model of therapeutic change which centres on co-creating an understanding of patterns of "*behaviour, beliefs or stories that have developed in family systems, and the wider context in which they live*" (Pote et al., 2003 p12). Pote et al.'s (2003) work theorises that change occurs through the therapist supporting the family to identify and understand beliefs and through working with the family to introduce new information and perspectives. Changing perceptions can be encouraged using active techniques and reflective and

circular questioning. These alternative and new patterns are then posited to interact with the family system to create change. Pote et al. (2003) also make it clear that it is important to highlight any occurring change so that families understand “*how the change was possible*” (Pote et al., 2003 p.12).

The second project has been the development of a competence framework for the delivery of systemic therapies. This work was commissioned by the Department for Health and carried out by a team of researchers at University College London (UCL) (Stratton et al., 2011) . The detailed explication of the skills and knowledge required to deliver systemic therapy was drawn from existing evidence-based effective systemic therapy research manuals and key texts on family therapy. The team conducted a thematic analysis of these texts to extract competencies. These were then discussed with an expert reference panel consisting of 14 practising clinicians (who were selected on the basis that they were involved in outcomes studies and developing treatments). The expert group took the themes from the thematic analysis and adapted them somewhat so that the competencies were in line with family therapy as it was practised (Stratton et al., 2011). The competency framework makes clear that understanding the change process is key in terms of both knowledge (being able to understand patterns in a family and how they relate to a presenting problem, and understanding the therapist’s role in changing those patterns) and skills (being competent in a range of techniques that are thought to promote change, e.g. circular questioning, externalising, reframing and the use of experiential techniques) (Stratton et al., 2011).

Despite both the above texts providing quite a clear exposition of the link between specified theories of change and interventions that bring about change in family therapy, it is still unclear exactly how this is operationalised by family therapists on the ground (e.g. do they in practice adhere to these models and protocols?). Pinsof and Wynne (2000) argue that whilst practice has become more integrated, very few research studies focus on examining this integration. Instead, much research has focused on evaluating pure forms of therapy (often as practised by the models’ originators). Perhaps more pressing is the scarcity of research which makes the link between models of change, therapists’ interventions and the outcomes of therapy, and this is the area of the research literature which is reviewed below (Heatherington et al., 2005; Smith, Moller, & Vossler, 2015).

A review of the evidence base for family therapy

Part one: a review of outcome research

Family therapy offers one of the few evidence-based alternatives to one-to-one therapies such as cognitive behavioural therapy (CBT) (AFT, 2011). The evidence for family therapy's effectiveness in treating a range of problems appears strong. In a recent review of the research base, Carr (2014) highlights numerous clinical conditions for which there is good evidence of family therapy's effectiveness and efficacy. These include mood and anxiety disorders, alcohol problems, schizophrenia, relationship distress, conduct disorder, eating disorders and psychosis (Carr, 2014a, 2014b). Similarly, a review of 20 meta-analyses concluded that "*marriage and family therapy* [the term used for family therapy in the United States of America] *is now an empirically supported therapy in the plain English sense of the phrase – it clearly works, both in general and for a variety of specific problems*" (Shadish & Baldwin, 2003, p. 567). Another recent review – a meta-content analysis which reviewed randomised control trials of systemic therapies in treating adult mental health – found that systemic therapy was an effective treatment for a variety of mental health problems and in addition that treatment effects were stable for up to five years post treatment (Von Sydow, Beher, Schweitzer, & Retzlaff, 2010).

The research base for family therapy appears very strong. However, a closer reading of the outcome research reveals some methodological problems across the body of work. Of most concern seem to be the inconsistent means by which family therapy is operationalised (Davey, Davey, Tubbs, Savla, & Anderson, 2012) and the use of outcome measurements with questionable construct validity (Sanderson et al., 2009). Taking each concern in turn, we can illustrate problems of definitional clarity by examining the criteria for inclusion in two recent meta-analyses. Carr (2014) takes a very broad definition for inclusion in his analysis, which focuses on a family context and encompasses systemic therapies, psycho-education programmes and interventions that engage with family members to solve problems. This approach means that some studies are included which appear to have very little focus on using systemic theories of change. Conflicting with this, Von Sydow et al. (2010) operationalised systemic therapy as having either referenced a leading family therapy theorist (e.g. Hayley, Minuchin) or specified the intervention using a clearly

defined systemic model (e.g. structural, strategic, solution-focused). Whilst both reached a similar conclusion regarding the efficacy of family therapy, it is clear that their definitions of what constituted family therapy differed widely. This definitional uncertainty is also reflected in the fact that there are very few protocols or treatment manuals used in family therapy outcome research (Diamond et al., 2003), and as Davey et al. recently commented, "*many of the founding principles of family therapy ... have not yet been operationalised clearly enough to translate easily into clinical practice and evidence-based research*" (Davey et al., 2012).

The issue of outcome measures forms another area of concern. A recent empirical examination of outcome measures in family therapy which reviewed 274 outcome studies highlighted several issues with the most commonly used instruments. Firstly, it was found that in the majority of cases (86%) the instruments were individual self-report measures, and in addition less than a third of the studies focused on the family (or couple) as the unit of analysis (Sanderson et al., 2009). This is problematic given the focus in family therapy on family-level (versus individual) change. Secondly, the review revealed that the field of outcome research lacks any accepted or standardised battery of measures, with a total of 480 different outcome measures being used in the 274 studies and 80% of these measures being used only once. Multiple measures mean that comparative analyses of outcomes (for example in a meta-analysis attempting to generate an effect size) are difficult, and the prevalence of instruments designed to be used with individuals means that many outcome measures could be accused of having poor construct validity. It could be argued that some of these issues are a result of the dominance of therapies with an individual focus (Barnes, Hall & Evans, 2008) and family therapy's resultant need to prove itself within this therapeutic milieu. This is perhaps reflected in the prevalence of the use of the Beck Depression Index in family therapy outcome studies (Sanderson et al., 2009), as it is often the instrument of choice in efficacy studies of cognitive behavioural therapy (Beckham & Watkins, 1989).

Despite the fact that outcome studies have focused on individual measures of change and that a number of studies could be criticised for not clearly operationalising family therapy, this does not deflect from the increasing number of methodologically sound studies that evidence various schools of family therapy as effective. It is also worth noting that in addition to the evidence that supports the

overall efficacy of family therapy, the literature also suggests that family therapy offers specific benefits over individual therapies. There is some suggestion for example that in certain diagnostic criteria and with certain populations (e.g. anorexia nervosa in young people (Lock et al., 2010)), family therapy can be more effective than individual therapy (Von Sydow et al., 2010). In a recent review, Stratton (2011) pointed to the growing body of evidence that suggests that family therapy is well liked and well tolerated (with lower dropout rates). Furthermore, a recent and comprehensive quantitative study (Hamilton, Moore, Crane, & Payne, 2011) showed that marriage and family therapists (in the US) had the lowest rates of dropout of all mental health professionals. A number of qualitative studies equally report that patients' experiences of family therapy are positive. For example, Sheridan et al. (2010) reported parents' experiences of family therapy as supportive and positive, and Stanbridge and colleagues found that families found therapy both helpful and preferable to other services they had experienced (Stanbridge et al., 2003). Additionally, there is evidence that family therapists are more cost effective, with better outcomes and lower dropout rates than therapists delivering individual therapy (Hamilton et al., 2011; Russell Crane & Payne, 2011). Family therapy is already a NICE recommended treatment for a number of mental health issues (e.g. anorexia for adolescents) (AFT, 2011). The above research would suggest that a case can be made for widening access to family therapy in the NHS. It is the argument of this dissertation that this case would be further strengthened if more rigour was applied to outcome research and if the research base was expanded to include more change process research which explored the links between moments in therapy and overall outcomes.

Part two: a review of research into the process of family therapy

Although there are several well-articulated theoretical accounts of the process of therapeutic change in the systemic therapies (see review above), there has been less research which evidences how these theories work in practice. In a recent review of family therapy research, Sexton and Datchi (2014) note that only 15% of the family therapy research published in the last 10 years can be classified as process-outcome research. They also note that the majority of the process research is focused on a handful of manualised multi-component treatment programmes (such

as multi-systemic family therapy and functional family therapy) (Sexton & Datchi, 2014).

What is known about the process of change in family therapy has been determined by a wide range of studies that have focused on a variety of different aspects of the therapeutic process. Broadly, the change process research in family therapy has been investigated in five main ways:

1. Research which focuses on micro-analytic processes such as speech acts or specific micro-processes associated with well-articulated accounts of therapy.
2. Research which is conducted qualitatively and asks broad questions about families' experiences.
3. Research which specifically focuses on the therapeutic relationship.
4. Qualitative research focusing on helpful factors (this approach has focused on asking therapists and families both separately and together).
5. Research which focuses on significant moments in therapy.

What follows is a review of some of the most pertinent studies along with a critical appraisal of the key points relevant to the current study.

Micro-analytic process design

This tradition of sequential process research looks in detail (turn by turn) at therapist/client interactions and responses and has been used most widely in researching aspects of specific therapeutic approaches that are considered key to change. For example, in multidimensional family therapy, Diamond et al., using Greenberg's task analysis methodology (Greenberg, 2007), have looked at the micro-processes involved in resolving negative parent-child interactions (Diamond & Liddle, 1999). They studied therapists' use of what they call 'shift-interventions', in which they demonstrated that therapists resolved impasses by blocking and dampening negative emotions and by increasing instances of constructive conversations by noticing and promoting these. Similarly, emotion-focused couple therapy (EFT) researchers have used this methodological approach to look at how therapists promote change (Furrow, Edwards, Choi, & Bradley, 2012). In their study, Furrow et al. (2012) looked at what is considered to be a key theoretical change mechanism in EFT: the 'blamer softening' event. Blamer softening moments occur when a hostile or critical partner adopts a position of vulnerability and directly asks

their significant other to help them meet their attachment needs (Johnson & Johnson, 2004). They found that therapists facilitated change by giving clients a clear picture of what secure attachment in their relationship would look like, acknowledging fears and promoting the processing of emotions and engagement between the blamer and the withdrawer.

Micro-process studies have also been used to study the impact of particular therapist interventions, such as reframing and reflection in functional family therapy (e.g. (Robbins, Alexander, Newell, & Turner, 1996). The process of change in narrative therapy has also been investigated. For example, Coulehan, Friedlander, and Heatherington (1998) conducted a detailed analysis of videotaped sessions in which they focused on the process of transforming problems from an individual conception to an interpersonal, systemic one. Their research highlighted the importance of emotional change as well as confirming some of the theoretical models of change as proposed by Sluzki in her theoretical model of narrative therapy (Coulehan et al., 1998).

Micro-analytic process studies have given detailed evidence of particular change processes in certain detailed therapeutic approaches. The strength of these studies is that the researchers give very detailed and rigorous accounts of their research process. However, they have been used to investigate highly specified mechanisms of change that proponents of particular models believe are key to encouraging change in that model. Hence, they are looking for evidence to support the theoretical view of change provided by the model. This makes it difficult to generalise findings from these studies to the more general practice of family therapy.

Qualitatively asking about experiences

A number of studies have been conducted which do not explicitly ask about the change process, yet have contributed to understanding how change might occur in family therapy. In general, these studies ask broad questions about participants' experiences and perceptions of family therapy. Examples include Kuehl, Newfield, and Joanning (1990), who interviewed families several months after therapy had ended to ask them about their experiences. Kuehl et al. found that families preferred a caring therapist and one that was able to make suggestions. However, due to the

time lag between therapy ending and the interviews taking place (an average of 5.5 months), the implications of these results for the current study should be interpreted cautiously as such a gap between therapy and interviews would privilege recall of content (what happened) over process (how it happened) (Rhodes, 2011).

With regard to family therapy conducted with couples, the researchers Bowman and Fine (2000) looked at client perceptions of couples therapy, interviewing five couples who were receiving (or who had just finished) couples therapy. They reported several factors which clients found helpful, such as a safe therapeutic atmosphere, gaining understanding about the relationship and seeing things in a different light. Couples also reported that they found unequal treatment, in which the therapist focused on one partner over another, unhelpful. Metcalf, Thomas, Duncan, Miller and Hubble (1996) looked at couples who had successfully completed solution-focused therapy. The study asked both couples and therapists about their experiences of the therapy. With regard to change, this study suggested that the therapeutic relationship was more important than particular techniques of solution-focused therapy.

In one of the few studies to ask about children's experience of therapy, Stith, Rosen, McCollum, Coleman, and Herman (1996) interviewed 16 children about their impressions of family therapy. One theme which described participants' sense of what had changed following family therapy suggested that children felt their families were more able to talk about their problems. In their ethnographic research into narrative therapy, O'Connor et al. (1997) found that clients recounted what was helpful about therapy. In particular, if therapists "*respected their perceptions*" and made them feel "*listened to, acknowledged and not blamed*" (O'Connor et al., 1997, p. 489), clients reported this was helpful.

Chenail et al. (2011) acknowledge the diversity of approaches taken and the wide variety of therapeutic models studied in a recent review of Family Therapy qualitative studies which focussed on clients' experiences of family therapy. They carried out a detailed and well-constructed qualitative meta-synthesis which utilized a thorough analysis of the literature and a grounded theory methodology to construct an account of how clients experienced family therapy (Chenail et al., 2011). Although the account did not explicitly focus on the process of change (perhaps because too few

studies make this an explicit concern), several themes emerged about change during family therapy. Chenail et al. (2011) call these “*changing the viewing*” (changes in how family members viewed themselves and their family) and “*changing the doing*” (how the family’s behaviour and communication changed). Both of these types of change were described as interrelated, but they were not explicitly linked to therapist characteristics or interventions (which were conceptualised as positive or negative). There was also in the study findings an inference that clients’ positive experiences of therapists would facilitate change; however, the study was not able to make a clear link between therapists’ actions and how change occurred.

With regard to the process of change, the main findings from these qualitative studies that focused on clients’ experience of family therapy are rather limited (given that they focus on experience). However, it appears that defining problems as interactional, feeling heard, and having a good relationship with the therapist(s) were seen as helpful (Kuehl et al., 1990; Lobatto, 2002; O’Connor et al., 1997; Sheridan et al., 2010). These findings are in line with the literature on individual therapy clients’ experience of therapy and suggest that a key component which contributes to change is the relationship with the therapist (Norcross, 2011) .

Therapeutic alliance

The quality of the therapeutic alliance in facilitating change has received a great deal of attention in the research literature on therapy and is broadly recognised as a robust predictor of a successful outcome in therapy (Norcross, 2002; Norcross, 2011a). In the context of family therapy specifically, this is also true (Flaskas & Perlesz, 1996; Friedlander, Escudero & Heatherington, 2006). An early handbook of family therapy confirms that, “*the ability of the therapist to establish a positive relationship ... receives the most consistent support as an important outcome-related therapist factor in marital and family therapy*” (Gurman & Knirkern, 1978 p. 875). Since this statement, the concept of the therapeutic alliance in family therapy has been investigated in some detail, and there is good empirical evidence to suggest that it is an important factor in family therapy (Friedlander et al., 2006). In individual therapy, a good alliance has traditionally been conceptualised as comprising an agreement on the goals and tasks of treatment as well as a strong emotional bond between client and therapist (Muran & Barber, 2010). Whilst these factors have been shown to be an important aspect of the alliance in family therapy, the significant

difference of having more than one person in the room has not been overlooked (Johnson & Wright, 2002). However, there is much less known about both what contributes to a good alliance in family therapy and the relationship between the process of change and the therapeutic alliance (Friedlander et al., 2006).

Various factors have been investigated with regard to the systemic alliance (the therapeutic alliance between family therapist and family) and, much as in individual therapies, there is no universally accepted definition of this construct. There is however agreement that it is important to form an alliance with all family members and that establishing a safe atmosphere is important (Baillargeon, Pinsof, & Leduc, 2005). Pinsof's view of the systemic alliance conceptualises it as both individual, within-system, within-sub-system and with the whole system whilst also using the bonds, tasks and goals constructs proposed by Bordin (Pinsof, 1994). More recently, Friedlander et al. (2006) have developed a multidimensional model of the systemic alliance which they call SOFTA. SOFTA conceptualises the alliance across several dimensions: engagement in the therapeutic process, emotional connection with the therapist, safety within the therapeutic context and shared sense of purpose within the family (Friedlander et al., 2006).

A recent empirical study by Escudero, Friedlander, Varela and Abascal (2008) used SOFTA to rate the alliance of 37 families (over an average of seven sessions) using videotaped family therapy sessions. They then compared the SOFTA ratings to families' and therapists' ratings of helpfulness of session and overall improvement. The results of this study not only confirmed that a system-wide alliance was a factor in change, but also suggested two specific aspects within the therapeutic alliance that were of particular significance to families. One was creating a "*shared sense of purpose*", and the other was "*safety within the therapeutic system*" (Escudero et al., 2008, p. 208). This research would thus suggest a role for these factors in the process of change. This paper is a particularly useful study given that it gives a very clear and detailed methodology and uses clients' ratings of improvement alongside ratings of aspects of the alliance taken from videoed sessions (assessed by independent and trained raters).

Qualitative helpful factors approaches

The body of research focused on helpful factors takes a qualitative approach with a focus on discovering what is helpful about family therapy interventions more broadly. This question has been asked of both families and therapists. This research is of particular relevance for the current study, because while it is not explicitly focused on change, it still often reveals how participants think about the mechanisms of change in family therapy.

Sundet (2011) for example interviewed families and therapists, basing his interview questions on five themes, including helpful/not helpful ingredients of therapy and effects/outcomes of therapy. The study is particularly interesting because the aim of the research was to understand how the therapy was experienced and described by both families and therapists and how these descriptions differed or concurred (Sundet, 2011). As a double description (e.g. based on analysis of both therapist and family data) the study yielded some clear and interesting themes. For example, the therapists thought it was important to “*be where people are*” and “*attain mutual definitions*” (Sundet, 2001. p 240), whereas families privileged helpful conversations (in which therapists asked questions and allowed time for exploration), mutual participation and the therapeutic relationship (Sundet, 2011 p 241). Unfortunately, the author is not explicit about how the interviews were conducted (at what point in therapy the interview took place), or whether the focus of the questions was on the therapy as a whole or one session, and this lack of clarity about the study design limits what can be ascertained about what is helpful at what point in the therapeutic process.

Research conducted by Blow (2001) used a Delphi methodology to explore marriage and family therapists’ concepts of what was helpful in change. The research involved multiple interviews as well as surveys of marriage and family therapists (registered in the US) in order to try and gain a consensus regarding the factors that are important in change. The study is to be commended with regard to its broad scope and extensive sampling. The methodology used yielded over 80 subcategories that were divided into three main categories: client factors (such as client motivation, personal agency and willingness to try new behaviours); relationship factors (for example, “*the alliance between therapist and client*”, “*a client’s trust in the therapist*” and the “*strength of the therapeutic relationship*”); and model/technique factors (for example,

therapist reinforces change, reframing the problem and consideration of alternative ways of viewing the problem).

In summary the helpful factors approach has yielded a great deal of qualitative data as to what clients find helpful in family therapy. This includes reformulating and giving feedback, the relationship being collaborative, gaining insight, being treated as an expert on their experiences, developing new perspectives, problem solving, and therapist empathy and warmth (Laszloffy, 2000; O'Connor et al., 1997; Stanbridge et al., 2003; Sundet, 2011). There is also some research which highlights what therapists feel might be helpful (Blow, 2001). However, all of this research has been conducted in the US, which potentially limits applicability to the practice of family therapy in the UK. In addition, and critically for the current study, the reviewed research is seldom directly focussed on the topic of how family therapy theory is implemented by therapists in the family therapy room to effect change.

Significant moments in therapy

The studies in this body of research use a mix of methodologies and are conceptualised by Elliott as the 'significant events approach' (Elliott, 2010). The research in this area is particularly pertinent to the current study because it is focused on what participants identify as key moments in therapy, in other words typically moments in which participants identify change as occurring. These studies are relevant because they move from an overall perspective of *what* might be helpful to a position of trying to identify *how* change occurs.

'Significant events' research designs can incorporate both quantitative and qualitative data. They differ from helpful factors research in that they incorporate a method for identifying important moments in therapy and use this as their starting point, often using video recordings as stimuli to encourage a focus on process. From this the research aims to generate a qualitative (and sometimes quantitative) description of what facilitates change in family therapy. These studies can thus provide a rich and detailed account of the change process in family therapy. However, whilst this methodology has been used more widely in process research in individual therapies, to date it has been used in a limited number of family therapy studies (Elliott, 2010; Sexton & Datchi, 2014).

One British study by Burck, Frosh, Strickland-Clark, and Morgan (1998) recorded a complete series of family therapy sessions with one family. The research team were explicitly looking for significant moments of change within the sessions. The sessions were transcribed and the data was analysed for themes relating to change using a grounded theory approach. The identified themes were then re-examined using discursive analysis. The study findings describe the therapist's management of change through discussions about control. Therapist interventions included encouraging different points of view and differing positions, and talking about how things have changed. The analysis also noticed the use of reframing and the ways in which the therapist confirmed alternative views, for example by introducing alternative discourses. Although the study gives an interesting insight into the practice of family therapy in the UK, there are some issues which weaken the findings. For example, the themes chosen for the discursive analysis come from discussions of the transcripts amongst the research team; following this, the transcripts were reread, looking at the therapist's contribution to change. Because of this, it is unclear whether these were indeed moments of change for the family. In addition, although the data was discussed within the team, there was no triangulation of the analysis with an alternative source (for example the family therapist, or an alternate practitioner) which would have strengthened the conclusions drawn. The study was also conducted some time ago, which means it is less applicable to current practice.

Strickland-Clark et al. (2000) also used a significant events approach to determine what children found significant about family therapy (as practised in a UK setting). Five children were interviewed on two separate occasions directly after a therapy session which had been video recorded. A semi-structured interview schedule was used to identify whether the children felt that anything significant had happened in the session. If so, this event was replayed to the children on a videotape and researchers asked about the context and the impact of the event during the replay. The children's therapists were played the same section and also interviewed about intent. A grounded theory revealed several themes from the children's interviews (the findings of the therapist interviews were not reported). Of the themes reported, those which related most to the process of change were: being heard, not feeling heard, feeling misunderstood, coping with challenge and solving problems. The analysis

also suggested that the children felt that therapists were not always successful in making them feel heard in sessions. This study is important for the current research because it utilises a methodology (video of sessions) also utilised in the current study. The authors state that they take a comprehensive process analysis (CPA) approach (an interpretive method developed by Elliot to understand significant therapy events (Elliott et al., 1994)) and are clear that they interviewed both children and their therapists about significant events. However, findings from the therapists' interviews are not reported, which is unfortunate, as a double description might have provided an insight into the link between therapists' perceptions, their actions and moments of change.

Campbell et al. (2003) used a different approach to investigate significant moments in family therapy with children diagnosed with depression (in the UK). In this UK study, a more ethnographic approach was taken in which therapists also acting as participatory researchers looked at videotapes of their own practice (selected from 14 sessions). Therapists then chose significant moments to play back to the other members of the research team. Moments were defined as significant if they were about the therapeutic relationship or if they progressed the therapy in some way. The research team (consisting of four therapists and one supervisor) then watched the videotape containing the significant moment and asked questions of the therapists regarding intention. These interview sessions were transcribed and a thematic analysis revealed a number of themes: creating a safe context, balancing hope and despair, staying connected, redefining the family depression as relational (e.g. shaped by relationships), hearing the child's voice, encouraging doing things differently (supporting examples of change) and redefining fixed narratives. This study is strengthened by the research team's focus on reflexivity and a commitment to an iterative process. They do however acknowledge that the lack of external validation could be considered to be problematic (Campbell et al., 2003).

Lloyd and Dallos (2006, 2008) conducted two related studies using a structured recall procedure to investigate the process in a first session of solution-focused therapy with families whose children had a learning disability. The primary researcher (who was also the therapist) audio-taped the first session for seven families and used a subsequent semi-structured interview to ask about helpful aspects of the session. Once moments had been identified, the researchers

interviewed mothers (as primary carer) and replayed the audio of the helpful moments, asking questions about the process of therapy. The researchers used thematic analysis to identify that the mothers' feelings of self-efficacy and self-worth increased when they reflected on achievements. It was also clear that they did not always find the miracle question (a standard assessment question in solution-focused therapy whose aim is to identify what might be different) helpful, but that they experienced the therapeutic relationship as hopeful, comfortable and collaborative (Llyod & Dallos, 2008).

In the related study (Llyod & Dallos, 2006) the therapist's perceptions of the audio data of the same sessions were noted down and transcribed and themes identified via a thematic analysis. These themes were triangulated by discussing the raw data and themes with a group of clinical psychologists and a group of solution-focused therapists. Any differences were discussed and the groups referred back to the original data until a consensus was reached. The themes identified came from the structure of the session and focused on the families' responses (as opposed to the therapist's interventions). Responses relating to change included parents talking about possibilities and parents assuming an active role (Lloyd & Dallos, 2008). As this study was focused on understanding the process of solution-focused therapy (in particular in relation to specific interventions such as the miracle question and scaling questions), it is not surprising that there are limited findings in relation to the overall change process. However, the importance of the therapeutic relationship was once again reinforced.

Summary and critique of existing process research

Taken together, the existing literature suggests a number of factors which consistently appear as playing a role in change within family therapy. Broadly these include: therapists conceptualising difficulties in relational terms; disrupting unhelpful relational patterns; a therapeutic alliance that includes the family; and the focus of treatment being on the family (not just the individual with named symptomatology) (Chenail et al., 2011; Sprenkle, Davis, & Lebow, 2009). Yet, as in outcome studies, too few studies are clear in how they define family therapy. In addition, the wide variety of epistemological and methodological approaches make it difficult to draw conclusions across the literature and to generalise findings.

There is also a bias in the literature towards studies which ask about the overall therapy process. Using the overall therapy as the unit of study limits what can be abstracted about the process of change, as it limits recall (McLennan, Twigg, & Bezant, 1993). For example, Lobatto (2002) asked children about their experiences of family therapy and conducted a grounded theory analysis of their responses, which produced a very broad account of how children felt about therapy with little focus on any specific aspect. A similar account was produced by Sheridan et al. (2010), who interviewed parents of adolescents post-therapy. Only four studies to date have studied what might be termed smaller units of therapy (specifically moments within a therapy session identified as important) (Campbell et al., 2003; Carlson & Kjos, 2002; Rober, Elliott, Buysse, Loots, & De Corte, 2008; Strickland-Clark et al., 2000). Two research teams (Campbell et al., 2003); (Rober et al., 2008) examined therapist intentions and thoughts within those moments; one study asked children about helpful and unhelpful moments in therapy (Strickland-Clark et al., 2000); and a further study looked at incidents of blaming within a session (Carlson & Kjos, 2002). In addition, only four studies (Burck et al., 1998; Campbell et al., 2003; Lloyd & Dallos, 2006a; Strickland-Clark et al., 2000) have looked at the process of family therapy as it is practised in the UK, and of those only one (Burck et al., 1988) explicitly investigated the process of change.

In a recent review of the evidence base surrounding the effectiveness of couple and family-based interventions, Sexton et al. (2014) note that “*there was a remarkable lack of attention to the relational and clinical models of change and very few systematic studies of the common core factors that may unify and cut across all intervention models. Few studies (12.68% and 14.6% respectively) examine the mediating influence of common and specific change mechanisms*” (Sexton et al; 2014, p. 627). The authors challenge researchers to move beyond studies which investigate outcomes and suggest a focus on investigations that specify the detail and effectiveness of interventions. They suggest that there should be more of a focus on attempting to uncover what the active ingredients of family therapy are.

As this literature review demonstrates, despite evidence to show that certain factors play a role in the outcome of therapy, there is little research that links theoretical models of change, how therapists apply these theories to engender change and how families perceive moments of change in therapy. Heathrington et al. (2005) echo

Sexton et al. when they call for researchers in the field of family therapy to move beyond research which looks at the overall efficacy of family therapy into a more detailed exploration of the processes that can or should (according to theory) instigate change. Moreover, they highlight the lack of what they call 'mid-range theories', which link theoretical ideas of how overall change might happen to defined therapy tasks/therapeutic interventions and specific moments in therapy. These links between theory, practice and process are important in order to build a complete, evidence- and practice-based model of family therapy (Heatherington et al., 2005) and are the focus of the current research project.

Context for the research and relevance to counselling psychology

The current context in which this research was undertaken is worth considering, as it explains the wider value that this research may bring. The NHS is undergoing a period of great change (Mongin-Bulewski, 2011). A key example is that mental health services are moving towards a system of 'payment by results' (Department of Health, 2013); in payment-by-results contexts, service users are assigned to one of several 'care clusters' (based on diagnostic criteria), which then indicates which care package (of a specified monetary value) they are entitled to (Speak, Hay, & Muncer, 2015). Providers are paid on the basis of the care packages and whether they achieve certain outcomes for the service user (Jacques, 2008). The care packages recommended are based on NICE guidelines, and therefore psychological therapies that can show good efficacy through randomised control trials (RCTs) are privileged (Jacques, 2008). The idea that randomised control trials constitute the most 'rigorous' evidence minimises the perspectives of both service users and clinicians and can be critiqued from a number of other standpoints (Barkham, Hardy, & Mellor-Clark, 2010). As a result, it has been proposed that 'practice-based' evidence should form a counterbalance to some of the inherent scientific susceptibilities of RCTs (Barkham & Mellor-Clark, 2003) and that building up a research base in the psychological therapies should be a circular and iterative process in which practice-based evidence informs and refines specific efficacy research (Barkham & Mellor-Clark, 2003).

From the perspective of a counselling psychologist (in training), the privileging of RCTs over other forms of evidence seems to be open to challenge (Newnham & Page, 2010). Counselling psychologists value the subjective experiences of the

client, practice-based 'evidence' and phenomenological approaches to research (British Psychological Society, 2005). These values account for the focus of my research being clinical practice and the experiences of families. As a counselling psychologist, I would argue that the voice and experience of the client is an equally valid form of evidence. In addition the social justice movement within counselling psychology has called for practitioners and researchers to address power imbalances and promote equity in terms of access to knowledge services and resources (Caldwell & Vera, 2010; Vera & Speight, 2003). This approach to research aligns with my own values as a counselling psychologist (in training) and influenced my desire to include interviews with clients in my research. The department of health also values research which incorporates the views of service users (Minogue & Girdlestone, 2010), yet in a recent review Minogue and Girdlestone (2010) revealed that service user involvement in research is still sporadic. This coupled with the current context within the NHS (of payment by results as outlined above) has consequences for clients that, as a counselling psychologist, I would challenge. Maintaining funding for pluralism in psychological therapies gives clients choice and a greater chance of achieving the outcomes they desire (Cooper & McLeod, 2011), but this pluralism is predicated on relevant and rigorous research. This then is the hoped-for wider value of the current research project: to promote practice-based evidence and the values that it embraces.

Research rationale

Despite some evidence to show that certain factors play a role in the outcome of family therapy, there is little research that links together theoretical models of change, how therapists apply these theories to engender change, and what families find important in therapy. These links between theory, practice and process, and families and therapists experiences, are important in order to build a complete, evidence- and practice-based model of family therapy (Heatherington et al., 2005) and are the focus of the current research project.

Research aims

A key first step when attempting to establish the efficacy of any therapeutic change model is to seek to clearly identify or define how it is being operationalised by practitioners. Although there are several definitions of how family therapy should be practised in the UK (for example, core competencies, standards for training, therapy

manuals), there has been little research into how it is practised on the ground. It is not clear how family therapists conceptualise their practice in relation to therapeutic change. Nor is it clear what they actually do with families to encourage change (e.g. what theories and interventions they use).

The primary aim of this research is to investigate how change processes are operationalised by family therapists. A secondary aim is to generate a detailed and multi-layered account of change which is more complete and incorporates multiple perspectives, so that there is a balance of depth and breadth in understanding the change process in family therapy. Specific moments of change in therapy are co-constructed between therapists and families, yet we know very little about how families see the process of change in family therapy. Thus it is not clear how much of a gap there is between theories of change, clinicians' change-focused interventions and how a family experiences moments of change in the therapy room (Heatherington et al., 2005). This study hopes to examine and describe that gap. It is hoped that the insights gained from this research project will aid in the development of models of change in family therapy that link theory, process and outcome.

Research questions

1. What do family therapists think makes a difference in family therapy sessions?
2. How do family therapists feel they promote change?
3. How do family therapists relate theory to what they do in practice in sessions?
4. What do families find important in family therapy sessions?
5. What were therapists' intentions in those moments?
6. What can be concluded by examining similarities or differences between therapists' and families' conceptualisations of important moments in therapy?

METHODOLOGY

Design

The current research used a range of qualitative interview methods to collect and analyse therapists' and families' descriptions of intentions and experiences during family therapy sessions, in order to create meaningful real-world accounts of the change process.

Rationale for a qualitative research methodology

The methodological design chosen fits with both the research questions and my perspectives as a researcher. As a trainee counselling psychologist and researcher, I am conversant with the scientist-practitioner model as endorsed by the Health and Care Professions Council's standards of proficiency documentation for practitioner psychologists and those in training and also the Professional Practice Guidelines of the British Psychological Society's Division of Counselling Psychology (British Psychological Society, 2005; HCPC, 2015). The scientific-practitioner model emphasises using scientific knowledge to inform practice, and counselling psychology guidelines focus on engaging with "*subjectivity and intersubjectivity, values and beliefs*" as well as respecting "*first person accounts as valid in their own terms*" (British Psychological Society, 2005, pp. 1-2). From this perspective, I wanted to use a research approach that was able to generate accounts of psychological processes that reflect the human experience in an ideographic and contextual way (Ponterotto, 2005; Smith, 2008). As a counselling psychologist, I embrace the scientific-practitioner model, but I am interested in the process and meaning of phenomena as opposed to solely being concerned with cause and effect. I would describe my ontological position as one of critical realism, believing that "*the way we perceive facts, particularly in the social realm, depends partly upon our beliefs and expectations*" (Bunge, 1993 p. 231). Thus, I don't deny the existence of a reality, but I would stress the importance of understanding the contextual and social circumstances that contribute to generating that reality. I adhere to the British Psychological Society's definition of a counselling psychologist as someone who

“seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology” (British Psychological Society, p. 1). Thus, I am interested in research that is practice-led, that respects and validates clients’ accounts, and that takes into account the social context accepting that knowledge can be subjective.

I chose a qualitative methodology as it allowed me to adhere to my own and my profession’s values while facilitating the aims of the study. One of the key questions posed by this study is around how family therapists conceptualise change, and how this is translated into sessions. The current evidence base (from both family therapy research and the more widely researched processes of change in individual therapies) indicates that the process of change in psychotherapy is complex and multifaceted (Elliott, 2010; Hanna & Ritchie, 1995; Kazdin, 2009; Sexton, Ridley, & Kleiner, 2004). Several researchers acknowledge that qualitative approaches can be advantageous in exploring complex processes. As Braun and Clarke argue, *“participants’ language can reveal both mess and contradiction in a way quantitative methods cannot”* (Braun & Clarke, 2013, p. 24). Morrow argues that, because qualitative approaches *“are so effective at examining processes, they are ideal for understanding psychotherapy process in depth”* (Morrow, 2007, p 209). In addition, research into the change process in family therapy is at a stage which calls for the development of well-articulated and robust models, and qualitative methodologies are well placed to generate detailed and rich accounts of process (Sexton & Datchi, 2014). There is also a well-established precedent for using qualitative methodologies in family therapy research, particularly within the field of process research (Heatherington et al., 2005), and it has been argued by several researchers that these methods are of particular use in informing or generating theoretical models (such as theories of change) (Gilgun, 2005; Heatherington et al., 2005).

Data collection strategy

The research questions are focused on family therapists’ understanding and perceptions of how change occurs and the comparative experiences of families. This required a methodology that not only took into account multiple perspectives (therapists and families), but that was capable of exploring both theory and practice (what therapists think about change and what they feel they do in practice). The choice of methodology was influenced by studies of other professionals such as

teachers and social workers (Meijer, Verloop, & Beijaard, 2002; Schaap, de Bruijn, Van der Schaaf, & Kirschner, 2009), as there was no clear precedent for this approach in the research literature on therapeutic practice.

Like therapists, it is assumed that teachers' and social workers' theoretical knowledge informs their practice in a classroom or with clients. Several authors have conceptualised the relationship between theory and practice in the professions as comprising declarative and procedural knowledge (Huijts, Bruijn, & Schaap, 2011; Verloop, Van Driel, & Meijer, 2001). In order to assess both these aspects of professional knowledge (and their interaction), researchers have adopted interactive data collection methods that have used mixed methodologies that are capable of assessing both theory and practice to get a fuller picture of a phenomenon. For example, Schaap et al. (2009) investigated social work students' understanding of what was important in their practice. They used a methodological triangulation and asked social work students to create concept maps of competencies. They then conducted semi-structured interviews with the same students as well as using self-report measures to generate a rich data set that contained both affective and abstract information. They found that the concept maps tended to generate accounts that were simple and unspecific, whereas the interviews generated a more specific account with greater insight. Farmer, Robinson, Elliott, and Eyles (2006) also adopted a multi-method triangulation in their study of language teachers' practice. They wanted to explore what they termed 'practical knowledge', which comprised knowledge and beliefs *and* interactive cognitions during a teaching episode. They examined this via three methodological approaches: a semi-structured interview (to elicit ideas), a concept mapping assignment (in which teachers identified concepts they felt were important) and a stimulated recall interview (in which teachers explained their thinking regarding a videotape of a lesson they had given). The semi-structured interview and concept mapping were designed to examine teachers' knowledge and beliefs, whereas the stimulated recall methodology was designed to capture the interactive cognitions (procedural knowledge and the process of teaching) (Meijer et al., 2002). In their study, each data collection method had a different focus, and by using them in combination they were able to develop a more comprehensive view of teachers' practice.

These kinds of methodological triangulation approaches were considered particularly relevant to the current study, as it is acknowledged that it is hard to conceptualise the process of change in therapy in the abstract (Rhodes, 2012). It is also acknowledged that a reliance on one method of data collection can lead to a very theoretical and abstract account of change which does not reflect real-world applications (Elliott, 2010). In addition there are concerns regarding qualitative interviews with professionals as participants may feel their professional identity is at stake (Coar & Sim, 2006).

There are several methods which have been used to attempt to access therapists' and clients' experiences of the process of therapy (for example task analysis (Greenberg, 2007)). The most commonly reported approach is to use some kind of structured interview or questionnaire to ask a specific question about process. An alternative approach is to interview participants after a therapy session and ask them to freely recall any significant thoughts or moments that occurred in a session (Elliott, 2010). However, both of these approaches have limits (McLennan et al., 1993). Although a guided inquiry approach offers the benefit of allowing between-interview comparisons, the use of a set of standard questions or measures imposes the researcher's preconceived theories onto the patient's experience. A free-recall approach removes this frame of reference, but the content of what is recalled is limited to what is salient and most recent thus this method has the tendency to produce answers that are focused on content (what happened) rather than process (how something happened) (Welsh & Dickson, 2005).

Acknowledging the limitations of each methodology, Elliot (2010) advocates using multiple methodological approaches when conducting process research. As the aim of this research was to encourage a detailed examination of the process of change which encompasses both theory and practice, it was felt that a methodological triangulation that combined a semi-structured interview with a stimulated recall methodology would be most appropriate. A contextualist approach to triangulation seeks to get a "*fuller picture, but not a more objective one*" (Fielding & Fielding, 1986, p. 33). Thus, coming from a critical realist perspective, which attempts to understand the context of a phenomenon it was felt that there was value in attempting to generate different perspectives and insights. Therefore the rationale for triangulation in the current study was less about increasing validity and more about

generating a more complete account. Methodological triangulation also had the benefit of allowing for an examination of complementarity, divergence and convergence between differing accounts, thus building a more comprehensive picture of the change process (Carter, Nancy, Denise, Alba, & Jennifer, 2014; Leech & Onwuegbuzie, 2007).

The design thus included a combination of prospective semi-structured qualitative research interviews with family therapists and a method called interpersonal process recall (IPR), designed to access views about the process of change in actual therapy sessions (from both the therapists' and the families' perspectives). Semi-structured interviews with therapists were chosen to gain insight into therapists' understanding of the change process. IPR was used to gain an understanding of change in practice from the points of view of therapists and families. This multi-modal approach, involving both methodological (interviews and IPR) and data source (therapists and families) triangulation, has been utilised as a data collection method for a thematic analysis in qualitative health research (Farmer et al., 2006; Walton, Macdermid, Taylor, & Icon, 2013), in assessing working alliances in occupational therapy (Morrison & Smith, 2013) and in bereavement research (Briller, Meert, Schim, Thurston, & Kabel, 2008), but it is a novel approach in psychotherapy process research.

Interviews with family therapists

Interviews are well suited to exploring understandings and constructions of phenomena that participants have some involvement with and can generate rich and varied accounts (Braun & Clarke, 2013). Kvale (1996) described interviewing as an activity whose purpose "*is to obtain descriptions of the life-world of the interviewee with respect to interpreting the meaning of the described phenomena*" (Kvale, 1996, p. 6); thus the level of structure of the interviewing process was considered. Although standardised structured interviews allow for clear comparisons between the interviews, the research sought to generate an account of therapists' own knowledge and understanding of change, and thus this approach was discounted, as it was felt it would impose existing assumptions. The opposing approach – an interview method that was unstructured – would not allow for the focus on the research questions that the current project demanded. For that reason, a semi-structured interview method was adopted (Brinkmann, 2013). Semi-structured interviews have the benefit of

allowing a focus on the issues that are considered important to the researcher and can generate a detailed account from a participant of the experience under study (Edwards & Holland, 2013). They are also flexible and allow for participants to talk freely and openly, thus providing a good balance between structure and openness (Gillham, 2005).

Consideration was also given as to whether to conduct the interviews in person or over the telephone. According to Knox and Birkard (2009), there is very little research that compares the advantages and disadvantages of both approaches. However, there is some research to suggest that the quality of data may be superior in face-to-face interviews (Jordan, Marcus, & Reeder, 1980). Face-to-face interviews also have the benefit of the observation of non-verbal information (Hiller & DiLuzio, 2004). Since the interview was designed as semi-structured, this feedback was considered important to allow for adjustment of questions (rephrasing, checking meaning, asking probing questions). Polkongorn (1994) described the importance of gaining trust and openness between interviewer and interviewee and believed that this can be best facilitated by in-person interviews. This is a view supported by Musselwhite (2006), who maintains that in-person interviews can also promote a more participatory experience. Both authors support the use of in-person interviews as a method of gaining in-depth descriptions of phenomena. Therefore, in-person interviews were chosen, as it was felt that this approach would increase the likelihood of generating a rich and detailed account of the change process as understood by family therapists.

Interpersonal process recall

A methodology called interpersonal process recall (IPR) has been shown to have the potential to explore conscious yet unspoken experiences, so that participants can recall their perceptions and subjective impressions of therapy at a detailed level (Elliott & Shapiro, 1988; Hill et al., 1994; Larsen et al., 2008). The IPR methodology was developed by Kagan (Kagan, 1963) and Elliot (Elliott, 1986) and is described as a flexible methodology that can utilise "*a number of different strategies ... depending on the interests and methodological predispositions of the researcher*" (Elliott, personal communication, August 2012). The method involves videotaping a complete one-hour therapy session. The participants are then interviewed separately and asked specific cuing questions about the pre-recorded therapy session whilst

being able to watch and control the video. The recording acts as a cue to memory and also slows down the interview process, giving time for participants to reflect on and differentiate their experience (Elliot, 1986).

The flexibility combined with its theoretical research base made IPR a particularly suitable secondary method of data collection for this study. It has been used extensively in process research in individual therapy (Balmforth & Elliott, 2011; Elliott et al., 1994; Hardy et al., 1998). There are also a number of studies in family therapy research which have used similar video recall methodologies (Bowen et al., 2002; Lloyd & Dallos, 2008; Strickland-Clark et al., 2000). A paper by Hill et al. (1994) looked at the use of IPR as part of a review of video-recorded recall methodologies and found good consistency and stability of client-reported reactions (Hill et al., 1994). The richness of the accounts of therapy provided by previous researchers using the technique also seemed to support the view that IPR allows participants to aid recall of unspoken and implicit processes that would not be captured by other interviewing methods (Bowen et al., 2002; Lloyd & Dallos, 2008; Strickland-Clark et al., 2000).

In deciding whether IPR interviews would be conducted individually or as group interviews, there were several considerations. Morgan (2010) makes the point that the most prominent difference between individual and joint interviews is the interaction between participants. Individual interviews may encourage participants to discuss thoughts and feelings that they might not otherwise share (in a more public interview) and give the interviewer more control over the interviewing session. Thus, the benefits of individual interviews are that each participant is free to give their own perspective, and this may allow for a more in-depth exploration of the subject. However, the current study is focused on the experiences of naturally occurring groups (family groups or the work group of the family therapy team), which raised some additional considerations. Both sets of participants are considered to be part of an interactional system. Family therapists (in the way family therapy is practised in the UK) do not work alone; they work in conjunction with another therapist or reflecting team. Eisikovits and Koren (2010), in their analysis of approaches to and outcomes of dyadic interviews, found that, even when interviews were conducted individually, partners/family members had a virtual presence in any interview about joint topics. Their research suggested that the interactional nature of the research

topic was likely to prompt a systemic focus in participants' responses. In addition, the founding concepts of family therapy are systemic in nature and suggest that change occurs at the level of the system. This needed to be incorporated into the research design so that the interview methodology was able to capture the collective and shared meanings of change for both families and family therapists, suggesting a joint interview approach.

Joint interviews also have the ability for participants to stimulate one another into discussing issues that might not otherwise be recalled or salient. Morgan (2010) suggests that the interactional advantage of group interviewing is due to the process of sharing and comparing. Kitzinger (1994) also discusses the importance of interaction in focus groups and illustrates how this can be utilised when interviewing natural groups (for example family groups, work groups) as a way of highlighting implicit knowledge. This would suggest joint interviews had an additional advantage for an IPR approach in which one of the aims is to uncover unconscious processes. This approach appears to be confirmed by Polak and Green (2015), who reviewed the literature on joint interviews and highlighted how this approach could add analytic value. They report that "*joint interviews provide some analytical advantages over individual interviews in studying tacit knowledge*" (Polak & Green, 2015, p. 1).

Although IPR has mostly been employed in the study of individual therapies (and therefore used individual interviews), there is one previous example of using IPR with group interviews. Van Roosmalen (2001) used IPR with family groups to examine therapist events that influenced the therapeutic alliance. This study yielded valuable information regarding conducting IPR in a group setting. The author found that IPR could successfully be applied in this context and that the group interview approach was a suitable match for the IPR methodology. The exception to this was families with young children. It was found that young children (age was not specified in the study) found it difficult to participate in the IPR interview, and in those families an additional semi-structured interview was used to interview the child.

The next consideration was selecting which sessions to record and it was also decided to exclude the first three sessions of therapy for the purposes of recording. This decision was taken for two reasons. Firstly, the assessment phase of therapy was not the current focus of research, and early sessions were likely to focus on

assessment (Carr, 2006). Secondly, a crucial aspect of early sessions is the establishment of the therapeutic relationship, and there was a risk that recordings may have interfered with this (Elliott, 1986; Hubble, Duncan, & Miller, 1999).

Consideration was also given to the fact that therapists might behave in a socially (professionally) desirable way, for example trying to exhibit some of the interventions they feel have been important. Families may also have been affected by the presence of the camera, and it is possible that they may have subconsciously wanted to be videoed as 'good' clients. To counteract this effect, the researcher stressed to participants that the focus of the research was on capturing a 'normal' therapy session and that participants would not be judged on the session's contents (see attached methodology paper for a full explanation).

Data analysis rationale

Deciding upon an analytic method to employ must take full consideration of both the research questions and the theoretical/epistemological assumptions of the analytic methods available (Braun & Clarke, 2013; Ponterotto, 2002, 2005). Three types of analysis were considered: grounded theory (GT), thematic analysis (TA) and interpretative phenomenological analysis (IPA).

Grounded theory (GT) is an approach to qualitative research, not just an analytic method. Originally developed by Glaser and Strauss (1967), it is a methodology that is designed to generate new theories that are 'grounded' in the data of a phenomenon. Although there are now several different approaches to grounded theory, they share a common interest in understanding social and psychological processes (Smith, 2008) and are "*an explicit method of constructing middle-range sociological theory from data*" (Charmaz & Henwood, 2008, p.243). GT requires a theoretical sampling approach, and a purist approach to GT requires minimal knowledge of the existing literature (to avoid theories being shaped by preconceptions). Core aspects of GT were thus incompatible with one of the main aims of this study, which was to test and understand the links between theory and practice. Theory development might have been an aim of this study, but in fact the core research questions revolve around comparisons with existing theoretical models (i.e., how is the reality on the ground different or similar to theory, and do families' and therapists' accounts differ or are they the same?).

An alternative analytic method that was considered for this study was interpretative phenomenological analysis (IPA). Like GT, IPA is generally considered a research methodology (not just an analytic method), grounded in a phenomenological approach to research. It is concerned with exploring people's lived experience and follows an approach in which the researcher aims to comprehend how participants are making sense of their world (Smith, Larkin, & Flowers, 2009). This focus on how participants understand and perceive a phenomenon was not fully compatible with the aims of this study. The aim of this study was not to understand how individual family therapists experienced doing therapy, but to gain an understanding of how family therapists felt they conducted therapy (with respect to change) and to establish whether this could be verified (or not) in practice.

TA has been described as a "*method for identifying, analysing and reporting patterns (themes) within data*" (Braun & Clarke, 2006, p.79). Its advantages in the current study are that it can be used both flexibly and rigorously and can take an inductive or deductive analytic approach (Braun & Clarke, 2006). It is not a complete methodological approach but an analytic method that has been used in a number of contexts (Braun & Clarke, 2014). The combination that TA offers of a robust systematic framework for analysing data and a flexible theoretical orientation is particularly suited to methodological triangulation, and indeed TA has been used in several studies that have employed a similar method of methodological and data triangulation to the current study (Briller et al., 2008; Farmer et al., 2006; Morrison & Smith, 2013). This fits with the ontological position taken in this research which is one of critical realism. This stance of being critical of our ability to know reality with certainty lends itself to a methodological approach which encompasses multiple observations and sources of data.

TA was used as a method in this study in two ways. Firstly, TA was used to generate an account of what therapists feel is important in change and what they feel they do to promote it (informed by existing theoretical constructs). Secondly, the analysis of IPR interviews examined the process of change in therapy to generate a second analysis that could be used for triangulation purposes. As this was imagined as a methodology that would capture the central aspects of the therapy process, the analytic approach to this data set was conceived to be less of a theory directed and more of a bottom-up data-driven analytic approach. Thus, TA was a good fit (Braun

& Clarke, 2006; Muir-Cochrane & Fereday, 2006). TA can be essentialist, constructivist or contextualist, in accordance with the interest and approach of the researcher. The aim of this research was to understand how participants described and made sense of family therapy. However, this was not without consideration of the wider social context and the impact this may have on participants' meaning-making. Braun and Clarke (2006) describe this position as a contextualist approach, and the ability to adopt this approach to the analysis was influential in the choice of TA as an analytic method. Madill, Jordan, and Shirley (2000) confirm the strength of a contextualist approach to triangulation, as it offers the possibility of "*retaining truly novel perspectives which may have been discounted when consensus (and hence probably conventional) understandings are valued*" (Madill et al., 2000, p. 10).

Method

Ethical approval for the study was gained from the National Health Services South West – Cornwall and Plymouth Research Ethics Committee and the University's Research Ethics Committee, and recruitment started in July 2013. See Appendices A1-A2 for all related paperwork).

Sampling strategy and recruitment

Sampling strategy and recruitment was influenced by the guidelines published by Patton (2015) and Robinson (2013). Robinson (2013) gives a four-point approach to sampling for qualitative methods. These are outlined with regard to the current study below:

1. Defining the sample universe: this involves setting inclusion and exclusion criteria and balancing homogeneity and heterogeneity. These parameters were set according to the research questions' focus and by determining who might best be suited to answering those questions. Thus, the inclusion criteria for the individual family therapists were that they had to be family therapists currently in practice who had completed at least intermediate training in family therapy. Trainees were discounted, as it was felt they would have insufficient experience of how change occurred in family therapy.

The inclusion criteria for families were that they had to be attending family therapy with one of the family therapists already taking part in the study.

Families were excluded from the study if they contained a family member whom the researcher (in discussion with the supervisory team) believed could not provide informed consent. Families were also excluded from the study if they contained a family member under the age of 16. This decision was made on the basis that ethical approval would be easier to secure and that recruitment would be limited to adult mental health. It was felt that ethical approval and recruitment in child and adolescent mental health services would be beyond the scope of the current study. In addition, a previous IPR group interview which found that younger children were unable to participate (Van Roosmalen, 2001). The inclusion criteria for family therapy team members were that they had to be part of the family therapy team currently treating the family; this sample included both qualified and non-qualified (training) staff participants.

2. Deciding on sample size: both Robinson (2013) and Patton (2015) are clear that sample size should take account of theoretical and practical considerations. They suggest considering the purpose of the study and the breadth of focus of the research topic. A broad research question may seemingly require a large sample, but too much data may result in an insufficiently in-depth analysis. Data can be highly relevant in a smaller sample, if the participants have good experience of the phenomenon under study (Cleary, Horsfall, & Hayter, 2014). So, a focused research topic (such as that of the current study) might adequately be served by a small sample (for example $n = 6-12$ individual interviews) (Patton, 2015). Braun and Clarke (2013) recommend that for thematic analysis a sample size of between six and ten for individual interviews and between two and four for group interviews is adequate, but that these guidelines depend on the relative depth of the interviews. Since both sets of interviews were envisioned as in-depth process-focused interviews, Braun and Clarke's (2013) recommendations were adopted [namely 8 individual interviews and 4 IPR group interviews (two with families and two with family therapy teams)].
3. Sampling strategy: following the guidance of Patton (2015), who suggests using a purposeful sampling strategy that meets the needs of the research, two sampling strategies were combined in three steps. The steps are outlined below:

- i. Chain sampling of family therapists. This pragmatic approach identified a source of potential participants that was geographically local. This included the local NHS mental health trusts and a number of charities in the south west that were known to conduct family therapy. Four organisations were approached to determine if their therapists would be interested in taking part, and three responded positively. The strategy began with contacting a small number of known therapist contacts (former colleagues or contacts of colleagues). From these contacts the sample was snowballed out to other family therapists known to the initial contacts. Once introduced, these potential participants were contacted directly, and they in turn were asked to recommend potential contacts.
 - ii. Once family therapists had been recruited (see sourcing sample), the next sampling strategy employed was snowball sampling to recruit families (for the IPR section of the research). Family therapists already recruited to the study were asked to contact potential families that met the criteria (i.e. were being seen in the family therapy clinic) to introduce them to the study. This was done via posters and face-to-face means (see below).
 - iii. The same snowball sampling strategy was applied to family therapy reflecting teams (for the IPR section of the research). Family therapists already recruited to the study were asked to contact reflecting team members to introduce them to the study.
4. Sourcing sample: as all participation was necessarily voluntary, the sample was subjected to self-selection bias, in which it is likely that participants who responded were more interested in the topic and open to questioning than those who didn't (Robinson, 2013). Recruitment also relies on disseminating the study information. This was done in multiple ways, through group email (within the organisations mentioned above), through posters placed in family therapy clinics (see Appendix B1) and through word of mouth.

Participants

Eight family therapists were recruited to the study, meeting Braun and Clarke's (2013) recommendations for an appropriate *N* for such a design. There were six women and two men, and they ranged in age from 30 to 50; all were white British. The levels of experience as family therapists varied; the majority of the family therapists had over three years' post-qualifying experience, with several having considerably more and one less than this.

Two families were recruited to the IPR interviews. Both families consisted of heterosexual couples between the ages of 30 and 60 who were white British. There were 2 men and 2 women participants.

Two family therapy teams were also recruited. These consisted of the existing family therapists (already recruited) and the additional reflecting team members. One reflecting team contained one additional member and the other reflecting team contained three additional members. Participants ranged in age from 30 to 50 years old. All members of the reflecting team were white British and female, apart from one white British male.

Data collection

There were three forms of data collection (see Table 2.)

Table 2:

Data collection type	Participant type	Number of interviews conducted	Approximate length of interviews
Prospective semi-structured interviews with family therapists	Family therapists	Eight	60 minutes
IPR interviews with families	Families	Two (4 people)	90–120 minutes
IPR interviews with	Corresponding	Two (6 people)	90 minutes

family therapy family therapy
teams team

Prospective semi-structured family therapist interviews – all participants who were interested in taking part in the study were contacted before interviews were arranged. They were initially given a participant information sheet (see Appendix B2) and consent form which highlighted the risks and benefits of taking part. They were then contacted via telephone to give them an opportunity to discuss the study and ask any questions.

Family interviews – special attention was paid to the issue of informed consent with family participants and the possibility of coercion of individual family members by other members of the family. To minimise this, the participant information sheet made it clear that each member must voluntarily give consent to take part. In addition, with any interested families, each family member was contacted individually. All participants were informed that they had the right to withdraw at any time.

After this phase, participants were asked to suggest a convenient time and place for the interviews. Prospective interviews with family therapists were conducted at their place of work, or at a home address. Interviews with families were conducted at their homes. Interviews with the therapy teams were conducted at the place of work.

Prior to conducting the interview (or recording the family therapy session in the case of IPR), participants were once again asked if they had any questions before they were asked to sign the consent forms (see Appendix B3). After each interview, participants were thanked and reminded of the information on the participant information sheet should they have wanted any further support or had any questions arising from the interview.

Prospective semi-structured interviews with family therapists

The semi-structured interview was devised using principles outlined by Braun and Clarke (2013) and Knox and Burkard (2009). An interview schedule was developed with questions that allowed for the need to try and obtain specific information, but that also remained open ended. The schedule served as a guide, and participants

were also probed and prompted with additional questions and queries. The initial questions were developed from a consideration of the existing literature and from discussions with the supervisory team. Particular attention was paid to the sequencing of the questions and the opening and closing questions. Opening questions were less probing, and questions were clustered in topics that moved from the general to the specific. The interview was finished with a closing question which checked whether participants had anything to add (see Appendix C1). Interviewees were given a choice as to where they would prefer to be interviewed in order that they felt relaxed and comfortable. Sufficient time was allowed for the interviews (which took between 45 and 90 minutes) and participants were encouraged to provide rich and full answers by appropriate pacing of questions and follow-up probes. All interviews were recorded onto a digital audio recorder and transcribed to an appropriate level of detail as described by Braun and Clarke (2006).

IPR filming and interviews

Both the family therapy sessions were video recorded in existing family therapy suites. To capture the full range of verbal and non-verbal communication during a session, all participants needed to be both audible and visible on the video recording. This required a camera that had a wide-angle lens setting and a high-quality omnidirectional microphone. The camera was mounted onto a tripod which was left in the therapy room. The researcher started recording before the start of the session and left the room, re-entering only to stop the recording once the session was complete. The sessions were recorded to an HDMI memory card, allowing the direct transfer of material to the playback screen.

The IPR interviews were then conducted within seven days of the therapy sessions. Elliot suggests a shorter gap between recording and interviews, but this was not possible due to the working patterns of the family therapists (Elliott, 1986). Families and family therapy teams were interviewed separately.

Families were given the choice of interview location (interviews should take place somewhere quiet and private where the participants feel comfortable). Families were offered the option of returning to the clinic to be interviewed or being interviewed at home. All the families interviewed opted to be interviewed at home. The system for playback of the video ensured that both the interviewer and all the participants could

see the screen. The playback machine had the capacity to play, pause, forward and rewind with ease, and the participants had the ability to control this.

Before commencing the interview, the focus of IPR was established. Prior to playing back the family therapy session, it was made clear that participants were being asked to explore their unspoken experiences. It was stressed that the focus of the interview was on exploring the participants' experiences, and they were encouraged to take an observer position with regard to the material (Elliot, 1986; Kagan, 1984). For example, participants were reminded that they were not being asked to comment on how they felt now (on watching the video), but that it would be helpful to recall the thoughts, experiences and emotions that had occurred in the session itself. Families were asked to stop the tape at any point when they felt something significant or important had occurred. They then had the opportunity to rewind and play back this section of the tape if necessary. As the interviews were conducted in groups, all members of the family were regularly prompted to make sure any differences in what was considered important were captured. During the playback sessions, a semi-structured interview schedule was used. This was designed to draw out emotional reactions, experiences and thoughts about the change processes (see Appendix C2). The questions were informed by the existing literature on change process in family therapy and by the existing literature on process methodologies. Particular attention was paid to the fact that all questions from the interview schedule were asked to all members of the family. By allowing participants to pause the recording when they wished, the IPR interviews privileged the participants' subjective understanding. It allowed the participants to dictate when they were having a salient thought or feeling related to the research question. The interviews were recorded onto a digital audio recorder and transcribed. Both IPR family interviews lasted between 90 and 120 minutes.

Once the family IPR interview had been completed, the researcher conducted another group interview with the corresponding family therapy team. This interview was conducted in the same manner as outlined above, with two differences. Firstly, the interviews were conducted in the therapist's workplace (in the family therapy suites), as these were the only available places to convene the whole team. Secondly, the moments of the video recording that were played back to the family therapy team were those selected by the families (in accordance with IPR

principles). The feedback from the families about the family therapy session was not shared. The interview questions followed a slightly different interview schedule (which was also informed by the existing literature, but had more of a focus on therapist process – see Appendix C3). The interviews were recorded onto a digital audio recorder and transcribed. These interviews were between 60 and 90 minutes long.

Transcription and data protection

In accordance with the NHS ethics guidance and university guidelines on data protection, participants' data was kept secure at all times. Both audio and video recordings were stored in a locked filing cabinet. The video recordings of the family therapy sessions were destroyed immediately after the IPR interviews, and audio recordings of the IPR sessions were immediately uploaded to a password-protected computer. All identifying details were removed, as the audio recordings were transcribed and participants were given a reference number which was attached to their transcriptions. All transcription files and NVivo files were encrypted and password protected to maintain data security. Participants were given a pseudonym in the final analysis that bore no resemblance to their real name.

Data analysis

The approach taken in the analysis followed Braun and Clarke's six phases of thematic analysis (Braun & Clarke, 2006). For the purposes of analysis, the data was initially treated as three data sets:

1. Prospective semi-structured interviews with family therapists
2. IPR interviews with families
3. IPR interviews with family therapy teams

The three data sets were analysed separately, with a full analysis (to the level of themes and sub-themes) of the prospective semi-structured interviews with family therapists being conducted first, prior to an analysis of the IPR interviews. Triangulation of the data occurred in the final phase of the analysis – phase six ("*producing the report*"). This comparative process was conducted with all data sets in parallel. This phase was strongly informed by Patton's (2015) guidance on mixed-methods triangulation, which observes that there is a common misunderstanding that triangulation should demonstrate consistency in results.

Patton encourages researchers to appreciate that “*understanding inconsistencies in findings across different kinds of data can be illuminative and important. Finding such inconsistencies ought not to be viewed as weakening the credibility of the result, but, rather, as offering opportunities for deeper insight*” (Patton, 2015, p. 661). Thus, care was taken that the initial analysis of the IPR data did not seek to confirm or disconfirm the findings from the prospective interviews, but was approached independently.

In the first phase of the analysis (“*familiarising yourself with your data*”), the data was transcribed and the transcripts reread for accuracy. At this stage, notes on ideas and features of the data set were also made. During phase two (“*generating initial codes*”), initial ideas were generated about the data, and codes were created that described the data and also interpreted it (see Appendix D1). The whole data set was worked through systematically and coded very broadly. In this stage there was no limit to the amount of codes a data extract could have. In the case of the prospective family therapists’ interviews, a more theory-driven approach to the analysis was adopted, meaning that not all of the content of this data set was coded – only that which related to the research questions (although at this stage I kept a very broad definition). The data was coded using the computer software programme NVivo, which allowed for collation of codes. Phase three (“*searching for themes*”) involved sorting the codes into potential themes. This was also done in NVivo, which allowed for multiple iterations of different groupings of codes into potential themes. At this point a great deal of time was spent considering the differing relationships between codes and themes and between different possible themes. This included considering possible sub-themes and main themes (see Appendix D2 for examples). Copies were kept of the possible groupings at each stage so that nothing that was considered was lost.

In phase four (“*reviewing themes*”), a process of refining themes began, moving between the candidate themes and the coded data to check if they could be considered meaningful categories in their own right or whether they needed to be collated with another theme. This involved rereading all the data extracts within a candidate theme and deciding whether together they formed a coherent pattern. If some of the data extracts did not fit, consideration was given to whether they needed to be moved to another theme or discarded. It also involved considering whether the

themes worked in relation to the whole data set. This meant coding and recoding any data that had been missed in the initial steps. The next phase (“*defining and naming themes*”) was about clearly defining and naming themes so that they captured the essence of the data and presented a “*concise, coherent, logical, non-repetitive account of the story*” (Braun and Clarke, 2006 p. 93). The final phase (“*producing the report*”) is presented in the analysis section. The supervisory team were involved in all aspects of the data analysis process. They read all transcripts and commented on emerging codes and themes. They gave feedback on the emerging themes and encouraged me to reflect on my own position to the data. In doing so they helped me to maintain a reflective stance and enhanced the quality and rigour of the analysis.

Rigour and reflexivity

This research project has been influenced by Morrows' (2005) guidelines on quality and trustworthiness in qualitative research as well as Tracey's (2010) conceptualisation of best practice in qualitative approaches. The topic selected was widely researched before being chosen, and consideration was given to its significance and relevance. Particular attention was paid to coherent use of methods that connected with the research questions, and several approaches were discussed and researched before the methodology was chosen. The use of methodological and data triangulation aids rigour by ensuring appropriate and sufficient sampling strategies, and there was a clear theoretical rationale for the methodological and analytic approaches taken (Tracy, 2010). Credibility has been enhanced by the use of thick descriptions and concrete details in the analysis and the fact that codes and themes were regularly checked with the supervisory team.

With regard to reflexivity, it is an expected tenet of qualitative research that the researcher is as engaged in the research as the participants. Gathering and analysing data in qualitative research involves making sense of people's experiences and stories; as such, the experience and views of the researcher are acknowledged to influence how material is presented (Berger, 2015). However, Shaw (2010) argues that because we always experience and interpret the world from our own unique perspective, we should integrate a reflexive attitude into qualitative research. In order to integrate a reflexive stance into the research project, I thought about my own values and biases right from the start of the research project. I outlined my initial assumptions regarding the research in a reflective research journal (Braun & Clarke, 2013) and throughout the research journey deliberately sought alternative perspectives about my project (for example from professional colleagues, fellow students and thesis supervisors).

Both Finlay and Gough (2003) and Etherington (2004) argue that, while having an awareness of previous knowledge and experience is useful, it is also important to accept the impact that this will have on a research project. Both authors also suggest that it is incumbent on the researcher to both embrace their own values and beliefs and share these with the reader. This enables readers to have a clearer understanding of a researcher's motivation for the research, assumptions and

presuppositions. Thus, at this point, it is important to make clear my own position to the research and to understand and make transparent how my perspectives and personal and professional experiences might contribute to my understanding of the data (Madill et al., 2000; Morrow, 2005; Morrow, 2007; Polkinghorne, 2005; Shaw, 2010).

My initial interest in the research questions came from my professional background as a couples counsellor. I have training in systemic approaches (as part of my couples counselling training), and I have practised a systemic approach when working with couples for over seven years. For several years I have also had an interest in family therapy, and as part of my doctoral training I undertook a placement with a family therapy team in a child and adolescent mental health service. I feel that the interactional nature of an individual's psychological problems is often overlooked in one-to-one therapies such as cognitive behavioural therapy (CBT) (which I also practise), and as a counselling psychologist I believe our relationships with others (particularly within our family) are key to good psychological functioning. During my doctoral training, I became aware that individual approaches to therapy dominated both the psychotherapeutic evidence base and the National Institute for Health and Care Excellence guidelines on approved talking therapies (Stratton & Lask, 2013).

As part of my doctoral programme, I conducted a second-year research project investigating how Relate family counsellors operationalised their practice of family counselling (Smith, Moller & Vossler, 2015). During this research, Relate family counsellors discussed what it was they thought they did (in practice) and what theoretical models they were informed by. This research developed my interest in understanding how practitioners talk about their practice and whether it relates to theories of practice and standards of competencies. As a trainee counselling psychologist, I was at this point learning CBT and was made aware of the competencies for practice (Roth & Pilling, 2008), as well as being assessed on those competencies using the Cognitive Therapy Scale-Revised (CTS-R) (Blackburn et al., 2001). However, I was also aware that in my local NHS trust there was no routine monitoring of patient outcomes, nor was there any monitoring of therapists' competencies or skills development with the use of video or audio recordings. This led me to become interested in what qualified and experienced therapists were doing

when they did therapy. These experiences, together with my interest in systemic and family therapies, are combined in the current research study.

Given my previous knowledge and experience, I acknowledge that my professional and theoretical constructions will influence my assumptions about the process of change in family therapy. As previously mentioned at the start of this research project, I made a note of my expectations and assumptions about family therapy, family therapists and the study itself. Through this process, I acknowledged that I hold a number of biases. This includes a belief that family therapy is efficacious and well liked by clients. My views of family therapists come from past experiences of working with them. I hold assumptions that they are typically warm and empathic practitioners, who have a particular focus on reflective practice. I also hold an idea of what family therapy practice entails, which stems from my training and practice as a systemic couples therapist. From this perspective, I believe that family therapy has an interactional focus and that change occurs when family members are able to see different points of view and shift positions. I have to understand that these perspectives may have had an impact on my research. For example, during interviews I may have given non-verbal responses that indicated approval or disapproval or not followed up on questions that did not match my own views. During the analysis phase, I may have overlooked information that contradicted my existing perspectives or downplayed certain findings. As previously noted, I have tried to counteract this by continually discussing my research with my supervisory team. This was of particular importance during the analysis phase of the project, in which both data, codes and themes were repeatedly shared and discussed with the research supervisory team.

ANALYSIS

The following section gives an overview of the themes that emerged from the three data sets (prospective qualitative interviews with therapists, IPR interviews with families and IPR interviews with therapists).

Several superordinate themes were identified, and the analysis presents the three major themes from the main data set (the prospective interviews with therapists) first. This is then followed by the themes that emerged specifically from the analysis of the IPR interviews. The analysis of the IPR interviews is presented in line with the methodological approach of triangulation outlined earlier, with particular emphasis on commonalities with or divergences from the main data set.

The analysis revealed a number of sub-themes within the superordinate themes, and these are summarised in the table below:

Themes from prospective qualitative therapist interviews:	
Therapist superordinate themes	Therapist sub-themes
Superordinate theme 1: Safe space	1a The importance of a safe space
	1b How to create a safe space
Superordinate theme 2: Perspective taking	2a The importance of perspective taking
	2b How to encourage perspective taking
Superordinate theme 3: Privileging the change	
Themes from IPR interviews:	
Superordinate theme 4:	Therapists: Expressing a clear rationale
Superordinate theme 5:	Therapists: Linking theory and process is difficult
Superordinate theme 6:	Families: Things we found helpful
Superordinate theme 7:	Families: Things we didn't like

Superordinate theme 1: Safe space

The first theme identified in the therapist interviews describes how therapists believed change was facilitated by the creation of a space for therapy that is containing, balanced and trusted by clients. It is presented first in the analysis because the safety of the therapeutic space was seen by therapist participants as a necessary condition for change. The theme is explored from two different perspectives: firstly, and theoretically, safety was presented by therapists as an important concept for which they gave a theoretical rationale; and, secondly, safety was also described in terms of the skills and interventions that therapists used in order to actively promote safety. This perspective was about what therapists thought

they did to create and facilitate a safe space. These two distinct aspects of safety constitute two distinct sub-themes: 'the importance of a safe space' and 'how to create a safe space'.

Sub-theme 1a: The importance of a safe space

The concept of a symbolic safe space was seen as important by many of the therapists. When asked what they did to enable change, therapists often talked about creating a safe environment so that families can "*feel like they can talk openly*" (Lucy). For example, Sandy wanted to "*somehow make it safe for everybody to be able to say what is important for them and what they're struggling with and what's not right*". Similarly Carl wanted to help families "*to be able to talk safely*". Furthermore, families feeling safe was seen as a precursor to any possible change, and there was a recognition that part of the therapist's job was to make it "*safe to do it [therapy]*" (David). The idea that safety is a foundation of change is exemplified in the following extract from Linda, a practitioner with over 20 years' experience, in which she talks about what she felt was important in family therapy:

[that we] are able to provide a space that can contain difficult feelings and won't let things get out of hand, because I think I probably feel as a core of what we offer is that – a safe place to talk about difficult things so that, yes, that would be what I would see as sort of the foundation for couple and family work when I've got more than one person in the room.

Linda's use of the word 'core' emphasises that she sees the creation of a safe space as essential to family work. It can be seen from the above extracts that many of the therapist participants believe that safety is a central factor in enabling any change. Given this, we should not be surprised that several of them also went on to explain why they thought safety was important and were clear about the theories and concepts that informed this.

One of the theoretical concepts that was used to substantiate the importance of safety was that of the secure base being provided by a safe therapeutic relationship. So, for example, Lucy talked about "*the idea of a secure base, or the idea of sort of the nature of the relationship between the therapist and the family being part of the vehicle of change*". Linda also references this when she acknowledged that "*I suppose it's – yes, I think any therapy needs a safe place and, you know, I – the*

way, part of how I would sort of conceptualise that would be in terms of attachment theory and needing a safe base to explore from". 'Safe' or 'secure base' are terms used in attachment theory (Obegi & Berant, 2009). From this theoretical viewpoint, the therapist is a figure who is reliable, attentive and responsive to family members' experiences. By providing a safe therapeutic relationship, therapists enable clients to take a chance on doing something different (Byng-Hall, 2008; Dallos & Vetere, 2009; Obegi & Berant, 2009). This is acknowledged by Sarah, who comments: "*I think the relationship is key, because I guess a lot of the research shows that 50% of it is the relationship, the therapeutic relationship, and that's key*", and she feels that it is "*about how to make it safe enough for them just to take the odd little risk, so they might discover that, you know what? There's another possibility.*" Thus we see that some therapists both stressed the importance of safety and grounded it in the theoretical idea of a safe (or secure) therapeutic relationship within which exploration of risk is less threatening.

Many therapists also wanted to stress the importance of a good therapeutic "*relationship*" or "*alliance*" (Eve) with all members of the family when it came to acknowledging the importance of safety and describing the components of this relationship. Therapists appeared to feel that an important aspect of a safe space in family therapy was the "*relationship you build with the family or about how there's more than one person, and the complexity that that brings*" (Lucy). Linda also acknowledges the importance of this: "*the thing about family work is you've got to create that space for more than one person at the same time, when sometimes what is safe enough for one of them feels unsafe for the other*". This differing approach to the therapeutic alliance is best exemplified in the following extract from Eve's interview, in which she stresses the need for "*thinking about everybody*":

Well I think it's the taking account of other people, and that might sound very obvious but it's very different to individual therapy where you can ally particularly with somebody and go gosh that sounds really terrible, without thinking about the impact of that alliance on other people ... that that person has relationships with. That's very distinct in family therapy. The alliance is very, very different, that's about thinking about everybody so that if you're working on changes that one person might be making it's all about how that might be impacting on everyone else and vice versa. That feels very distinct and important to think about.

Here Eve discusses the importance of being able to hold in mind the effect of her alliance with one person on everyone else in the family. This is seen as “*distinct*” because an intervention with an individual may well have a differing impact on different members of the family. Having already acknowledged the importance of a safe therapeutic relationship, the above extracts demonstrate how family therapists conceptualise this relationship as needing to be thought of differently in family therapy.

Sub-theme 1b: How to create a safe space

The second sub-theme, ‘How to create a safe space’, focuses on therapists’ descriptions of what they thought they did to create a safe space in therapy sessions. These skills and interventions were described in terms of both approaches that were specific to family therapy, and generic therapy skills and techniques.

Having described the creation of a therapeutic alliance with everyone as being unique to family therapy, therapists also talked about how they used neutrality as a key strategy in promoting this alliance, as Sarah describes.

I suppose in terms of a good therapeutic relationship, it’s about the challenge of being able to engage people so that they feel that you’re interested in them – the concept of neutrality, that you’re not going to take sides, that you are going to be able to see it from a range of different points of view.

This non-blaming neutral approach is seen as a key concept in creating a safe therapeutic alliance with everyone in the family for many of the therapist participants. As Carl comments: “*neutrality is really important, and I couldn’t imagine being any other way really*”. Neutrality was seen as promoting efforts to create a safe therapeutic alliance with all family members, because, as Lucy explains:

The relationship’s really important and I suppose in that I’m covering lots of a, you know, the – the centrality of some of the concepts that the early systemic family therapists were using, about neutrality, hypothesising circularity; that neutral position about taking – feeling so that everybody feels they are being heard but also that you’re not taking sides.

Like Sarah, Lucy stresses the importance of “*not taking sides*”, suggesting that therapists believe utilising the concept of neutrality enables them to remain balanced

and fair. This balance is in turn seen as important in promoting a good therapeutic relationship with all members of the family – an important factor in creating a safe space.

Another skill which therapists described as specific to family therapy was the ability to control conflict and manage emotion. The key to this was an acknowledgement that *“in couple and family therapy it’s actually about hearing, as a therapist, hearing everybody but also helping the people in the room hear and listen to each other”* (Linda). In order to facilitate everyone being able to *“hear and listen to each other”* (Linda) and to *“somehow make it safe for everybody to be able to say what is important for them”* (Sandy), several therapists placed emphasis on their ability to manage the affective climate of therapy – or, as Sarah described it, to *“be able to be containing in terms of emotions”* (Sarah). Some therapists went further, explicitly discussing how they contained problematic interactions and emotions. For example, Linda mentioned *“stepping in to manage conflict”* and Sarah described how *“a lot of the work is around managing the emotions”*. In other words, to make it safe enough for everyone to be able to discuss their concerns, therapists felt they had to be able to manage difficult exchanges. Sandy talked about the specific things she might do in order to achieve this: *“it’s about being prepared to sort of signal ... I often use hand signals to signal that they need to stop this.”* She also mentioned *“setting ground rules or negotiating ground rules”* and being quite clear in sessions: *“I often will say, ‘I just need to stop you there because I’m finding what you’re saying is quite scary. Did you know that you can come over that way?’”* From these examples we can see that sometimes therapists used specific skills and techniques to control the level of conflict and emotion so that the safe space was maintained.

As well as the skills that therapists identified as important in creating a safe space and which they felt were specific to family therapy, therapists often talked about therapy skills and attributes which are found in all models. For example, when Sandy was talking about how she encouraged trust, she commented that *“there’s lots of little things that you can do, which is like using their own terms, their words, their understandings; feeding that back, being in their frame of reference, showing ... demonstrating that you’ve understood, feeding back stuff. There’s umpteen multiple basic counselling techniques that you use”*. Therapists talked about trying to convey a sense of safety through being warm and inviting, getting to *“that sort of position*

where it's professional but it's warm, it's sort of enabling, it's safe" (Sarah). There was a suggestion that this was not about following a particular theoretical model but about "relying a little bit more, I suppose, on slightly, I don't know what you would call them, slightly softer kind of therapeutic skills which are about engaging people" (Lucy). Other therapists described particular common therapeutic skills, such as empathising. For example, Sarah talked about "understanding how awful it is, [which] is an important part. Sometimes they really need you to understand that because nobody's ever done that."

In summarising safe space, it is clear from the therapists' narratives that creating a safe space is an important aspect of the therapy process for family therapists. They are aware of the importance that the therapeutic relationship plays in creating this and are clear about the complexities of trying to create a safe therapeutic relationship with every member of the family (as opposed to an individual). Mindful of this, they also give an account of the skills that they use to try and promote a safe space. The next theme describes how therapists believe they used the platform of a safe space to encourage change through promoting perspective taking.

Superordinate theme 2: Perspective taking

The second superordinate theme, 'perspective taking', acknowledges the emphasis that therapists placed on encouraging families to acknowledge different perspectives. As with the previous theme, therapists discussed perspective taking theoretically, i.e. 'why perspective taking is important', and in terms of their practice: 'how I think I encourage perspective taking'.

For therapists, clients' perspective taking is seen as key to change. This can be seen not only in the multiple ways in which it is discussed (see below), but also in the emphasis placed on it. As David puts it: "*I think that, for me, the understanding perspective-taking part is the bedrock of change.*" Therapists talked about it being "*really, really key*" (Kate) and "*in everything I do*" (Linda). It is of such importance that one therapist participant (Lucy) seems to suggest that it is an overarching aim in the majority of her therapeutic work with families:

I think it would be fair to say that in most situations and aspects what I would be trying to achieve would be to sort of get people to take a different position in relation to themselves and the other people in the family. So yes, so to be able to

take a different perspective, to be able to ... or to be a bit more flexible in their kind of perspective, if you like.

With perspective taking seen as so important, it is not surprising that many of the therapist participants were also keen to expand on the rationale for perspective taking and what they did to promote it.

Sub-theme 2a: The importance of perspective taking

The sub-theme 'The importance of perspective taking' explores two main rationales that therapists gave for their focus on perspective taking. Firstly, they suggested that it encourages flexibility; and, secondly, they believe it encourages families to work collaboratively to do things differently.

Encouraging flexibility was one of the reasons therapists gave when asked why perspective taking was important. Therapists' narratives suggest that problems often occur in families when they become "*stuck*" (Linda) or "*that sometimes people are in too rigid positions*" (Kate). Encouraging flexibility was seen as important in changing this. For example, when Sarah talks about why she feels perspective taking is important, she focuses on an aim of lessening rigidity:

People only change when they become less certain of the positions they hold, and the difficulty is when people are stressed then they hold more rigidly onto the positions they hold. So it's not about – you're not – you can't make people change, you can only work with them to invite them to find some ways.

Sarah's use of the word "*invite*" implies she encourages flexibility because she cannot "*make people change*", suggesting perhaps that she introduces different perspectives to "*work with*" the family. There is a sense that in a session the focus on different perspectives would be about encouraging or inviting flexibility as opposed to rigidity. This invitational approach is also echoed in Sandy's thoughts on perspective taking as a process by which "*meanings*" will be "*softened and heard and felt differently*". This promotion of flexibility over rigidity is best exemplified in the following extract from Lucy:

It's almost like, I suppose, there's a sense in which developing curiosity and interest and people being slightly questioning of their own thoughts, behaviours,

whatever, and someone else's is actually part of that process of freeing people up from sort of entrenched positions or entrenched ways of thinking.

Another reason given for the importance of perspective taking was that it encouraged families to work together to do things differently. Lucy makes this link when she comments on family members taking an observer position:

It feels like what they are doing is they are being able to slightly stand outside themselves and stand outside their interactions and relationships and be observers of their own situation in order to then potentially do something different.

Here Lucy identifies the link between being able to take a different perspective and the possibility of doing things differently. Therapists' narratives showed that they hoped that by encouraging families to see each other's point of view or "some sort of negotiation between perspectives" (David), they would increase the possibility that families will get "joined up behind the problem" (Linda). Thus perspective taking is presumed to enable the families to negotiate and agree to do something different, as demonstrated by David's thoughts about promoting change:

I'm hoping people are able to see this, that there's a possibility of flexibility, that it doesn't have to be my way or your way, that we can negotiate something that's different that could possibly work for both of us.

The idea here is that being flexible enables family members to acknowledge one another's viewpoint and that this adaptability increases the likelihood of collaborating to do things differently. Thus, therapists justify their focus on perspective taking in terms of its impact in creating behaviour change for clients. The rationale for encouraging different perspectives seems to be about increasing flexibility, with the hope that this will free up families to behave and act in a different way.

From the above examples, it can be seen that therapists believe that encouraging different perspectives is seen as an important factor in change. From this position, the analysis also begins to provide an explanation of what therapists felt they did to encourage perspective taking.

Sub-theme 2b: How to encourage perspective taking

One way in which therapists thought they encouraged perspective taking was by inviting families to consider different positions: "I suppose successful therapy would

invite them to consider that you can have a range of possibilities” (Sarah). In this way, therapists saw themselves as trying to get families “to get a better understanding of their patterns and inviting them to be more curious about some of their beliefs, or each other’s beliefs, or each other’s behaviour” (Lucy). Lucy goes on to give a detailed account of how she might invite family members to consider different perspectives:

[It’s] about then getting people to talk about what might be going on in their heads at each point in that interaction for them each, so that’s about getting, I guess, two people’s thoughts and assumptions about the other person in that situation, and very often the suspected assumptions of each partner are very different than actually what the other person is experiencing, or feeling, or thinking ... So that’s, you know, I suppose a very literal way of kind of getting people to take a sort of outsider kind of perspective.

When reflecting on the specific techniques they used to encourage families to consider different perspectives, several therapists described using particular types of questions. For example, Carl suggested he would “*always try to make sure that I’m including as many people in the room as possible when I’m asking a question, you know, kind of how that affects other members of the family*”. There were a number of references to what therapists called “*circular questioning*” (Kate) or “*interventive interviewing*” (Carl). For example, Linda listed questioning techniques like “*checking out meanings, checking if people have heard each other, checking if what they’ve said surprises the other one, checking out what people think the other one thinks*”. These were seen as tools that helped families to “*hear and listen to each other’s*” perspective (Linda), as illustrated in this extract from Kate:

‘Would you describe this the same or differently as this person?’ ... So those kind of circular questions or that checking out other people is helpful I think for relationships and that people ... I don’t think everybody always ... I think people forget to talk or ask or just assume that they know and that helps relationships to go, ‘Oh, I didn’t know that’ or to hear something that the other person’s holding or to hear how the problem’s affecting other people.

Here Kate gives an example of how she might use questions to bring out into the open the (as yet) unspoken thoughts of a family member. Therapists frequently

reported that they would use questions to bring out into the open all perspectives in the hope that this allowed each member of the family to hear the other members' positions.

In these accounts offered by therapists, perspective taking is seen as important to the change process. Therapists believe this is because it increases flexibility and encourages families to do things differently. Therapists also hope that perspective taking helps families compromise and solve their problems. They see themselves as facilitating perspective taking by inviting families to consider different positions, and feel that they do this by asking questions that are circular and reflective in nature.

Superordinate theme 3: Privileging the change

The theme 'Privileging the change' encapsulates therapists' beliefs about the importance of noticing change and the ways in which they thought they emphasised and affirmed change.

It was clear from the therapists' narratives that "*this is about change*" (Sandy) and that they were focused on making change happen. This is exemplified in Carl's statements about his overall aims: "*Overall what am I trying to do? I'm trying to implement change, I guess that's kind of obvious.*" This focus on change was so strong that Sandy even went so far as to suggest that she would probably not work with a family if they "*just want to dump and they don't want to change*".

As well as focusing on making change happen, therapists were very clear that they were "*looking for opportunities*" (Clare) to talk about the families' narratives around change. This seemed to be about noticing examples of change that they would then discuss with families: "*So I suppose part of it is also, I think, I ... I think I am trying to help people to notice and story the changes they make*" (Kate). It was also clear that therapists were trying to notice the changes that the families were reporting rather than create a therapist-led story about change. As Sandy comments, it's "*about being in alongside them, hearing what is changing and softening and double-checking all the time where they want to get and what that change means*". This is exemplified by Carl, who thought it was:

Really important for them to feel like they've devised this and to keep looking back at those outcomes and checking out with them at the end of the session – 'How far do you think we are towards getting there now, you know, reaching this and

making you feel safer or wherever it is?’ So I think that’s a really important thing to help encourage change.

Therapists also talked about what they thought they did to emphasise and affirm the change. Drawing attention to change was felt to be very important because it was *“bringing to the fore what’s actually going quite well and getting people to think about that”* (Lucy). This emphasising of positive change was an explicit focus for several therapists who talked about trying to *“promote change”* (Carl). There was an idea that it was not simply *“celebrating change”* (Linda) but about *“noticing when things are changing and sort of trying to amplify it”* (Linda). This technique of underlining and strengthening change is best summarised in the following extract from Kate:

And I think it’s very affirming you know there’s a lot of noticing positives. Like you put a lot of emphasis in highlighting and noticing kind of things that seem to be quite ... Yeah those positive affirmations, I think that’s pretty powerful for people to hear.

Kate feels that emphasising the positives is very meaningful for families, and thus she places great importance on *“noticing”* and *“affirming”* them.

We can see from the above extracts that one of the things that therapists felt they did to encourage change was to explicitly notice when change was happening. They also believed that it was important to reinforce any positive change by affirming examples of change.

Themes from IPR interviews

The first three themes presented in the analysis are from the prospective qualitative interviews with family therapists and highlight what therapists say they feel is important and intended in their practice, and what they do to facilitate this. The second part of the research examines family therapists’ and their teams’ perspectives on therapy as it actually happened in a family therapy session using IPR interviews. Furthermore, the perspectives of the families themselves are also explored using IPR. This data is used as a form of triangulation for the first analysis and is presented below in four main themes. The remainder of the analysis presents these themes with particular emphasis on areas of convergence or divergence with the themes previously identified in the prospective interviews. In other words, the

second part of the analysis provides a comparison of what therapists say they do and how with what they and their clients observe within therapy.

Family therapy team IPR interviews

Superordinate theme 4: Expressing a clear rationale

The family therapy team IPR interviews give examples of both convergence and divergence with the original accounts of family therapists' practice. This is encapsulated by the fourth superordinate theme, 'expressing a clear rationale' (on the one hand), and the fifth superordinate theme, 'linking theory and process is difficult' (on the other hand).

The superordinate theme 'expressing a clear rationale' describes how the family therapy teams were able to reflect on the process of therapy and make clear links between their actions and intentions in sessions. The practices they recognise they are engaging in within the sessions converge with some of those identified by the family therapists in their prospective qualitative interviews. Perhaps most clearly, family therapists in the IPR interviews were focused on encouraging perspective taking. For example, there were several instances across both recorded sessions where family therapists talked about "*giving other perspectives*" (Sandy, as part of Therapy Team 1). This was particularly the case when therapists were asked about the intention behind an intervention. So, for example, Lucy (as part of Therapy Team 2) reflected that "*I suppose what you're saying in terms of the intention, the something about broadening out of perspective*". Linda (as part of Therapy Team 1) was also clear about her intention during a moment in the therapy session when she said:

It's all about trying to open up different perspectives. It's kind of responding to what he said, it's, it's (pauses). I'm kind of thinking of this triangle of trying to, trying to draw out what it is that she wants to say in the face of him going 'What?', 'I didn't know, it looks different from where I sit'.

Here Linda describes her aim of encouraging perspective taking as she discusses trying to get Rose (the woman in Family 2) to voice her thoughts in order that Peter (the man in Family 2) can hear her point of view. Perspective taking is also given as an aim by Sandy (as part of Therapy Team 1), who, when asked about a particular moment in the session, stated that she was "*trying to clarify who is communicating*

what to whom and how they do that in a way that each of them understands what was there". Importantly, the analysis of the therapists' reflections on sessions seems to suggest that therapists not only talk prospectively about the importance of perspective taking and what they do to make it happen, but that they also clearly identify examples of this focus in their practice.

In addition to recognising moments of encouraging perspective taking, therapists were also able to provide a clear rationale for other interventions. For example, Nicola (a member of the reflective team in Team 1) gave a very clear explanation for an intervention in the following description:

It is also a really concrete way of being able to notice change. What is it that other people are saying, is sometimes just a bit easier. I guess I'm also kind of conscious of it's also a way of reaffirming what they are doing differently and that that seems to be helpful. Yeah and that's often helpful I guess in terms of getting people to talk about and I guess really kind of clarify what are you doing differently.

This explanation for a therapeutic intervention exemplifies ideas about privileging the change. We also see a concrete change-focused rationale given by Sandy (as part of Therapy Team 1): "*The more they talk about how it's working, the more they reflect on what has been helpful.*" This idea of getting families to reflect on exactly what had been helpful is exemplified by Sandy later on in the session with Anna and Mark:

Sandy: That was me being transparent with attention that I felt from me. But also very aware the more I say, am I missing anything or is there anything else? They will always come up with something. I always want to check that I'm not cutting off ...

Interviewer: When you say 'thickening up their skills', what do you mean?

Sandy: For me, the more they talk about how it's working, the more they reflect on what has been helpful and what hasn't and what is really good and what they're celebrating. As they're talking about that they are getting more confidence and understanding about this is what has been happening and that makes it more real.

It seems that therapists are clearly able to articulate occasions when they are privileging change in their sessions. Consistent with the ideas therapists articulated in their prospective interviews, they also reasoned that the intention of doing this was to provide an opportunity to discuss the detail of the change process and thus reinforce this for families. The analysis of the therapist IPR interviews thus suggests that therapists can, at times, give a clear rationale for their focus. It also shows, importantly, that there are areas of convergence with their prospective interviews regarding these rationales. Thus, in part, the IPR analysis suggests that what therapists say they do to promote change is also what they believe themselves to be doing in practice.

Superordinate theme 5: Linking theory and process is difficult

Despite the previously identified convergence, it was not always the case that family therapy teams and the family therapist within them were able to give a clear rationale for their practice. Thus, this theme outlines the difficulties family therapists sometimes had in explaining what they did in sessions. A close reading of the family therapist IPR interviews reveals that family therapists sometimes struggled to provide a clear theoretical justification for the interventions when reviewing examples of their therapeutic work.

Family therapists' struggles to provide a theoretical rationale can be seen in their hesitant language and in the moments in which they found it difficult to communicate confidently. There are for example moments in the narrative in which experienced therapists would qualify their responses. Thus, Lucy (as part of Therapy Team 2) was tentative when she replied, "*So I suppose that's the intention*", and Linda was also unsure when she offered a rationale for a particular intervention, saying, "*I suppose it's about moving on*" (Linda, as part of Therapy Team 2). This uncertainty is most evident in the following exchange in which Lucy was asked to reflect on a particular moment from the recorded therapy session.

Interviewer: What was your thought about why it would be useful?

Lucy: I suppose now you said that, it isn't only about him, it is about her as well. In terms of trying to get her to be clear in her own mind, what is that that is holding her back? Again I think it was about this idea of how do we facilitate them getting to a point where their conversations happen and feel safer. And so if she's

saying in session 'I'm aware I feel kind of cautious', I suppose it feels quite important to know what that is about. And whether there are things that she or Peter could do differently, do you know what I mean? I suppose it links to what we are trying to achieve in the session which was, umm, you know, how it evolved anyway, which was around, you know, what is the nature of these conversations and how can they happen and how can they both feel okay about having them? I suppose it links to that.

In this section, Lucy's use of language is tentative: she "*supposes it links*", and she "*thinks it was about*". She also seeks to have her ideas confirmed: "*do you know what I mean?*" There is also a suggestion that this tentative language may be because Lucy is struggling for a post-hoc rationale for the intervention. She opens by saying, "*I suppose now you said that*", which seems to suggest her response is framed in the here and now rather than from the perspective of her intention in the session.

The other way in which therapists' difficulties in giving a theoretical rationale are expressed is by therapists focusing on the position of the clients as opposed to their own process. Despite careful structuring of the IPR interviews and the use of process-focused questions, when asked about their interventions, family therapists often responded by focusing on the content of the family therapy session or talked about the family members' actions (either in the session or from previous sessions). For example, they noticed that "*I've not really observed that dynamic before of him sitting back so much*" (Linda, as part of Therapy Team 2), or they are curious about what the family members are doing: "*I suppose it's interesting she was, just watching it back, she thought about it quite carefully and I suppose she was quite clear about, and she was not locating the problem in Peter either*" (Lucy, as part of Therapy Team 2). This tendency to focus on the family's material rather than the question being asked (about their therapeutic intent) is exemplified in the following section, in which Linda was focusing on describing the family as opposed to discussing her hoped-for intention.

Yes, one of the things it's really interesting about this couple and family is that they are basically very supportive, very articulate, very together. They do a lot of talking. And the result of that is that in the early sessions we had the daughter there and she

was so helpful that we had to get her out of the sessions. Because we couldn't do any therapy, because she was so busy trying to mediate between her parents. So it's like because they, part of that dynamic is being protective of Rose (the mother) in a way that is actually becoming disempowering, I think, would be a way of putting it.

Here we see Linda using the IPR interview as another opportunity to reflect on and analyse the family. This tendency to think about the clients (and their patterns and interactions) made it difficult at times for therapists to reflect on their own process of therapeutic practice and make links between theory, practice and interventions.

The analysis shows that sometimes family therapists found it difficult to give a clear rationale for actions and interventions in therapy sessions. This was expressed through hesitancy, but also through a tendency to talk about other things (such as what the families were doing at a particular moment in the session). Throughout the IPR analysis the superordinate themes reveal that there is both convergence with and divergence from the theories and practices that the therapists thought were important for change in their original interviews.

Families' IPR interviews

An analysis of the families' IPR interviews reveals that there are discussions about moments that facilitated change and that were experienced as helpful (superordinate theme six, 'things we found helpful') and also sections of the narrative in which they discuss things that they experienced as unhelpful (superordinate theme seven, 'things we didn't like'). The sixth theme from the IPR data, 'things we found helpful', comes from the families and encapsulates the actions and attributes of the family therapy teams that families experienced as helpful in encouraging change. This theme illustrates areas of convergence with the prospective qualitative therapist interviews. Importantly, the analysis shows that the themes of 'safe space', 'perspective taking' and 'privileging the change' are represented within 'things we found helpful'.

Families' IPR interviews, superordinate theme 6: Things we found helpful

The families' narratives frequently touched upon how helpful they had found particular moments in the sessions. Participants were readily able to identify moments and reflect on their value. For example, Mark (the male partner in Family 1) commented that a particular intervention "*was incredibly helpful*" and Anna (the

female partner from Family 1) responded to a section of the tape by pointing out that “*that was great*”. Similarly, in Family 2, the participants were able to notice moments that were “*totally different and very helpful*” (Rose, Family 2).

When asked to expand on the detail of what was helpful and the processes underlying this, the families were able to give a clear account of what they found helpful, much of which tallied with the aspects of therapy that therapists thought promoted change. For example, having a safe therapeutic space seemed to be something that was important in families’ narratives. Peter (the male partner in Family 2) talked about the relationship between the family and the therapy team and how they “*got to know each other and we got an arena that I should say feels fairly safe*”. There were also moments where family members recognised that they felt safe, as Mark acknowledged in the following extract:

I was worried about bringing up these things that had been worrying me that I hadn’t wanted to talk about. But I always felt safe discussing things in that environment. So I didn’t think I was sort of bringing back the past, it was always a safe place to say look you know this happened.

Here Mark seems to suggest that a safe place allows him to discuss even “*worrying*” thoughts and feelings. In another example, Rose talks about how feeling safe allows her not to worry about getting upset:

Certainly in terms with me with safety, in thinking if I get really upset it doesn’t matter here. Whereas in some situations it would. In terms of, I don’t know, self-respect, pride or whatever. I just feel that this is a very nurturing environment.

Mark’s use of the word “*worry*” and Rose’s reference to getting “*really upset*” both suggest that feeling safe encourages them to express emotion. This may be why a safe space is seen as important in families’ narratives, and certainly has some resonance with therapists’ previous assertion in the prospective interviews that it is important for them to manage the affective climate.

Families’ narratives also provided examples of helpful moments in therapy that were focused on perspective taking. For example, Mark picked out a perspective-taking intervention when he noticed that Sandy had asked “*have you understood what the other person is saying*” (Mark quoting Sandy). He found this helpful because “*she’s*

actually narrowed it down again to say, okay, well now you're using the word which might mean different things to different people". Mark also commented on a helpful moment in the session by reflecting that the therapist was "just trying to just do a kind of checks and balances on the communication, you know, make sure that what I was saying and what Anna was hearing was the same thing and vice versa". When asked why a particular intervention was important, Rose responded by saying: "I think it's the way the questions, I think it's the way [family therapist] Linda persists with the questions ... but there's also the feeling that Peter is listening." Thus, for Rose, there is something important about how Linda's questions enable her to voice her perspective in front of Peter. For Anna, the perspective-focused interventions go beyond just enabling her to give voice to her views and are more about having an interpretive function. She describes how the family therapist Sandy "tends to just intervene just at the right time and just sort of translates what we are trying to say to each other that's quite amazing really". It seems that what's important for Anna is that Sandy is able to summarise or rephrase her words in such a way as to enable Mark to understand her perspective.

When asked to provide more detail about why interventions were helpful, family members often talked about perspective taking as enhancing communication and understanding. Or, as Mark puts it, it's about "*ensuring that that communication is that what's transmitted and what's received is the same*". Mark acknowledges that this explicitly came from the work with the family therapy team: "*She [the family therapist] did get us to check with each other. Again this is sort of the obvious thing. You know the truism, make sure you understand what someone is saying, rather than what you think they're saying. But she made us do it.*" The benefits of this are best summarised in this extract from Anna:

I think I said in this session that that had been a game changer. You know that getting ... Because she had got Mark to understand that I love him and that I'm going to stay with him and he hadn't heard that from me before. We just assumed something, he'd just assumed that [the] future wasn't certain. I don't know what you heard but she managed to make Mark listen to me, what I was really saying and that really changed things.

The use of the phrase “*game changer*” highlights the significance of being heard and understood to Anna. There is an emotional resonance to her words here, which seems to suggest that she really valued the therapist’s attempts to help Mark hear what she had been saying. In this example, Anna describes how her and Mark now have a joint understanding of her love for him, suggesting that they now have a shared perspective on this particular aspect of their relationship.

Another area of convergence between families’ perspectives and the prospective therapists’ interviews was the recognition of privileging change. Families talked about this in two ways. Firstly, they felt it was important when therapists noticed change. Families noticed when they have been asked about change, and in their IPR interviews they often focused on sections of the session where this was happening. For example, when asked why she found a particular intervention important, Rose replies that “*I think it was just her asking how is it changed?*” The families’ narratives also seem to suggest that without the therapist’s interventions, they would not normally focus on how things have changed. For instance, in the following extract, we see Mark talking about a particular intervention Sandy had used to ask about change.

She said, ‘What are the things that were worrying you before? Is it different now to how it was then?’ And it was so different from how it was then that I remember saying, ‘Wow! Did I really say that?’ She said, ‘Are you, so do you still think the children are frightened of you?’ And I thought that hadn’t even crossed my mind. I’d clearly said it and I’m sure it was true at the time. And that was a really useful intervention so I remember that moment jolly well.

What appears to be important here is the explicit asking of the question and the therapist’s attempts to draw Mark’s attention to what was different. The impact on Mark is that he begins to think about what had been problematic (“*Wow! Did I really say that?*”) and consider how different things are now. He recognises that without this intervention the difference wouldn’t have “*even crossed my mind*”. Moreover, as he later admits, without this process “*what Anna was feeling and all the behaviour she was seeing and all that kind of stuff would have gone undiscussed*”.

Secondly, aside from noticing the change, families also found therapists’ efforts to emphasise and amplify the change helpful. Families saw this as a process in which

they felt that the progress was being confirmed and strengthened. Mark in particular centred his account on how the emphasis on change in the session helped him to understand what had changed and how. So, for Mark, it was “*quite good in a way to actually examine how you have dealt with things*”. In the following extract, he clarifies a process by which Sandy’s emphasising of change helps him acknowledge what he has done differently:

In each of those three moments what she is really doing is just tying back what you’re saying to a previous moment and what you felt and thought then. And then saying, ‘So, right, is there change?’, or if there is, what sort of change? So that is kind of the common thread that she is stitching back through time, and then you can compare and contrast things in a way in which you might not otherwise do.

Here we see Mark’s process laid out. With Sandy’s guidance, he is reflecting in detail about his thoughts and feelings, so that the detail of the change is clearly defined. This clearly aids Mark’s ability to crystallise exactly what he has done to make the change happen. The process seems to be at the core of what has been helpful about the family therapy for Mark (which is perhaps why it was a strong theme in his narrative about the session). This is exemplified in the following extract:

You are not going to spend the rest of your marriage with Sandy there. So you are going to have to do a little bit of Sandy yourself, aren’t you? And if you can take that tool that you’ve been given and see that there is value in saying where are we now, where were we then, what’s different, what can we draw from that or how might we do things in the future – well, that’s useful.

The analysis will now examine sections of the IPR interviews which were divergent from the perspective qualitative interviews.

The seventh theme from the IPR interviews comes from the families’ IPR interviews. ‘Things we didn’t like’ describes the aspects of the family therapy sessions that families found unhelpful. In particular, it describes how not being heard and feeling that there was a bias had implications for the therapy process.

Superordinate theme 7: Things we didn’t like

The superordinate theme ‘things we didn’t like’ explores the aspects of family therapy that families found unhelpful. The analysis reveals that the men in both

families felt that they were not attended to in a balanced way. Whilst therapists profess to work hard to ensure balance and neutrality, the male narratives would suggest that they do not always achieve this. For example, Peter (from Family 2) found parts of his session frustrating and expressed often feeling like he would say things that were not attended to, leaving him wondering if *“I wasn’t explaining it very well or people weren’t listening to me”*. Peter also acknowledged that he *“got frustrated”* when the therapy team did not attend to what he was saying. This is expressed most strongly in the following extract in which he is commenting on his thoughts regarding a series of exchanges in session: *“Please will someone hear my voice! I remember thinking right there, I’ve just given you something which I think is fairly factual and please will someone hear me.”* Peter’s frustration is evident. He clearly feels unheard and he later admits to *“consciously giving up on the particular track that I was trying to go along”*. Thus, the perception of being unattended to has the effect of preventing him from participating.

Mark in Family 1 also expressed frustration when he perceived a lack of balance in how his therapist attended to him and his partner. For Mark, this was most pertinent when he felt his behaviour had become too much of a focus in the session, as seen in the following account:

I’m on the spot for almost all of the session almost all of the time. And a lot of it is ‘Mark has done this and it had an impact on us,’ and ‘Mark is not managing this very well, and he’s not communicating this very well’. Look I’m on the spot all the time. So quite often I feel a bit sort of defensive and a bit angry.

This extract demonstrates that the perceived lack of balance in how family members are attended to creates quite a strong emotional reaction from Mark. He becomes *“defensive”*, intimating that he is less likely to be open and share difficult thoughts. As the above extracts illustrate, there are times when the men in the families feel that they are not heard or treated equally, and this contributes to moments when they do not experience the therapeutic encounter as balanced and neutral.

As well as not feeling equally heard and attended to, Peter’s narrative also highlights moments when he feels his perspective is not taken into account. This is exemplified in a series of exchanges in which Peter addressed his partner Rose and talked about how his therapist (Linda) *“was agreeing with you quite strongly on the things you*

were saying. And generally not agreeing with me.” Peter felt his perspective was not given any prominence and goes so far as to say *“If one were to run back one would find that several of the things that I said quickly got dismissed.”* This lack of recognition of his perspective is not seen as helpful. In fact, Peter described his therapist’s inability to acknowledge his perspective as *“pretty unhelpful”* and having the effect of making him feel that he was *“on a parallel universe”*. The above extracts suggest that when therapists don’t demonstrate to family members that they hold *“other people’s points of view in mind”* (Family Therapist: David), this can be experienced very negatively. This is in contrast to times when family members feel heard and comfortable enough to open up to the invitation to take a different perspective.

Summary

The aim of this study was to explore the links between theory and practice with regard to the process of change in family therapy. The study has yielded a rich data set from both the individual prospective interviews with therapists and the IPR interviews with both families and therapists. The thematic analysis outlined above has demonstrated that therapists shared a common understanding of the change process in family therapy and saw a number of things as important in promoting change in their practice. The three main themes that were identified as being important in change were ‘safe space’, ‘perspective taking’ and ‘privileging the change’. Furthermore, a thematic analysis of the IPR interviews demonstrated that families observe a number of important moments in therapy which map to the themes identified by therapists. Therapists are also able to notice and describe moments in their actual therapeutic practice that exemplify the themes they identify as important. However, there are also moments in sessions that families find unhelpful and are not in keeping with what therapists claim to do in their practice. There are also times when therapists struggle to articulate what it is they do in practice.

DISCUSSION

The aim of this research project was to investigate how change is understood and operationalised by family therapists. An additional aim was to generate an account of how closely these concepts match what therapists do in practice and whether families experience them. The analysis provides evidence to suggest that family therapists understand the process of change in several ways. The data yielded three themes that therapists saw as relevant to the change process: 'safe space', 'perspective taking' and 'privileging the change'. The thematic analysis of the IPR data also suggests that therapists recognise these factors in their own practice. In addition, what families felt encouraged change also maps onto the themes from the qualitative interviews. However, the IPR analysis also suggests that making the links between theory, practice and interventions and actions is difficult and that therapists' accounts of their practice did not always match how families experienced therapy. The links between these findings and the existing research base are explored below. The discussion also examines the implications for practice, strengths and limitations of the study, and recommendations for further research.

The discussion is structured so that the three themes from the main data set and links between any commonalities within the IPR data set are examined first. The divergent data from the IPR data set is then discussed separately.

Overview of findings

'Safe space' findings from qualitative interviews with therapists and IPR interviews

The analysis of prospective interviews clearly shows that a safe space was seen by therapists as an important factor in the change process. This supports previous research conducted in the US, in which safety has been highlighted by both therapists and clients as an important precursor to change. For example, in a qualitative analysis of couples' perspectives on change, Christensen, Russell, Miller, and Peterson (1998) found that couples felt that safety was an important precondition to change. Bowman and Fine (2009), in a similar study on couples' perceptions of helpful factors, identified the helpful aspects of what the authors called the "*therapeutic atmosphere*" (Bowman & Fine, 2000, p. 299) – amongst these

were trust in the therapist and safety in the session. From therapist perspectives, Blow and Sprenkle's (2001) research, which used a Delphi methodology to explore marriage and family therapists' concepts of change, reported that: "*The panellists believed that one of the crucial roles of the therapist is to provide a context of warmth and safety in which therapy can take place*" (Blow & Sprenkle, 2001 p. 393). This is also reflected in the resulting factors that were reported as important, such as "*the alliance between therapist and client*", "*a client's trust in the therapist*" and the "*strength of the therapeutic relationship*" (Blow & Sprenkle, 2001). In Davis and Piercy's study, both therapists and clients from several different family therapy approaches were interviewed about change, with both sets highlighting safety as an important factor. Therapists thought that safety was important, and client accounts mentioned feeling safe (Davis & Piercy, 2007).

As well as being clear that safety is an important factor in change, therapists also discussed *why* they thought safety might bring about change. They believed that safety operated through the context of the therapeutic alliance and the provision of a secure base. Therapists inferred that by providing a safe therapeutic alliance or safe space, they would enable families to risk doing things differently. There is some evidence in the literature that supports this view.

Although the therapeutic alliance and the concept of a safe or secure base are two separate constructs, there is an emerging consensus that there is an overlap in how they might operate in relation to encouraging change. For example, Holmes (2001) conceptualises the therapeutic alliance as an attachment bond that shares many of the parameters of a secure base. Likewise, the System for Observing Family Therapy Alliances (SOFTA) is a tool for evaluating the alliance in couples and family therapy (Friedlander et al., 2006) . Two of its four dimensions (emotional connection to the therapist, and safety within the therapeutic system) share characteristics of a secure base. Trusting that the therapist "*is there*" for the client, that the relationship is based on affiliation, trust, care and concern, and that the client has a sense of comfort are defined aspects of SOFTA that map with the concept of a secure base as someone (i.e. a therapist) who is consistently available, responsive and emotionally attuned (Friedlander et al., 2006).

The notion that change operates through the safe and secure components of the therapeutic relationship is also suggested by proponents of attachment narrative therapy, who state that “*change is facilitated when people feel safe and secure*” (Dallos and Vetere, 2009, p14). The suggestion is that safety is an aspect of the therapeutic alliance that may be important in change because of its ability to encourage exploration of new thoughts and emotions in much the same way a safe attachment figure might. The current study supports this theoretical viewpoint with two possible explanations. Therapists may be using the construct of a secure base to inform what they believe they do in practice. Alternatively, therapists’ experiences as practitioners may be leading them to believe that providing something akin to a secure base is a helpful factor in the change process.

This study also found that therapists believed that creating a safe therapeutic alliance with everyone in the family was an important aspect of facilitating change. These findings mirror previous research, which suggests that splits in the alliance (for example in which one family member has a strong alliance and others don’t) are an impediment to change (Coutinho, Ribeiro, Hill, & Safran, 2011; Escudero, Boogmans, Loots, & Friedlander, 2012; Muniz de la Pena, Friedlander, & Escudero, 2009). It also supports Escudero et al. (2008), who claim that safety within the therapeutic system as a whole is an important contributing factor to change in family therapy. In their recent research (which has moved beyond using individual therapy constructs of the alliance towards creating a systemic understanding of the alliance), they see safety as a particularly important component of the systemic alliance (Friedlander et al, 2006). A recent empirical study of families’ conceptualisations of the systemic alliance offers evidence that supports this position (Escudero et al., 2008), suggesting that it is important to create a safe therapeutic relationship with each member of the family.

As well as advocating for the importance of safety, therapists also described how they would try and promote safety by being non-blaming and neutral, by managing conflict and emotion, and by using interpersonal skills. Neutrality is a key concept from the influential Milan school of systemic therapy (Cecchin, 1993) and involves the therapist being careful not to judge one family member over another or ally with one grouping or member within a family (Stancombe & White, 2005). The principle of not taking sides is seen as key in creating a therapeutic alliance with all members of

the family, but there is little existing literature that specifically examines how a neutral stance operates in terms of effecting change. However, the findings from the current research do echo research by Christensen et al. (1998) on the process of change in couples therapy. In that study, clients (in this case couples) were asked to comment on therapist interventions and the factors that facilitated change. One of the factors that couples thought was important was 'fairness', which was described as being balanced and not taking sides, and seeing both points of view (Christensen et al., 1998). This would seem to support the view that neutrality is important in creating safety.

Family therapists' skills in managing conflict and emotion are more widely discussed in the literature regarding the therapeutic alliance and safety. This focus is unsurprising given that what a person says or does in the therapy room may jeopardise another family member's sense of safety. Where therapists' participants talked about managing emotions and conflict as a way of encouraging safety and promoting change, they support the suppositions made by Friedlander et al., (2006) who believe that managing the heightened emotions that can occur in sessions is an important therapeutic skill. Friedlander et al., (2006) propose that the family therapist's ability to manage interfamilial blame and hostility is central to the creation of a safe therapeutic alliance. There is some empirical support from the literature on this position. Two recent studies indicate that couples therapists who successfully manage attempts at blaming and hostility increase the likelihood of positive change (Bradley & Furrow, 2004; Furrow et al., 2012). However, in the current study, managing emotion and conflict is described in terms which suggest therapists see it more as a precursor to change rather than part of the change process itself.

The IPR data also reflected the theme of 'safe space'. Family perspectives confirmed the importance of safety in their experiences. Families demonstrated an awareness of the importance of safety both in moments when they felt safe and on the occasions in which they did not. Although it is not clear from this study exactly how (in practice) therapists made families feel safe, the results do give some indication of how family therapists might jeopardise safety. In particular, this study would suggest that not being acknowledged and perceiving a lack of balance contribute to family members feeling unsafe. Therapists' actions that precipitate this include not responding adequately to a family member and focusing on the actions of one family

member over another. Interestingly, this tallies with what family therapists believe is important in how they create safety (using balance and neutrality to enable a therapeutic alliance with everyone). It is also in accordance with previous research that has looked at helpful (and unhelpful) factors in couples and family therapy, which suggests that clients in family therapy value balance and neutrality (Bird, Butler, & Fife, 2007; Bowman & Fine, 2000; Davis & Piercy, 2007a). The current study also echoes previous research which suggests that family members can become frustrated and dissatisfied with the process of therapy if they perceive their therapist to be biased (Bischoff & McBride, 1996; Bowman & Fine, 2000; Kuehl et al., 1990).

‘Perspective taking’ findings from qualitative interviews with therapists and IPR interviews

The findings from the current study demonstrate the importance of perspective taking in the process of change in family therapy. This is highlighted not only in therapists’ beliefs about their practice, but in families’ and therapists’ descriptions of family therapy sessions.

Therapists’ emphasis on perspective taking is in accordance with a central concept in family therapy, which is that family therapy should encourage a relational conceptualisation of problems (Carr, 2006b; Dallos & Draper, 2010; Sprenkle et al., 2009). This central concept posits that family therapists should use a systemic framework to encourage families to view problems as interactional and reciprocal rather than located in an individual. It is therefore not surprising that encouraging perspective taking is seen by therapists as important in the current study. These findings mirror those of Davis and Piercy (2007), who asked couples therapists about what they thought was important for change. In their study, they found that therapists believed it was important to encourage each partner to see how their thoughts, feelings and behaviours might influence the other (Davis & Piercy, 2007). They called this conceptualising difficulties relationally (Davis & Piercy, 2007).

Family therapists also indicated why they thought perspective taking was important for change, citing aims of encouraging flexibility and instigating behaviour change. This too is in accordance with the theories of change proposed by several schools of family therapy, including strategic and structural approaches, the Milan school, and

narrative approaches (Carr, 2006a; Dallos & Draper, 2010). The current findings are also supported by a recent meta-synthesis looking at families' perceptions of family therapy. Chenail et al. (2011) reviewed and synthesised qualitative studies of families' conceptions of family therapy. Their research found that families noticed changes in how they thought about themselves and other family members as well as changes in behaviour and communication. Families' accounts from the meta-synthesis suggested that insights into different perspectives allowed them to become more reflective about others' positions. They also described how changes in how they viewed things led to changes in how they did things, often seeing this process as reciprocal (Chenail et al., 2011). This mirrors therapists' accounts of their rationales for promoting perspective taking in the current study.

Findings from the families' IPR interviews contain some complementary data regarding the importance of perspective taking. Taken together, the present study adds to the existing conceptualisation of perspective taking and relational conceptualisation in the change process. The results show that families notice perspective-taking interventions in the family therapy sessions. They also indicate that families see perspective taking as an important factor in the process of change. The results also give an indication of *how* families believe perspective taking is helpful. It appears that families respond to particular invitational questions (in which therapists phrase interventions so as to invite families to think about things differently). Families suggest that they find these particular perspective-taking questions helpful because taking up this invitation assists them to understand one another better. This joint understanding seems to increase the bonds between family members. Thus a perspective-taking intervention may well operate by encouraging understanding and empathy.

By beginning to make links between therapists' conceptions of how perspective taking encourages change and how families experience therapists' interventions on perspective taking, the current study allies with Davis and Piercy's (2007a, 2007b) research. Their research demonstrated that disrupting dysfunctional relational patterns and conceptualising problems in relational terms was both an important aspect of change for couples therapists and something that couples noticed as important to change (Davis & Piercy, 2007a, 2007b). Both these constructs involved an element of perspective taking followed by a move to greater understanding and

flexibility and ultimately a change in behaviour. In Davis and Piercy's study, clients reported a greater awareness of the interactional cycle and their role in it and a move towards seeing things differently and doing things differently. The current research would support a similar process occurring in family therapy. Therapists encourage perspective taking by asking particular questions that enable family members to hear and understand one another. Families respond to these questions and understand things differently, and this in turn may promote the possibility of doing things differently.

'Privileging the change' findings from qualitative interviews with therapists and IPR interviews

The analysis demonstrates that 'privileging the change' is seen as key in promoting change in family therapy. Therapists talk prospectively about the fact that they feel that they actively look to notice and amplify change and talk about the specific things they might do to achieve this. The analysis suggests that therapists are deliberately looking for examples of change. When change is mentioned, they use the opportunity to ask questions about the detail of the change with the hope that they may enable the family to reflect on what they are doing differently and what the impact of that might be. This approach resembles the techniques advocated by proponents of solution-focused therapies (Macdonald, 2007; Trepper, 2012). In this approach, therapists work towards identifying families' strengths and resources by searching for exceptions to the problem and then examining the skills used to highlight the potential for change (Franklin, 2012). Although 'privileging the change' clearly maps to the theories of change and interventions used in solution-focused therapy, only one of our family therapists identified themselves as following a solution-focused model. Thus the findings from the current study would suggest that family therapists have integrated aspects of the solution-focused model into their work.

The current study also provides evidence to illustrate not only that family therapists think that 'privileging the change' is important in change, but that it might be an important aspect of *how* change occurs in family therapy. We see this from the families' IPR interviews. In families' accounts of their sessions, they notice and discuss moments when they believe their therapists have highlighted and amplified change. Families appear to experience this as important because they feel that their

efforts are being confirmed, and this strengthens both their understanding of the process of change and their motivation to carry on implementing change. Families also find exploring the detail of change important, as this helps crystallise the exact nature of the change. These findings mirror the findings from the therapists' IPR interviews in which they discuss their rationales for interventions in session. When reflecting on moments in sessions that families have identified as relating to privileging the change, family therapists talk about trying to notice change and to get families to reflect on the detail of what is working.

These findings are in accordance with the literature on change processes within solution-focused family therapy (Lloyd & Dallos, 2008; Metcalf & Thomas, 1995). Lloyd and Dallos' (2006, 2008) two-part study examined both the content and process of an initial solution-focused family therapy session as well as the perspective of the mothers who took part in that study. A thematic analysis of the content of the session revealed that therapists focused on competencies and achievements (Lloyd & Dallos, 2006b). In an exploration of the mothers' reflections on the same first session, the research revealed that the session brought to mind ideas about "*making the best of it*" (Lloyd & Dallos, 2008 p14). A key component of this idea was that when therapists enabled mothers to reflect on achievements, they increased their feelings of self-efficacy and worth. Similarly, Metcalf and Thomas (1995) looked at the experiences of solution-focused therapy from the perspective of six couples and their therapists. They asked both therapists and clients about the role of the therapist and what helped the most in terms of questions and interventions. One key finding was that couples found that a focus on the positive aspects of their relationship was helpful. They also reported that the therapist focusing on moments when they got along better and asking about what was going well was helpful (Metcalf & Thomas, 1995). The results from the current study appear to be consistent with the existing evidence base regarding aspects of change within solution-focused therapy, but they also reveal that these aspects are found in the practice of therapists who would not necessarily identify themselves as solution-focused practitioners.

Divergent themes from the IPR interviews

Things we didn't like

The analysis of the families' IPR interviews revealed that there were times when families' experiences of therapy did not ally with family therapists' professed practice. In the main, these divergent accounts reflected moments in which families felt they were not heard and acknowledged. They also reflected moments in the session in which they perceived a lack of balance or that their perspective wasn't taken into account. Families expressed their frustration regarding these moments. There is also some evidence to suggest that lack of balance might have had the effect of causing a family member to withdraw. This diverges with what family therapists believe they do prospectively, and we find no suggestion in the therapists' IPR interviews that they felt their interventions were unbalanced. So whilst therapists profess to use neutrality and balance to create a safe therapeutic alliance, there were occasions where clients did not experience the therapists' approach as balanced.

This finding of a mismatch between client and therapist accounts of practice is not unexpected given previous research which suggests that therapists' perceptions of how well therapy is progressing are often incorrect (Hannan et al., 2005). In fact, a recent review of the research on the therapeutic alliance across all therapeutic modalities by Hovarth and Bedi (2011) suggests that there are significant differences between clients' and therapists' ratings of the alliance. In addition, research from individual-orientated therapies suggests that therapists' and clients' accounts of the overall process of therapy often do not tally. In a study of 40 therapist–client pairs, Llewelyn (1988) asked both therapist and client about what was helpful and unhelpful about their therapy session. A combined qualitative and quantitative analysis revealed significantly divergent accounts. Of note is the fact that the greatest mismatch between accounts occurred in those therapist–client pairings in which the outcomes for the client were the poorest. Thus, although the finding from the current research is not unexpected, it is important to note, given that a strong therapeutic alliance is one of the best predictors of outcome in family therapy and that a lack of neutrality may impact the alliance (Escudero et al., 2008).

The accounts of divergence were largely from the male family members, and it is worth considering the possibility that gender was playing a role in creating a split family alliance. Families that experience disparate alliances with their therapist tend to do less well in treatment (Johnson & Caldwell, 2011), and the existing literature has explored this phenomenon with respect to gender (Blow, Timm, & Cox, 2008). In

a review which looked at the role of therapist gender in therapeutic change, Blow, Timm and Cox (2008) concluded that the gender of the therapist (and this interaction with differing gender configurations of families) had little direct effect on outcomes. However, gender is a factor in help-seeking behaviours, with women more likely to identify the need for family therapy (Cauce et al., 2002). This may then influence how positively men and women view therapy. Therapists may also unwittingly conform to gender-role stereotypes, and there is evidence to suggest that therapists respond differently towards defensive positions depending on whether the family member was male or female (Brown-standridge & Piercy, 1988). The current study provides no conclusive evidence for either view. It is possible that gender may play a role in a family member's perception of a family therapist's balance and neutrality. It is also possible that therapists respond differently to family members according to gender and thus instigate differing alliances.

Linking theory and practice is difficult

The current study reveals that there are times when family therapists struggle to articulate the process of their practice and make links between theoretical models or concepts and their interventions. This finding offers a new insight into how therapists make links between theory, practice and process. It suggests that it is not always easy for family therapists to reflect on their practice and give a clear rationale for their actions. Understanding how family therapists reflect on their practice and make use of evidence-based theories and techniques *in* practice is not something that has been empirically evaluated in family therapy process research. However, there have been several authors who have reflected on their own practice, and these accounts would support some of the difficulties of having a constant and coherent approach which links theoretical models and practice (Flaskas, 2005; Rycroft, 2004). In a discussion of the relationship between theory and practice in family therapy, Rycroft (2004) suggests that theory can "*abandon us*". Rycroft (2004) also acknowledges that sometimes practice is influenced by personal style, values, beliefs and other aspects of our world view and argues that theories and models only go so far to provide solutions. It is possible therefore that one explanation for the difficulties therapists sometimes experienced in giving a theoretical rationale for their practice is that they do no practice in a theory led way.

In considering explanations for why linking theory and practice is difficult, we can draw on some of the evidence from other psychological therapies and knowledge bases. Bennett-Levy, in his model of cognitive therapists' skills acquisition and reflective practice, suggests that there are three systems in operation: declarative knowledge, procedural skills and the reflective system (Bennett-Levy, 2006). In his model the reflective system makes the links between declarative knowledge (for example about theories of change in family therapy) and procedural skills (the actions and practical interventions of therapy) (Bennett-Levy, 2006). The IPR interviews were designed to provoke therapists to observe and reconstruct moments in therapy as well as engage in elaboration, self-questioning and analysis (Larsen et al., 2008). This would be likely to encourage the use of all three systems. Bennett-Levy argues that the more skilled and experienced a practitioner becomes, the less they use conscious declarative knowledge. Additionally, in expert therapists, procedural knowledge becomes more automatised, and reflection in action is key (Jennings & Skovholt, 1999). This would suggest that expert therapists are less consciously aware of their use of theoretical models and use procedural skills more tacitly, which may explain the difficulties and hesitations that our expert family therapists had in recalling their motives and models during the IPR interviews. Models of the acquisition of expertise and decision making from social and cognitive psychology, such as pattern recognition and unconscious thought theory (Benner, 1984; Dijksterhuis & Nordgren, 2006; Peña, 2010), support the idea that experts' performance can be unconscious and automatic in nature. As this implicit knowledge is not always fully accessible, it can be difficult to give a coherent verbal account of implicit knowledge (Dienes & Perner, 1999). This literature further supports the idea that experts (such as the family therapists interviewed for this study) often practise in ways which are automatic and implicit and thus may find it harder to give an account of their decisions.

An alternative explanation as to why family therapists found it difficult to link theory and practice comes from an understanding of the tradition of reflective practice in family therapy. Reflective practice is seen as integral to contemporary family therapy practice (Stedmon & Dallos, 2009). The primary mode of reflective practice is through the use of reflecting teams (Stedmon & Dallos, 2009). The exact detail of this practice can vary, but the essence of the approach is that a reflective team (who

have observed a family therapy session) offer feedback, reflections and different perspectives to the family and family therapist at the end of the session. The process is active, with the family having a chance to respond to the reflections (Pender & Stinchfield, 2012). In general the focus of these reflections is on the family's interactions and processes, and they are *not* conceptualised as an opportunity to reflect on the therapist's practice (Brownlee, Vis, & McKenna, 2009; Friedman, 1995; Pender & Stinchfield, 2012). Thus, for family therapy teams, reflection on sessions is primed as an activity whose focus is the family, and they are unfamiliar with therapist process being a focus. As the IPR interviews were conducted in the family therapy suites (for pragmatic reasons) and the team was convened to watch a family therapy session, we might reasonably assume that the family therapists were primed to respond with family-focused reflections. This may provide a partial explanation as to why interviewees often used the IPR interviews as another chance to analyse their families.

The difficulties that family therapists sometimes experienced in reflecting upon and articulating the process of therapy in terms of theory and practice may also have been exacerbated by the dynamic between interviewer and interviewees. As a trainee counselling psychologist, I was aware of my novice status in relation to the qualified family therapists that I was interviewing. Having reflected on this, I acknowledge that it is possible that I was tentative in my attempts to maintain a focus on therapist process during the interviews due to my status as a trainee. There is a small evidence base that acknowledges the power imbalance between trainees and qualified psychologists as supervisors and the impact that this can have on a trainee's practice (Nelson & Friedlander, 2001). This literature acknowledges that trainees self-moderate their behaviour with supervisors (for example by choosing what to disclose and by trying to exhibit desired behaviours) (Olk & Friedlander, 1992). Although I was not consciously aware of any overt reluctance to press my interviewees to become more focused on process, on reflection this may have been a factor in the interview process.

Implications for the theory and process of change in family therapy

As outlined above, the current study confirms previous research which highlights the importance of creating and maintaining a safe therapeutic environment in family therapy practice. It suggests that it is a necessary condition for any change to occur.

Yet this is an underdeveloped area in the theory of change in family therapy. The exceptions to this are the theories and frameworks in attachment narrative therapy (ANT) (Dallos & Vetere, 2009, 2014). In ANT there is an explicit focus on creating a safe base as a precursor to change, and a clear theoretical rationale is given which offers an explanation of why this might be important. Other approaches to family therapy and research which articulate an integrated approach (for example Pote et al. (2003) do not appear to give prominence to the importance of safety (Pote et al., 2003). Safety and the therapeutic relationship is also not promoted in the literature on the competencies and skills required by family therapists. For example, in the recently published competencies to practise systemic therapy, building a trusting relationship with clients is listed as a generic competency, with little detail given on the skills and knowledge this requires beyond “*the ability to maintain an even handed stance*” (Pilling, Roth, & Stratton, 2008, p. 16). The implication of this is that the theories of change in family therapy need to incorporate a greater focus on safe therapeutic relationships, as the growing evidence from research in the field suggests that for families this is important. This supports the recent focus (in both practice and theory) on the importance of attachment and suggests that integrated approaches such as ANT may have much to offer contemporary family therapy (Dallos & Vetere, 2009, 2014).

Greater acknowledgement that safety is a factor in change should also encompass a renewed focus on the nature of the multiplicity of therapeutic relationships in family therapy. The current study confirms the importance of creating and maintaining a safe therapeutic alliance with each member of the family. This requires attending to multiple alliances, for example with each family member, with a subsystem of the family (e.g. the couple, or children) and with the family as a whole. The importance of attending to balance and neutrality as a means of fostering multiple alliances is an important theoretical construct in the family therapy literature. The current study suggests that this theoretical idea does translate into practice and that neutrality and balance may well be important in facilitating the process of change.

As previously discussed, most schools and models of family therapy promote perspective taking as a means of facilitating change. Taken together with previous research, the current study strengthens the argument that this aspect of the theory of change is both conceptualised and utilised by family therapists. In the context of the

practice of family therapy in the UK, this study provides evidence that competencies from the national competencies framework – such as an ability to “*promote development of new perspectives*”, to use circular interviewing to “*explore different views, beliefs and feelings*” and to “*promote increased understanding*” – are being utilised by practitioners on the ground.

The current study also provides some evidence to suggest that for families, the process of change involves being able to see different perspectives, which facilitates doing things differently. Taken together with existing research, this begins to suggest a consistent narrative about perspective taking. Perspective taking can be seen as an important factor in theories of change, the application of these theories by therapists in their interventions and the process of change for families.

Theories of change in family therapy already include a focus on privileging change. Much of this focus comes from the influence of solution-focused ideas on family therapy, although exploring exceptions can also be seen in narrative therapy approaches. The findings from the current study would suggest that family therapy as practised in the UK has incorporated and integrated aspects of solution-focused and narrative therapies with respect to privileging the change. This gives support to the idea that therapists facilitate change by “*attending to the strengths and solutions in the stories that the family system brings to therapy*” and that “*once change is beginning to occur, therapists highlight this process to families, enabling them to develop further changes and develop their understanding of how change was possible*” (Pote et al., 2003, p. 34).

The analysis also begins to shed light on how families experience privileging the change, suggesting a process of reflection and rehearsal of things that are different. This maps onto the theoretical rationales given by proponents of the solution-focused approach as to why a focus on exceptions promotes change (Franklin, 2012). The theory states that detailing the change allows clients to construct a rich and well-specified alternative story and that this detail helps solidify the changes (Bond, Woods, Humphrey, Symes, & Green, 2013; Metcalf, 1996). The current study is supportive of the idea that this process happens in practice and that therapists are aiming to encourage this process in their interventions.

The findings from the current study have particular implications for the debate about integration versus model-specific ways of practising. The 'common factors' debate (as it has been called) centres on understanding what is responsible for therapeutic change. Proponents of model-specific answers to this question suggest that change occurs because of the unique ingredients of a therapeutic model. Common factors advocates suggest that the mechanisms of change are the same across all effective therapeutic approaches (Sprenkle et al., 2009). Although there is strong evidence to suggest that common factors (such as the strength of the therapeutic relationship) account for a great deal of change, the field of family therapy has placed a great deal of store in the importance of models of practice (Flaskas, 2005; Sprenkle & Blow, 2004; Sprenkle et al., 2009). Sprenkle and Blow (2004) argue that there are common factors that are unique to couples and family therapy, and whilst models are not irrelevant, they are only important because they offer a framework for practice through which common factors can effect change.

Since all but one of our family therapists self-identified as operating from a theoretical stance which integrated differing models of family therapy, the current research offers an insight into the claims made by common factors proponents. The first thing of note is the finding that family therapists working in the UK are integrated practitioners. This is perhaps not surprising given that AFT's current training requirements state that family therapists should be able to integrate several models (AFT, 2011). Importantly, the current study provides evidence to suggest that an integrative approach *is* being practised on the ground. In addition, the current study is the first to examine, with reference to the change process, how this integrative framework is operationalised in the field. These findings (previously outlined) would appear to offer some support for the common factors approach to change in family therapy. Sprenkle, Davis and Lebow (2009) suggest four factors that are common across all models of couples and family therapy in terms of promoting change. They are: conceptualising difficulties in relational terms, disrupting dysfunctional relational patterns, expanding the direct treatment system and expanding the therapeutic alliance (Sprenkle et al. 2009 p. 34). The first two factors align with 'perspective taking' and the second two with the aspects of 'safe space' that relate to creating a safe space with all family members. The current study offers evidence to suggest not just that these factors are believed to be important by family therapists, but also that

therapists believe that they use them in their practice and that families feel they are important. Thus the current study would tend to support the common factors model as proposed by Sprenkle et al. (2009).

Recommendations for practitioners, training providers and professional bodies

There are three areas of consideration for practitioners, training providers and professional bodies. These are reflective practice, promoting a safe space and feedback-informed practice.

A somewhat surprising finding from the current study is the difficulties family therapists sometimes had in reflecting on their therapeutic practice. As already highlighted, there may be several reasons why this occurred, but it should be considered in terms of implications for practice. Practitioners of family therapy should consider the methods they use to reflect on their practice and the possibility that there is a bias towards offering reflections on the family as opposed to reflecting on practice. This could be addressed by utilising IPR in supervision. IPR has been used as a reflective tool in supervision in one-to-one modalities (Bernard, 1989). Reflective capacity could also be enhanced by a focus on this process during training. Training organisations should consider incorporating using IPR-type supervision exercises as part of their training programmes. Professional bodies might also consider the idea of IPR supervision as a component of continuing professional development.

The findings highlight the importance of safety within the therapeutic space, and they also reveal that there are times when families do not feel safe. Further research is needed to ascertain if these findings are generalizable. In the interim, training organisations and professional bodies need to place a greater emphasis on equipping family therapists with the skills and knowledge needed to enhance their capacity to create safety. Further research may also lead to a review of the core competencies required to practise systemic therapy in the UK, as current standards of competency appear to underemphasise safety as a factor in change.

The current study has highlighted that there are times when therapists and families are not in agreement about the process of therapy. Although our family therapists professed to practise in a balanced and neutral way so as to promote safety, there

were times when families did not feel safe and occasions when family members felt overlooked. The family therapy teams did not acknowledge these instances. These divergent accounts are a threat to the outcomes of family therapy, and efforts should be made to address this. The use of routine feedback measures is becoming more commonplace in one-to-one therapies (Duncan, 2010a, 2010b). Measures such as the Session Rating Scale (SRS) explicitly ask clients for feedback on aspects of the therapist's practice (such as therapeutic relationship, approach and method) in every session. Evidence suggests that formal client feedback is far superior to therapists' clinical judgements of the therapeutic alliance and progress in treatment (Duncan, Miller, & Sparks, 2004). Thus family therapists and family therapy services should consider the routine use of client feedback forms (such as the SRS) in order to obtain a good assessment of how therapy is progressing.

Relevance for counselling psychology

The findings of the current study are very relevant to counselling psychology in terms of both practice and research. Counselling psychology seeks to emphasise the subjective experience of individuals and also seeks to understand inner worlds and individuals' constructions (Woolfe, Dryden, & Strawbridge, 2003). It privileges the notion of "*being with*" rather than "*doing to*" clients (Woolfe et al., 2003, p. 11). These values and principles are similar to those espoused by researchers and practitioners of family therapy, but in addition, counselling psychologists embrace a scientist practitioner model (Sauer & Vespia, 2006). Thus, the current research presents a challenge and an opportunity for counselling psychologists to work with family therapists to promote ways of working which are integrated and relational in focus.

Whilst the values and principles of counselling psychology and family therapy are undoubtedly of benefit to families, they stand in opposition to the dominant model of practice within NHS mental health services. Within the NHS, mental health services are largely informed by the medical model (Beecher, 2009). This model emphasises diagnoses of an illness and privileges biological explanations for mental ill health. The medical model places much less emphasis on contextual factors such as life events and factors such as gender, culture and class (Jackson, 2006). Counselling psychologists, who alongside their understanding and valuing of contextual factors

have expertise in generating evidence-based-practice accounts of therapeutic work, are well positioned to challenge these models. They also have experience and skills in mediating between different world views and in communicating with colleagues who work from a more medical model (Frankland & Walsh, 2005; Walsh, Cross, & Frankland, 2004). Thus counselling psychologists should feel well equipped to rise to the challenge of influencing services to become more relational and integrated in their approaches to working with families.

Of additional relevance to counselling psychology is the demonstration of the IPR research methodology as a method which has unique potential to bridge the gap between research and practice. IPR is a methodology that is particularly compatible with the ethos and philosophy of counselling psychology, as it can explore the reflections and decision-making processes of both clients and therapists and produces a co-constructed account of therapeutic practice (Larsen et al., 2008; Rhodes, 2012). This makes IPR of particular interest to counselling psychologists, as it enables counselling psychology researchers to investigate both client and therapist perspectives on therapy in great detail. The demonstration of IPR as an applicable research method presents an opportunity for counselling psychologists to adapt this research method for use in their own areas of research interest and gain a unique insight into the detailed processes at play in therapeutic work.

Strengths and limitations of the study

Although the current study provides rich and detailed data from a number of sources to generate an account of the change process in family therapy, it is not without a number of significant limitations, which will be discussed below:

1. Although the sample captured wide-ranging levels of experience in family therapy, there was a high percentage of female family therapists. In addition, all participants were Caucasian. Thus the sample did not represent culturally diverse viewpoints.
2. The data was explored and discussed with the research supervisory team during the analysis stage of the research. This aided research reflexivity and rigour. However, due to limitations of time it was not possible to check the themes with the participants themselves, which would have added a greater level of rigour.
3. The study could be criticised methodologically because of both its sampling strategy and the small sample size of the IPR data set. The IPR elements of the study used a type of chain referral sampling in which family therapists were recruited to the study first, and then families were recruited from those selected therapists' clinics. Inevitably this meant that family therapists could act as gatekeepers to recruitment of families. It is possible that family therapists (consciously or unconsciously) discouraged families whom they perceived as difficult or complex or for whom family therapy was not proving useful so as to maintain an image of competency. This may account for the low number of families recruited to the study. It may also mean that the findings are biased because families who were more distressed or stuck were not able to have a voice in this study. In addition, the small sample size in the IPR data set means that findings that are unique to that data set must be treated with caution.
4. The study was purposefully designed so that the IPR interviews were group interviews. It was hoped that this would stimulate wide-ranging and interactional perspectives, including joint recollections and differences of opinion. However, there is a risk that this approach limited the freedom family members and family therapists had to express themselves. Family members may have wished to reconstruct their thoughts and feelings in a session in order to present a particular perspective. It is possible that family therapists

were also affected by a need to self-monitor what they were saying in a group interview so as to present an image of a competent professional. The interviewers may have thus created a somewhat positive bias in which participants were trying to create a particular narrative around their reactions (in the case of family members) or their actions (in the case of family therapists).

Suggestions for further research

The themes identified in the current study give an indication of what might be important in the process of change in family therapy. Because the study identified several components of change, it is suggested that further research could focus on exploring those factors in more detail. Previously cited literature suggests that these components may already be the focus of the common factors approach to change in family therapy, but as yet there is little empirical research on these factors. Further research is needed to investigate whether these common factors are found in a range of settings and therapeutic approaches, including in practitioners who claim to practise from a more pure model of family therapy.

The study focused on what therapists believed about change and how they put these beliefs into practice; it did not attempt to look at the relationship between change-focused interventions/moments in therapy and outcomes. Thus the study was predicated on *the predictions* of what families thought were currently helping them change. Further research is needed to understand how the factors that may instigate change interact with outcomes. In particular, more research is needed to understand the possible longer-term impact of change-focused interventions.

There is some suggestion from the current study that the family members' gender may have an impact on how therapy is perceived, or perhaps that family therapists behave differently towards family members according to their corresponding gender. One possible avenue of further research would be to examine the role of gender (both of family members and of therapists), by looking at the role and impact of gender pairings on both the change process and on outcomes of therapy.

Conclusions

The study offers an original insight into the complex process that occurs in the practice of promoting change in family therapy. The results have shown that family therapists are informed by three key concepts when thinking about how to promote change in family therapy: 'safe space', 'perspective taking' and 'privileging the change'. This new finding demonstrates that family therapists in the UK employ aspects of theory that are widely discussed in the literature and present in the competencies required to deliver effective systemic therapies in the UK (Pilling et al., 2008). There is also some evidence to indicate that these theoretical constructs have an influence on practice and that they are important to families. These three factors also appear to align with common factors that have been identified in the practice of family therapists in the US.

In addition, the study offers evidence to suggest that, at times, theory and practice do not match and that family therapists find it hard to identify when this occurs. In particular, a lack of balance and a lack of safety went unnoticed by family therapists. Given the importance placed on reflective practice, this finding is somewhat unexpected. As such, this research demonstrates the difficulties of tracking the complex and often implicit and unacknowledged processes that contribute to change in family therapy.

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Appendix A1 Project Approval Certificate NRES



Health Research Authority

NRES Committee South West - Cornwall & Plymouth

Bristol Research Ethics Committee Centre
Level 3
Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone:

0117 342 1330 24 June 2013

Ms Harriet Smith

Relate Avon

133 Cheltenham Road, Bristol

BS6 5RR

Dear Ms Smith

Study title: Mind the Gap- A qualitative study exploring how families and therapists view important moments in Family Therapy.
REC reference: 13/SW/0157
IRAS project ID: 93859

The Research Ethics Committee reviewed the above application at the meeting held on 18 June 2013. Thank you for attending with Dr Naomi Moller to discuss the application.

1. The Committee requested clarification of whether the Chief Investigator had previous experience of obtaining informed consent.

You replied that you had completed ethics training on obtaining informed consent as part of your doctorate and confirmed that you would work to the principles of the British Psychological Society of which you were a member.

2. The Committee questioned what would happen if there was a session in which the family did not identify any key events. The Committee was unsure whether a further session would be held or whether an additional family would be recruited.

You acknowledged that this was a possibility and confirmed that this data would still be useful as the participants could still discuss what they thought worked well and what they thought did not work in the sessions. You clarified that if no key events were identified, you would still need to recruit an additional family.

3. The Committee noted that although the title of the study was to explore how families viewed important moments in therapy, all of the participants in the families would be over the age of 18. It was discussed that this was not representative of what is typically meant by the term family. The Committee questioned why participants under the age of 18 would be excluded, as the value of the study would be limited by excluding younger participants.

A Research Ethics Committee established by the Health Research Authority

You stated that you had been concerned about coercion and obtaining assent by including participants under the age of 18. You explained that you had initially proposed a larger sample but comments from the peer review indicated that the project would take a substantial length of time to complete. You clarified that you had responded to this by narrowing the focus to exclude participants under the age of 18, as including younger participants would have increased your workload as you would have had to recruit across two sites.

4. The Committee was pleased to note that the families would be reimbursed a maximum amount of £25 for their expenses but expressed concern that the professionals would also be paid as conducting the therapy sessions was part of their job.

You explained that you had wanted to compensate the therapists for their time in the same way that the families would be compensated. You stated that the therapists might be involved in the study during their usual NHS employment hours or the study may involve the therapists working evenings or additional hours. The Committee considered this explanation and agreed that expenses for the therapist should only be paid if they were working outside of their usual NHS hours.

5. The Committee questioned whether £25 was the absolute maximum amount which could be reimbursed as childcare costs might be more expensive than this.

You confirmed that this was the maximum amount available as there was no funding in place for the study so the budget was very limited.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further

information, or wish to withhold permission to publish, please contact the Co-ordinator Charlotte Allen, nrescommittee.southwest-cornwall-plymouth@nhs.net.

Ethical opinion

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

NHS 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.

1. Please amend the consent forms in order that there is a space for the researcher to sign and date the form below the participants’ signature.
2. Please amend the title of the study on the relevant documentation to say „family group” rather than „families”.
3. The consent forms should contain a footer to label the documents as to which group they were intended for i.e. families or therapists.
4. The PIS for families should state that a decision not to take part or to withdraw from the study would have no effect on the standard of treatment which they would receive.

5. The PIS for therapists should state that a decision not to take part or to withdraw from the study would have no detrimental effect to their employment.
6. Please amend the PIS for the therapists to state that expenses occurred from taking part in the study outside of their contacted NHS working hours would be reimbursed up to a limit of £25.
7. Please correct the typo in statement two of the consent forms.
8. Please correct the typo in the first paragraph of the poster.

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. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

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

Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study 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 a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

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

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

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		24 May 2013
Evidence of insurance or indemnity		09 July 2012
Other: CV - Ms Harriet Smith		21 April 2013
Other: CV - Dr Naomi Moller		15 March 2013
Other: Recruitment Poster	1	24 May 2013
Participant Consent Form	1	24 May 2013
Participant Information Sheet: Family	1	24 May 2013
Participant Information Sheet: Family Therapist	1	24 May 2013
Protocol	1	24 May 2013
REC application	3.5	24 May 2013
Referees or other scientific critique report	Copy of RD2	05 March 2013

Membership of the Committee

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

There were no declarations of amendment.

Statement of compliance

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

After ethical review

Reporting requirements

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
- Notification of serious breaches of the protocol

- 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.

Feedback

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.

Further information is available at National Research Ethics Service website > After Review

13/SW/0157

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

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

Yours sincerely



Canon Ian Ainsworth-Smith Chair

Email: nrescommittee.southwest-cornwall-plymouth@nhs.net

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" (via email)

Copy to: Ms Leigh Taylor

Dr Julian Walker, Avon And Wiltshire Mental Health Partnership NHS Trust

Appendix A2: Project Approval Certificate, Avon and Wiltshire Mental Health Partnership

NRES Committee South West - Cornwall & Plymouth

Attendance at Committee meeting on 18 June 2013

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Canon Ian Ainsworth-Smith	Retired Hospital Chaplain	Yes	
Mrs Suzanne Lesley Blowey	Clinical Nurse Specialist (Pain)	Yes	
Mrs Sheila Bullard	Clinical Research Project Manager	Yes	
Mr Rich Crowe	Retired Planning Manager	Yes	
Dr Veronica Maynard	Senior Lecturer Postgraduate Clinical Education	Yes	
Mr Louis Pobereskin	Consultant Neurosurgeon	No	
Mr Rory Rickard	Consultant Burns & Plastic Surgeon	No	
Dr Hilary Sanders	Retired Senior Lecturer in Statistics	Yes	
Mrs Sue Smith	Manager, Mustard Tree Centre, PHNT	No	
Miss Rosalyn Squire	Research Nurse	Yes	
Mrs Caroline Theyer	Solicitor and Board Member of Tamar Housing Society	Yes	
Mr Roger Watkins	Retired Consultant Surgeon	No	
Mr Christopher Winfield	Programme Manager	Yes	
Mr Robert Wosley	Research & Quality Manager	No	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Charlotte Allen	Coordinator

Title of study: Mind the Gap : A qualitative study exploring how families and therapists view important moments in Family Therapy.
IRAS ref: 93859
Approval date: 12 July 2013
End date: 09 June 2014

Thank you very much for applying to undertake your research in AWP, we pride ourselves on a straight forward and rapid process for research governance and project management.

We are pleased to advise that we have been able to grant R&D Permission at Avon and Wiltshire Mental Health Partnership NHS Trust (“the Trust”).

We hope that you are successful in your recruitment aims and objectives. Please make sure that you let us know at the end of your study how it went by providing us with a copy of your final report. This way we can ensure those involved within the Trust are aware of your findings and can consider your recommendations. Please send a copy of your final report to research@awp.nhs.uk.

The R&D Permission in the Trust is valid until **09 June 2014**. If you require any extension to this in the future please contact us to arrange.

The documentation listed below has been received and all the relevant governance checks have now been completed.

I am therefore happy to provide R&D Permission for the above study across all locations within the Trust parameters.

Document	Version	Date
Covering Letter		24 May 2013
Evidence of insurance or indemnity		09 July 2012
Other: CV - Ms Harriet Smith		21 April 2013
Other: CV - Dr Naomi Moller	1	15 March 2013
Other: Recruitment Poster	1	24 May 2013
Other: Recruitment Poster	2	25 June 2013
Participant Consent Form	1	24 May 2013
Participant Consent Form	2	25 June 2013

Continued...

Chair
Anthony Gallagher

Headquarters
Jenner House, Langley Park, Chippenham. SN15 1GG

Chief Executive
Iain Tulley

Participant Information Sheet: Family	1	24 May 2013
Participant Information Sheet: Family Therapist	1	24 May 2013
Participant Information Sheet: Family	2	25 June 2013
Participant Information Sheet: Clinicians	2	25 June 2013
Protocol	1	24 May 2013
REC application	3.5	24 May 2013
Referees or other scientific critique report	Copy of RD2	05 March 2013

Please be aware that if there are any amendments to the above documents they must be sent to Hannah Antoniadès, Research and Development Operations Manager for permission prior to use within the Trust.

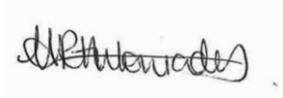
You are reminded that you must report any adverse event or incident whether or not you feel it is serious, quoting the study reference number. This requirement is in addition to informing the Chairman of the relevant Research Ethics Committee. You are also required to submit to the Research and Development Operations Manager (Hannah Antoniadès) a final outcome report on completion of your study, and if necessary to provide interim annual reports on progress. Should publications arise, please also send copies to Hannah Antoniadès for inclusion in the study's site file.

You must also abide by the research and information governance requirements for any research conducted within the NHS:

- Work must be carried out in line with the Research Governance Framework which details the responsibilities of everyone involved in research.
- You must comply with the Data Protection Act 1998 and where required, have up to date Data Protection Registration with the Information Commissioners Office. Where staff are employed, this includes having robust contracts of employment in place and ensuring that staff are made aware of their obligations through training and similar initiatives.
- You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice:
(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253)
- You must have appropriate policies and procedures in place covering the security, storage, transfer and disposal of information both personal and sensitive, or corporate sensitive information. Any information security breach must be reported immediately to the Trust.
- Where access is granted to sensitive corporate information, this must not be further disclosed without the explicit consent of the Trust unless there is an override required by law. Where disclosure is required under the Freedom of Information Act 2000, the Trust will assist you in processing the request.

Please note that, as a public authority, the Trust is obligated to comply with the provisions of the Freedom of Information Act 2000, including the potential disclosure of information held by the Trust in connection with this study. Where a request for potential disclosure of personal, corporate sensitive, or contract information is made under the Freedom of Information Act 2000, due regard shall be made to any duty of confidentiality or commercial interest.

Yours sincerely

A handwritten signature in black ink, appearing to read 'H Antoniadou', enclosed in a light grey rectangular box.

Hannah Antoniadou
Research & Development Operations Manager
Avon and Wiltshire Mental Health Partnership NHS Trust

CC: Ms Leigh Taylor
Dr Julian Walker



**Department of Psychology
University of West of England**

Understanding how family groups and therapists view key moments in therapy

PARTICIPANTS NEEDED FOR RESEARCH

We are looking for volunteers to take part in a study to help research psychologists better understand how families and therapists view key moments in family therapy.

The aim of this research is to improve the provision of family therapy by asking families about their experiences.

As a participant in this study, you would be asked to allow us to video one of your family therapy sessions. We would then interview you using the video as a prompt to help you answer questions about what was important about the session. The interview would take approximately 90 minutes.

In appreciation for your time, you will receive remuneration for any expenses occurred.

For more information about this study,
please contact:

Either your family therapy team or
The researcher: Harriet Smith
(*Department of Psychology, University of the West of England*)
at

07775783303

Email: (harriet2.smith@uwe.ac.uk)

This study has been reviewed by, and received ethics clearance through the NHS ethical review process.

Appendix B2: Participant information sheet, family therapists



University of the
West of England

IN #

Family Therapist Participant Information Sheet

Exploring how family groups and therapists view key moments in therapy

Please take the time to read the following information carefully; if there is anything that is not clear or that you would like more information about, then please do ask.

You are being invited to take part in a research study. Before you decide if you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. We can go through the information sheet with you and answer any questions you have. We suggest this should take about 15 minutes. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the research?

Currently there is very little research that focuses on important moments that might facilitate change in family therapy and this project aims to get a better insight into this process. It also aims to understand what families feel is important in sessions, alongside the therapists' views of the same moments. Specifically, it aims to understand and explain families' experiences of change in a therapy session and compare them with Family Therapists' understanding of change.

Who is carrying out the research?

This project is being undertaken by Harriet Smith of the University of the West of England, (a trainee Counselling Psychologist). The research will form part of a doctoral thesis and may also be submitted for publication in an academic journal or presented at conferences. The project is supervised by Dr. Naomi Moller of the University of the West of England.

Why have you been invited to participate?

You have been invited to contribute because you are a family therapist practising within Avon and Wiltshire Mental Health Partnership Trust.

Do I have to take part?

It is up to you to decide whether or not to take part. 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 up until the point that the data has been written up for publication. You can withdraw without giving a reason. A decision not to take part or to withdraw from the study would have no detrimental effect to their employment

What will happen to me if I take part and what do I have to do?

If you do decide to take part you will agree to allow families from your family therapy clinic to be recruited to the study. Recruitment will take place via one of two ways. You can approach families directly and give them the recruitment poster; you would also be asked to post recruitments posters in the family therapy clinic waiting room. The researcher will give you family participant information sheets which can be given to any families who express an interest in taking part. The family are then free to contact the researcher directly to arrange the next part of the study.

Yourself and any families that agree to take part will arrange for one on-going family therapy session to be video recorded. This session can be any session between the third session and the penultimate session. Within forty-eight hours of this recording (at a pre-agreed time)

we will arrange an interview with the family and the researcher. This will either take place at their home or at the family therapy clinic, whichever is most convenient for the family. Once this family interview has been conducted, we will then ask to interview you. Again, this interview can take place at your home, or at the family therapy clinic. You will view the video recording of the family therapy session and the researcher will show you the section(s) of the video that the family have identified as important. The researcher will ask you some questions about your experience of the therapy session and you will be able to use the recording as a prompt to help you answer them. This interview will last about 90 minutes and will be audio recorded by the researcher.

Expenses and payments

Any expenses that you incur from taking part in the study outside of your contracted NHS working hours as a result of taking part in this research will be reimbursed to you up to a limit of £25. This means that you can be compensated for travel, meals or child-care costs that occur because of the time taken to be interviewed.

Will my participation in the study be kept confidential?

All information collected for the study will remain confidential. Confidentiality will only be broken if the researcher has reason to believe someone is at serious risk of harm. In this instance the researcher will discuss this with the family before contacting their care co-ordinator and if necessary the crisis team. Similarly if the researcher has reason to believe that there has been a breach of professional code of conduct the researcher will discuss with the projects clinical supervisor, Shane Mathews [tel: 01275 796200].

Once the interview session has been conducted the video recording of the original therapy session will be destroyed. Also, the audio recordings of interview session will be destroyed on completion of the research project. For the duration of the research project audio recordings will be kept as audio files on encrypted computers and transcribed material will be kept on similarly encrypted computers.

The audio- recording of the interview will be transcribed and all potentially identifying information will be removed from transcripts so that you cannot be recognised. Although direct quotes may be used in the final write up they will not be attributed to individuals.

Signed consent forms will be kept in locked cabinets.

What happens if you decide at any point that you do not want to carry on with the study?

You may withdraw from the study at any time until the point of submission of the doctoral thesis and any data collected from you will be destroyed.

What are the possible disadvantages and risks of taking part?

There is no physical harm inherent in the project but it is possible that talking about your therapeutic work in a research interview may be emotionally difficult. You may find that it causes you to reflect on what was said and see things in a different way. This may affect relationships with the family and between yourself and other family therapy team members.

What are the possible benefits of taking part?

In terms of benefits, you may find that the opportunity to talk about your therapeutic practice is beneficial and informative. In addition it is hoped that the research will make it possible to better understand families' experiences of family therapy and so improve how family therapy is delivered in the future.

What if something goes wrong?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions [tel: 44 (0)7775 783303]. If you remain unhappy and wish to complain formally, you can do this by contacting the researcher's academic supervisors Naomi Moller via email [naomi.moller@uwe.ac.uk] or phone [0117 32 82967] and Christine Ramsey-Wade via email [Christine.Ramsey-Wade@uwe.ac.uk] or phone [0117 32 82193].

If you experience distress as a result of this study, or feel it has raised an issue relating to your therapeutic practice we have arranged that you can contact a psychologist outside of the team but within the trust. If this is the case for you please contact the project's clinical supervisor, Consultant Psychologist Shane Mathews on 01275 796200.

What happens at the end of the research study?

The interview data will be analysed to find themes across all participants. The findings will be written-up and submitted as part of a doctoral thesis. The study results may also be written up for publication in an academic journal and presented at academic conferences. The research will also be presented in summary and posted or emailed to all participants. The researcher will also give a talk presenting the main findings to members of the Family Therapy Clinic; the date for this talk will be advertised in family therapy clinics.

What if there is a problem?

If you have concerns about any aspect of the study you can contact the researcher Harriet Smith harriet2.smith@live.uwe.ac.uk , tel: 07775 783303 or her supervisors, Naomi Moller [naomi.moller@uwe.ac.uk] and Christine Ramsey-Wade [Christine.Ramsey-Wade@uwe.ac.uk or 44 (0)117 32 82193].

What should I do now?

If you are interested in taking part in this study, please contact the researcher **Harriet Smith** via email harriet2.smith@live.uwe.ac.uk or tel: 07775 783303. She will arrange a time to discuss the study with you and answer any questions you may have.

Appendix B3: Participant information sheet, family members



University of the
West of England

ID # _____

Family Participant Information Sheet

Exploring how family groups and therapists view key moments in therapy

Please take the time to read the following information carefully; if there is anything that is not clear, or that you would like more information about, then please do ask.

You are being invited to take part in a research study. Before you decide if you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. We can go through the information sheet with you and answer any questions you have. We would suggest this should take about 15 minutes. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the research?

Currently there is very little research that focuses on how families experience family therapy and this project aims to get a better insight into this experience. Thus, the aim of this research project is to examine how families experience moments of change in family therapy. Specifically, it aims to understand and explain service users' experiences of change in a therapy session and compare them with Family Therapists' understanding of change.

Who is carrying out the research?

This project is being undertaken by Harriet Smith of the University of the West of England, (a trainee Counselling Psychologist). The research will form part of a doctoral thesis and may also be submitted for publication in an academic journal or presented at conferences. The project is supervised by Dr. Naomi Moller of the University of the West of England.

Why have you been invited to participate?

You have been invited to contribute because you and your family are currently taking part in family therapy.

Do I have to take part?

It is up to you to decide whether or not to take part. 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 up until the point that the write-up of the study findings have been submitted. You can withdraw without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not effect the care you are currently receiving or the standard of treatment which you receive.

What will happen to me if I take part and what do I have to do?

If you do decide to take part you will agree to allow *one* on-going family therapy session to be video recorded. Within forty-eight hours of this recording (at a pre-agreed time) we will arrange an interview with the researcher. This can either take place at your home or at the family therapy clinic, whichever is most convenient for you. You will view the video recording of your session and the researcher will ask you some questions about your experience of the therapy session and you will be able to use the recording as a prompt to help you answer them. This interview will last about 90 minutes and will be audio recorded by the researcher.

Expenses and payments

Any expenses that you incur as a result of taking part in this research will be reimbursed to you up to a limit of £25. This means that you can be compensated for travel, meals or child-care costs that occur because of the time taken to be interviewed.

Will my participation in the study be kept confidential?

All information collected for the study will remain confidential. Confidentiality will only be broken if the researcher has reason to believe someone is at serious risk of harm. In this instance the researcher will discuss this with you before contacting your care co-ordinator and, if necessary, the crisis team.

Once the interview session has been conducted the video recording of the original therapy session will be destroyed. Also, the audio recordings of interview session will be destroyed on completion of the research project. For the duration of the research project audio recordings will be kept as audio files on encrypted computers and transcribed material will be kept on similarly encrypted computers.

The audio- recording of the interview will be transcribed and all potentially identifying information will be removed from transcripts so that you cannot be recognised. Although direct quotes may be used in the final write up they will not be attributed to individuals.

Signed consent forms will be kept in locked cabinets.

What happens if you decide at any point that you do not want to carry on with the study?

You may withdraw from the study at any time until the point of submission of the doctoral thesis and any data collected from you will be destroyed.

What are the possible disadvantages and risks of taking part?

There is no physical harm inherent in the project but it is possible that talking about your therapy in a research interview may be emotionally difficult. You may find that it causes you to reflect on what was said and see things in a different way. This may affect relationships within the family and between yourself and your therapy team.

What are the possible benefits of taking part?

In terms of benefits, you may find that the opportunity to talk about your experiences is personally beneficial and informative. In addition it is hoped that the research will make it possible to better understand families' experiences of family therapy and so improve how family therapy is delivered in the future.

What if something goes wrong?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions [tel: 44 (0)7775 783303]. If you remain unhappy and wish to complain formally, you can do this by contacting the researchers academic supervisor Naomi Moller via email [naomi.moller@uwe.ac.uk] or phone [0117 32 82967] and Christine Ramsey-Wade via email [Christine.Ramsey-Wade@uwe.ac.uk] or phone [0117 32 82193]. If you experience distress as a result of this study, or feel it has raised an issue relating to your therapy or therapists we have arranged that you can contact a psychologist outside of the team but within the trust. If this is the case for you, please contact the project's clinical supervisor, Consultant Psychologist Shane Mathews on 01275 796200.

What happens at the end of the research study?

The interview data will be analysed to find themes across all participants. The findings will be written-up and submitted as part of a doctoral thesis. The study results may also be written up for publication in an academic journal and presented at academic conferences. The research will also be presented in summary and posted or emailed to all participants. The

researcher will also give a talk presenting the main findings to staff in the Family Therapy clinic.

What if there is a problem?

If you have concerns about any aspect of the study you can contact the researcher **Harriet Smith** harriet2.smith@live.uwe.ac.uk , tel: 07775 783303 or her supervisors, Naomi Moller [naomi.moller@uwe.ac.uk] and Christine Ramsey-Wade [Christine.Ramsey-Wade@uwe.ac.uk or 0117 32 82193].

What should I do now?

If you are still interested in taking part in this study, please contact the researcher **Harriet Smith** via email harriet2.smith@live.uwe.ac.uk or tel: 07775 783303. She will arrange a time to discuss the study with you and answer any questions you may have.

Appendix B4: Consent Form



ID # _____

Consent Form

Title of Project: Exploring how family groups and therapists view key moments in therapy

Name of Researcher: Harriet Smith

1. I confirm that I have read and understand the information sheet dated.....
(version.....) for the above study. I have had the opportunity to consider the information,
ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time up
until the point the research has been submitted as part of a doctoral thesis. After such time in
the research it will not be possible to withdraw consent. I understand that I can withdraw
without giving any reason, without my medical care or legal rights being affected.
3. I understand that data collected during the study will be looked at by Harriet Smith (the
researcher) as well as by her academic supervisors. Where it is relevant to my taking part in
this research, I give permission for these individuals to have access to my contact details
(name, address, telephone number) in order to communicate with me.

4. I agree to take part in the above study.

By signing below you are indicating that you consent to take part in the study.

Signature (participant) Date Print name

Signature (researcher) Date Print name

Appendix C1: Schedule of Questions Prospective semi-structured interviews with family therapists

Prospective Interviews Family Therapists

With regard to your clinical practice how would you describe yourself?

What does this mean?

Can you explain what you feel is important in successful family therapy?

Tell me about what it is you are trying to do in a family therapy session?

Specific techniques? Theories you are using?

What makes a difference as to whether families change or not in family therapy?

Are you coming from a particular theory of how families might change?

Can you describe what you do to encourage change in family therapy sessions?

Is there anything you would like to add?

Tell me more about that

Can you elaborate on that

What do you mean by that

Appendix C2: Schedule of Question IPR interviews family

Questions for Family IPR Interviews

We are trying to explore the processes of therapy, using the tape to help you access the memories of how you were thinking and feeling at the time. What we're interested in is looking at the most significant or important moments in the session.

What are your memories of how you were thinking/feeling at that time

What was happening when your therapist said that?

How did you feel when your therapist said that?

What was that like for you in the session?

What do you remember thinking at that point in the session?

What was important about what your therapist said or did?

What's the most important thought or feeling that occurred to you at this moment?

How did this affect you?

What do you think was the impact of this?

What might possibly change for you because of this event?

As you reflect on that moment in therapy

Take a step back from that moment

Timings of Events:

From: To:

From: To:

From:

To:

Appendix C3: Schedule of Question IPR interviews family therapists

Therapists and reflective teams IPR Interview Questions:

The tape of the session is cued to the beginning of the section that the clients have selected as most significant. We are trying to explore the processes of therapy, using the tape to help you access the memories of how you were thinking and feeling at the time We are going to watch the whole 'event', but we can review the tape as many times as needed.

What was your intention?

What were you working towards or trying to do?

Description of state of therapists: what were you feeling, how might you have been coming across

Why did you chose that intervention

What characteristics of your approach to therapy are relevant to this event?

Theoretical rationale?

What did you expect the impact to be?

Relevant context: client characteristics, previous sessions

What (if any) changes did you expect from that intervention

Appendix D1: Example extract of transcript with initial coding: Therapist prospective interviews.

SARAHS INTERVIEW TRANSCRIPT	
TRANSCRIPT	CODES
<p>Can you explain what you feel is important in successful family or systemic therapy?</p> <p>Well, I think the relationship is key because I guess a lot of the research shows that 50% of it is the relationship, the therapeutic relationship, and that's key and I suppose, interestingly, they show that a significant bit is change also comes by other changes in the families [laughing] [00:03:37] so there's that little bit if you can actually make a difference too,.</p>	<p>The therapeutic relationship is important</p> <p>acknowledging that some part of change is down to the family</p>
<p>but I suppose in terms of a good therapeutic relationship, it's about the challenge of being able to engage people so that they feel that you're interested in them; the concept of neutrality, that you're not going to take sides, that you are going to be able to see it from a range of different points of view and that you're going to be able to be containing in terms of emotions, that it's going to be safe enough to touch on some really difficult stuff but not too heavy going for some people</p>	<p>Focusing on engagement</p> <p>Being balanced between different family members</p> <p>Creating a safe enough place for the family to talk and share</p>
<p>So it's that relationship of trying to gauge what the family style is and what might be safe and not safe for them so that you can create a safe base that they might be able to explore some things that are difficult to explore otherwise, or to say some things that aren't- are unsaid.</p> <p>And a lot of that will depend on their attachment styles with, you know, through the generations and of the therapist needing to find ways of managing it because if somebody's got quite an avoidant pattern style or they're indiscriminately very connecting but not professional, if you get some of these families who just want to be your mate and pet you on the back and all of that.</p>	<p>Creating a safe place for the family to talk and share</p> <p>Thinking about their relationship style</p> <p>Creating a safe relationship with everyone</p>
<p>So getting that sort of position where it's professional but it's warm, it's sort of enabling, it's safe but at the same time not too comfortable, because with too comfortable then</p>	<p>Making it safe enough</p> <p>But...</p>

<p>they're not going to be able to make a difference</p>	<p>Being able to push a bit</p>
<p>and I think a lot of it is the ideas, drawing on Gregory Bateson, founding father of systemic therapy, was around that the job is to make enough difference it can be noticed, but not too much difference, because if you make too much difference then people will just be feel- their integrity's assaulted and they'll just cling to what they know best. So you were asking me about systemic therapy?</p> <p>Yes-</p>	<p>Finding a balance between challenging and pressurising</p>
<p>What helps?</p> <p>-what you felt was important and successful.</p> <p>Yes. So yes, the relationship's really important and I suppose in that I'm covering lots of a, you know, the – the centrality of some of the concepts that the early systemic family therapists were using, about neutrality, hypothesising circularity; that neutral position about taking- feeling so that everybody feels they are being heard but also that you're not taking sides with people who aren't in the session, or against them, or you're not being disrespectful of other people in the system.</p>	<p>Neutrality and circularity</p> <p>Being balanced between different family members</p> <p>Creating a safe relationship with everyone</p>
<p>and I suppose in terms in- I've said about that bit about it not being too comfortable, being able to challenge so you need to make a connection and from that to be able to invite them to make little challenges</p>	<p>Finding a balance between challenging and pressurising</p>
<p>so that part of it is around the Barry Mason idea, which is around people only change when they become less certain of the positions they hold and the difficulties when people are stressed then they hold more rigidly onto the positions they hold. So it's not about- you're not- you can't make people change, you can only work with them to invite them to find some ways</p>	<p>Encouraging flexibility of beliefs</p> <p>Being invitational</p>
<p>So I suppose the idea of circularity is that you're being able to attend to the feedback from them and that to form the basis of your questions through that and not it being, you know, a checklist and that part of it is not so much the therapist gaining information, but inviting them to get a better understanding of their patterns and inviting them to be more curious about some of their beliefs, or each other's beliefs, or</p>	<p>Using questions to..</p> <p>encourage different perspectives</p> <p>help people to understand each other</p>

<p>each other's behaviour and starting to make some connections for themselves</p> <p>and of, you know, often when people are in trouble they have a very much black and white, either/or, and our culture encourages that, you know, it's right or wrong</p>	<p>sometimes their beliefs can be quite rigid</p>
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Appendix D2: Example of initial themes with illustrative data extracts: Prospective therapist interviews

Initial list of possible themes from prospective family therapist interviews

accepting difference	
Cha: nging the viewing changing the doing	
checking they feel understood, checking its helpful	
context	
creating a shared sense of purpose and goals	
encouraging the questioning of patterns changing patterns	
exploring patterns can help families to see that its interactional	
having the whole system in mind when focusing on an intervention	
helping clients to understand that current relationships and experiences are shaped by past relationships and experiences	
historic relationships or context can influence current relationship and problems	
its not always about the therapy	
keeping in mind wider contexts and systems	
Miscellaneous	
modelling different perspectives	
Privileging the change	
Providing a safe space for everyone	
reflecting on the detail of what I do is difficult	
renegotiating roles	
self-reflection important useful feedback on how family might be	
to improve relationships	
Trying to gauge how the family is responding. timing	
working on a previously agreed goal	
'working with' rather than 'doing to'	

Examples of possible data extracts examined during analysis when considering potential Theme 'Working with rather than doing to' (also considered naming 'non-expert non-judgemental') from prospective family therapist interviews:

<Internals\Therapist interviews part 1\Therapist 1 MD> - § 2 references coded [2.57% Coverage]

Reference 1 - 0.51% Coverage

What I feel is important? I think the first thing that is important is joining with people and meeting them where they are and that would be for everybody in the room to try from the beginning to develop a relationship with people that come back again - because that's like the first challenge is for people to feel that they're somewhere that's going to be helpful to them - and I suppose part of that would be around establishing from the beginning a sense of a kind of, you know, non-blaming, neutral,

being able to hear every kind of perspective, not taking sides. So that would be the first thing and the next part of that, which would be quite closely related, would be about creating a sense that this is a safe place and that me, if it's just me, or me and my team are able to provide a space that can contain difficult feelings and won't let things get out of hand because I think I probably feel as a core of what we offer is that- a safe place to talk about difficult things so that, yes, that would be what I would see as sort of the foundation for couple and family work when I've got more than one person in the room.

Reference 2 - 2.06% Coverage

I don't need to know, in a sense, whether there's any real empirical foundation for those ideas because they fit with what I see in a way that helps me be compassionate to both people to- even to look- to maintain a sort of empathic and compassionate stance to people who otherwise I might become judgemental towards and I think that's one of the real challenges of being a family therapist; is how to cultivate and maintain that sense of compassion to sort of all-comers. So some ideas I think – there's a sense in which I don't care whether it's got a real empirical basis or not; if it helps me maintain what you might call an ethical stance towards those people and the other- helps me communicate what that stance is to other people. So I suppose it's partly that: how can I help other people, also, you know, maybe other team members, or other people who are struggling sometimes to- well it's like, well, we don't know what's happened in the past in those relationships that are making this challenging now and here's an idea that is helpful to understand how that might work for people. So that would be another sort of set.

<Internals\\Therapist interviews part 1\\Therapist 2 NT> - § 15 references coded [16.08% Coverage]

Reference 1 - 0.94% Coverage

Well I think always responding to the clients and I think enabling the clients to feel that they've got control over what's going on and I think that comes from again my past jobs where we've kind of had a model to stick to and there hasn't been a lot of flexibility around how we're meeting the particular needs of the client; whereas I think what's important for me in the systemic theoretical framework is the emphasis on the client having power and expertise on their own family and I really like the position that's talked about where I think Barry Mason talks about safe uncertainty and I really find that model, like quadrant, really fits well for me because I see myself moving around it, but you know, I'll always start a session by emphasising to the client that they are the experts in their own lives and I've got some expertise in helping them trying to look at some of their issues as a family. And I really like that because it makes me feel as though I'm- there's no expectation on me to be some kind of superhero who can fix the family. I'd hate anyone to think that was what I was there for, so I find that kind of liberating and I always start any assessment by referring to that idea. So that's really important, I think it's the most important thing to me.

Reference 6 - 0.79% Coverage

I think it's important that they identify that they need to address issues around that and not for me to say 'look what you're doing'. I mean at the end of the day if it came down to it, it's not that I wouldn't challenge around domestic abuse or sexual offences whatever, but if there's always a chance for them to identify and verbalise it themselves in their own words and then to agree to work towards achieving whatever that outcome is, then ultimately it comes down to them because they

own it; is that what I'm trying to say? I think that's really important for them to feel like they've devised this and to keep looking back at those outcomes and checking out with them at the end of the session 'how far do you think we are towards getting there now, you know, reaching this and making you feel safer or wherever it is'. So I think that's a really important thing to help encourage change of any sort really, it's ownership of-

<Internals\\Therapist interviews part 1\\Therapist 3 CB> - § 2 references coded [2.69% Coverage]

Reference 1 - 1.88% Coverage

I think there's sometimes there's that idea that, the systemic one, that the therapist gets too married to their hypothesis or is too purposeful in their actions you usually find that, actually, the session doesn't go so well because basically they're caught up in trying to persuade a family that, you know, I've got this good hypothesis and you need to swallow it,

Reference 2 - 1.46% Coverage

Well, that's a really good question because there've been times where I've been incl- when it's not been going so well, when I've been inclined to think, how do you do good family therapy with a family that appears in inverted commas to lack capacity in psychological mindedness, it's really, really difficult. But actually I don't think that's- and that may or may not be being harsh on the people who are sitting in front of us, depending on what I mean by psychological mindedness, but actually I think the problem's not the family's problem; the family is the family, they turned up and they're asking for help. The problem is our problem in that we haven't adapted what we're doing to work alongside where a family's at and some families are completely open to adapt and sort of flexibility and all sorts better type conversations and that works well, I've found it much more- I suppose we- often get described as much more concrete or much more down to earth and that- I think that, so- it's our-it's the way we adapt our style of working can be a major challenge, I don't think, at the clinic that I work in, don't happen to think we're that good at it. Just remind me of the question again.

Appendix E1: Example extract of transcript with initial coding: Families IPR interviews.

TRANSCRIPT OF FAMILY	INITIAL CODES
<p>Interviewer: do you remember anything about it?</p>	
<p>Man: yes it was kind of mirroring back what she'd said. Especially (pauses) I thought that just summed it up. I was still a slightly parallel path to be truthful, but I do remember thinking yes that's what A (partner) means.</p> <p>Interviewer: how did this affect you? Do we need to see it again at all?</p>	<p>The therapist re-interpreted and summarising helped me to understand.</p>
<p>Woman: it was quite positive because I felt we were moving somewhere. And to me it might help clarify my thoughts a bit, which were a bit woolly. And also writing it down was really helpful because with the best will in the world I tend to forget. And I find it difficult afterwards to remember what we did cover.</p> <p>Man: I do remember thinking at that moment, but that's not what A (partner) said, I do remember thinking that. 'Cause it wasn't what you actually said I don't think</p>	<p>Summarising helps to reinforce</p> <p>Therapist got it wrong</p>
<p>woman: no no, (pauses) go on</p> <p>man: no no just that. And I kind of let it go and it does happen in this situation sometimes anyway. It wasn't actually (pauses) I don't think is actually what you said. I think what X said then is "what you're saying is busyness makes those things go away and you become ill, sort of thing and you stop doing those things". I got very frustrated, well very? I got frustrated because I was thinking stop for a second what actually happens is that A (partner) is doing</p>	<p>Feeling frustrated and misunderstood</p>

<p>perfectly okay creative things and when she becomes depressed they stop. Or she is doing perfectly creative things like concerts or whatever and when she becomes high they go to extremes. They are not precursor is, the loss of them all the increase in them is not a precursor to your becoming ill. So my sense was a frustration.</p>	<p>Feeling frustrated because I didn't feel my perspective was heard</p>
<p>Interviewer: so why did you feel frustrated?</p> <p>Man: because I didn't think that, I think I that either I wasn't explaining it very well or people weren't listening to me. I'm prepared to set except that it was either of those I'm not saying it was me. I think that was my message and then I began to think then that even though I didn't see it that way it might be helpful thing to pursue given that situation. So I did abandon it. Because I suddenly thought, well it's not important that I get my message, my words across really what's more important is that this process is helpful. So I kind of gave it up fairly quickly but in that moment I felt frustrated a bit. As I say I think the summary was not a summary of what A (partner) said actually in that moment.</p>	<p>I didn't feel heard</p> <p>Starting to see that maybe I see things differently</p> <p>Hard to let go of my perspective/viewpoint</p>
<p>Woman: I was still trying to process what B (partner) didn't understand, so frankly I didn't really concentrate on what X was saying at all, ummme I was aware she was saying something, but I thought well I have to ask her to repeat it I haven't got it. But I was trying to work out what the issue was were you didn't really understand, or didn't seem to understand why I had mentioned.. (Tails off)</p>	<p>Trying to see it from the other person perspective</p> <p>Focusing on understanding</p>
<p>man: right.... I'd only really began to understand it about 10 minutes ago really in this session. Because what we were meant to be talking about, what we were talking about is indicators that you might become ill. This is what this bit was about, indicators. And what I was saying was was that that these things are not indicators, when they happen it's too late. But what you said about 15 minutes ago also</p>	<p>Reflecting after the session</p>

<p>which I hadn't picked up before, was that "if I can get up to a higher level before I can become ill maybe I won't go down so much or up so much"</p>	<p>Thinking about something again to create a different understanding</p>
<p>woman: (interrupting) or it might not last so long</p> <p>man: so that's out of this session</p> <p>woman: that's what I meant by topped up I wasn't even sure so maybe I should've (tails off)</p> <p>man: yes yes I now understand it</p> <p>woman: you know a bit like a battery, but charges up a bit</p> <p>man: well we did have that analogy later on, I think X uses it the analogy is a battery, so I think maybe we got there in the end.</p> <p><i>Pause</i></p> <p>(interviewer moves tape on)</p>	<p>Reflecting on the session gives a different understanding</p>
<p>Man: yes it was then that I began to think well, shut up because this could be a really useful point to talk about so I shut up I think.</p> <p>Woman: I was beginning to think this is a bit like an interview way you express your interests and hobbies and I was thinking come on think of another one. I think there was, I felt quite a lot of pressure, internally in terms of well there must be something else I'm doing, you know? It was, I suppose I sense there was a lot of silence and there was a lot of expectation that I should mention whole list of things which I'd prepared which might be useful. And I hadn't, I was just thinking as I spoke.</p> <p>Interviewer: so how helpful was that or not? At that point</p>	<p>Using the session to have space to listen to the other</p> <p>Feeling pressured to answer in a certain way</p>

<p>woman: quite helpful actually, I think I might of liked some feedback from somebody as I was going in that I didn't know whether or not to keep on carrying on mentioning things or whether to go to one of them in more detail but I thought that was for me to sort out later so it didn't really matter.</p>	<p>Being asked to focus on something was helpful</p>
<p>Man: you say, if one had taken this film a year ago, know that's too long ago six months ago, you did take a much more active part, you did take risks and go out on a line a bit. I think that's a good sign.</p>	<p>Noticing that things have changed</p>
<p>Woman: yeah because I sense it might be useful, you know what I've done loads and loads of thinking on my own but actually talking it through with other people listening and actively listening and taking note of is totally different and very helpful.</p> <p>Interviewer: what you think it is about that process is helpful?</p>	<p>Having people actively listen and notice change or difference is helpful</p> <p>Acknowledging the change is helpful and reinforces it</p>
<p>Woman: a whole load of things. I suppose one is that I might get a different slant on things when it's reflected back, I might get affirmation about yeah that's a good idea. Or (pauses) it just gives me a chance to explore more which is much harder on your own. I mean I can write notes on what I'm reading my thoughts but I don't necessarily put them into action. The something much more active about this.</p>	<p>Getting another perspective is helpful</p> <p>celebrating the change is helpful as it makes you think about it more</p>
<p>Man: I think one of the great positives about any group encounter is that it's a pretty safe environment in which to talk. One is expected to talk, whereas in some other environments, for example with a bunch of friends or family, you do tend to think of gosh I'm going on a bit. Whereas in a sense that's an occasion where one is meant to go on a bit. Which is a great luxury really, in a way. So I think that is one of the great positives of that sort of encounter.</p> <p>Interviewer: is that what you meant when you said you were sort of being prompted, being</p>	<p>It being a safe environment to talk is very positive</p> <p>Being encouraged to talk is important</p>

encouraged to...	
A woman: yes yes it encourages me to think more clearly and to and to focus on something rather than general thoughts, oh yes that would be a nice thing to do.... Or... maybe... It's much more focused.	Having a focus is useful

Appendix E2: Example of initial themes with illustrative data extracts: Family IPR interviews.

Initial list of possible themes from family IPR interviews

Feeling frustrated and unheard
Learning to see another perspective viewpoint
Thinking about something again to create a different understanding
The reflecting team is helpful
Sometimes reinforcing one party makes the other feel dismissed
Setting the goals is helpful
Naming or rephrasing thoughts or what was said is helpful
Having the team stops you arguing your point as much because you're not trying to persuade
Having the team is useful because it offers different perspectives
Having stuff interpreted or reflected back was useful
Having different genders in the team is helpful
Getting us to see patterns across generations is helpful
Feeling heard because someone therapist understands that this is relevant to me
Feeling acknowledged and understood helped me feel less anxious
Difficult emotions are evoked in the session
Being questioned repeatedly and in different ways to elicit in depth answers is helpful
Being given the space to think about things is useful
Being able to have input and control is important
Asking us to talk about specific things in front of each other encourages conversations that would happen otherwise
Asking us to check how we understand each other's communication has helped us
Being helped to see different perspectives viewpoints
Acknowledging the change reinforces it and is helpful
It being safe is important
Being encouraged to think and do things differently
NOT going well

Examples of possible data extracts examined during analysis when considering potential Theme 'Learning to see another perspective/viewpoint' from family IPR interviews:

<Internals\family interviews\Transcription of family one this is a transcription of the first family> - § 5 references coded [6.39% Coverage]

Reference 1 - 1.09% Coverage

I think I said in this session that that had been a game changer. You know that getting.... Because she had got B to understand that I love him and that I'm going to stay with him and he hadn't heard that

from me before. We just assumed something, he'd just assumed that future wasn't certain. I don't know what you heard but she managed to make B listen to me what I was really saying and that really change things.

Reference 2 - 1.66% Coverage

she's actually narrowed it down again to say okay well now you're using the word which might mean different things to different people. She says "I've met thousands of people who've been depressed and they are all depressed in different ways" so the word depressed means different things to each of them. And she checked with us, do you mean depressed sad? Or do you mean..... So that was, again..... I guess if there is a second theme it is that communication and ensuring that that communication is that what's transmitted and what's received is the same. And that is a microcosm of it, because she is just talking about one word.

Reference 3 - 0.69% Coverage

she tends to just intervene just at the right time and just sort of translates what we are trying to say to each other that's quite amazing really. I don't know whether it's just because it comes from her that we listen, but.. I've sort of learnt so much from her

Reference 4 - 1.82% Coverage

the other good thing that is in there is, which is a good intervention is that X says "what differences with the children see?" And that's quite a powerful way of making us think about things again. Because you try and stand outside your relationship, and you go "our yeah right I wonder what they do see", and not only does it make you reflect on your own circumstances and your own relationship from a third party's point of view it also makes you consider more actively, so what's the impact on the children. What will they be feeling about the situation. And of course it's not just our relationship, you know, it's the four of us altogether. So we are trying to look after the whole unit

Reference 5 - 1.12% Coverage

any time X brings up children. Like when I talk about childcare earlier and how much I enjoy it. It gives me such a surge of positive feeling, kind of love and and that I want to care for them and stuff like that. It always, it is always powerful for me. And so that perspective kind of reminds you of the importance of you know this isn't just about us kind of negotiating as it were. It's about the whole family. It's good.

<Internals\\family interviews\\Transcription of family two> - § 11 references coded [10.29% Coverage]

Reference 2 - 0.95% Coverage

I was still trying to process what B (partner) didn't understand, so frankly I didn't really concentrate on what X was saying at all, ummme I was aware she was saying something, but I thought well I have to ask her to repeat it I haven't got it. But I was trying to work out what the issue was were you didn't really understand, or didn't seem to understand why I had mentioned..

Reference 3 - 0.46% Coverage

I was beginning to think that moment that we were in a bit of a cul-de-sac to be honest and I think it was because we were viewing things from a slightly different perspective perhaps

Reference 4 - 0.77% Coverage

I was trying to convey the fact that there is a lot of general worry around that I so can't very happily, well not that happily. And particularly with D (daughter) that someone I feel responsible for. I'm not saying that you don't feel responsible. But I think you come at it from a very very different angle.

Reference 5 - 0.35% Coverage

at this point I'm thinking how come you don't need to talk to people? And just aware that we are all different, it's great that we all are.

Reference 6 - 0.98% Coverage

I suppose it was useful because it made me think afterwards it isn't about time at all, it's not about do I get enough time off duty as it were. But it's about what you do with that time. And thinking about, but I need to have that because it's important to me and it doesn't seem that B (partner) has such a time. And I find that curious. I mean he reads, but for me that wouldn't be enough.

Reference 7 - 0.62% Coverage

Whereas, I suppose you could do it in a one-to-one, but there's also the feeling that B (partner) is listening, the other two are listening (reflecting team) and maybe somebody could put something into this too, that's another angle on the same issue

Reference 8 - 1.84% Coverage

it's about somebody who is not in the situation he's looking at it from outside and maybe has another viewpoint that they may or may not express but at least they are listening and at some level taking it in and reflecting on it, that's useful. Even if they don't come back directly. I mean I'm sure during this the reflecting team will be thinking "oh really gosh.. I'd like to say something" but they don't, and the setup is that they can't at that point. But there is a point where they can. And I just think that that is quite useful in terms of people reflecting on it, and from me helping me process it rather than it just being a load of questions and a load of answers. It moves it on the me, that's the best where composite really.

Reference 9 - 0.63% Coverage

I was also at this moment thinking well if the roles reversed I would like to be trying to think of a way to help the person. But I'm not quite sure how and the other person might not know either but it's certainly an area that is very very relevant.

Reference 10 - 0.86% Coverage

well, it was A (partner) talking about the fact that it didn't happen and it was my saying, "but hold on I'll listen to anything" and then you were saying "but you know, maybe it's the wrong moment" and I was saying "is it because you won't like the answer, is that the reason?". So I think it was a bit iterative, it did seem to wander round.

Reference 11 - 1.51% Coverage

I'm left with a lot of things to think about but I haven't necessarily come to them yet in my own thinking, and this is one of them you know, why am I fearful of starting conversations like this or why do I not want to explore it. And I've so far not really a definite idea of why not. But as X (therapist) said noticing has been very useful work there because I don't feel I've got to come up with a solution (I've got it for this week), but it's something you can notice as it happens. And something might occur, but it might not, but at least you can notice it and that puts me in a different position.

Appendix F1: Example extract of transcript with initial coding: Family therapy team IPR interviews.

TRANSCRIPT	INITIAL CODING
<p>Interviewer: (talking about new section of tape) shall we locate yourself, you're talking about making time for each other.</p> <p>Therapist one: with this in terms of, talking about this, this is one of the bits of it where I am relying on my personal experience of what helps relationships in terms of being able to talk with your partner. And actually sometimes, and it's kind of my personal experience is that in the hullabaloo of day-to-day life you may just talk about practicalities or chitchat or gossip or whatever. But in terms of having times to talk about more central stuff if you don't have a decent time where you sit down together when you're not you know both knackered or preoccupied with other stresses or whatever, then it's very easy important conversations not happen.</p>	<p>Sometimes I use my own personal experience of what works in relationships</p>
<p>So that's what I'm drawing on my own experience of what it is to be part of a couple in thinking about this. But I what don't want to be too explicit, about.... You know I'm imagining that that is kind of important for most couples. But, so in terms of, I'm trying to suggest different ways in which you might do it, but leave that quite open as a sort of opened list because there might be other ways you would do it as compare to actually some of the things that I'm picking out of my list of what I do with my husband.</p> <p>Therapist two: and I suppose the other thread is that, is that this isn't the first time we talked about this.</p>	<p>Using myself as an example of how things might be</p> <p>Suggesting possibilities to try and encourage different thinking</p>
<p>Interviewer: you say that in this piece don't you?</p>	

<p>Therapist two: and what quite interesting is it's something that (female client) has bought up a number of times and (male client) has sort of gone "oh yes yes yes, yes it's important, will try and do that" and I suppose what I find interesting is that it hasn't really happened. So I suppose what we're doing is, it feels like that that is..... It's almost the idea of thickening the idea up, thickening the story about actually this would be something useful to do. We've talked about it a number of times and and it sort of gradually getting to a point where it might actually look like something.</p>	<p>Being curious about why patterns repeat</p> <p>Reiterating something so that it takes hold</p>
<p>Therapist one: yes and I suppose it's, within this context of doing this list it feels like a good moment to be looking at that and doing more on it. Which is why I think we probably gone back to it.</p>	<p>Holding an overall view of the therapy</p>
<p>Therapist one: and its that—quality (<i>emphasises</i>) is a keyword. And I think earlier in the session we had talked about the quality of something else. So the something about using their language sometimes, although that language of "quality time" would be something that would come very naturally to me. In this particular occasion I think he had said something about the quality of....</p> <p>So I've taken that as an opportunity to go back to "let's look at the quality".</p>	<p>Using the clients own language</p> <p>Demonstrating understanding</p>
<p>Interviewer: do you remember what you thinking at this point?</p> <p>Therapist one: I'm kind of wondering is their change? Is it happening more? Are they doing more stuff together? I mean they just had this long holiday and is it that he's thinking they're doing it more because they actually have been doing it more recently. Or is it that he's seeing it in a different way? So I am sort of wanting to check out, you know what's, what's..... You know making sure understanding. Kind of getting us all on the same page in relation to this would be a way of putting it. Trying to check out "is it like this" or "is it like that". And</p>	<p>Being curious about what's going on</p> <p>Trying to understand and name everyone's perspective</p>

<p>giving (names female client) the opportunity to say "yes but "or "no" or whatever she's going to say.</p>	
<p>Therapist one: this is where she's saying "(inaudible)" and she is linking it to before she was ill. First of all she says a year ago but actually what she means is maybe two years ago, before her last episode. Because in the passage of time it was actually 18 months now since she was really ill. So there is a bit of clarifying, about when it was easier. But this is really key, her putting her hands up and saying "things aren't how I want them to be right now".</p>	<p>Talking about the clients process</p>
<p>Interviewer: Do you remember thinking in the session, where am I going to do with this?</p> <p>Therapist one: there is a lot of (names female client) is talking now about "how can I keep this going". And one of the things I was feeling, after the session we did discuss this, a lot of the times they were talking together and we didn't need to do much. But there is sort of something about when do I need to intervene to keep this going in a way that enables (names female client) to do what she is just beginning to do which is to say "actually it used to be better, and it's not quite how I want it right now".</p> <p>Interviewer: so was there a particular thought you had about the nature of the question?</p> <p>Therapist one: I think first of all were just clarifying still.</p>	<p>Reflecting on what happened in the session</p> <p>Thinking about the timing of the intervention</p> <p>Uncertain</p>
<p>Interviewer: why that particular intervention?</p> <p>Therapist one: blimey! (Laughs) why did I asked that? I think, it's all about trying to open up different perspectives. It's kind of responding to what he said, it's it's (pauses). I'm kind of thinking of this triangle of trying to, trying to draw out what it is that she wants to say in the</p>	<p>Encouraging perspective taking and relational thinking</p>

<p>face of him going "what?", "I didn't know, it looks different from where I sit". So I suppose I am asking, and I suppose I'm thinking..... I guess again is based on my experience, you can have a lot of time together but there can be times when you think actually now is not the moment</p>	
<p>Or you can think I will talk to him about that, or I don't know when be able to talk to him about that because I don't know when we'll have the right bit of time. So I suppose partly that will be a question that is coming out of, again, my experience of what it is to find the right moment to discuss something that, that is more significant in a relationship. So that would be part of were that question would be coming from.</p>	<p>Using my own experience of what works in relationships</p>

Appendix E2: Example of initial themes with illustrative data extracts: Family therapy team IPR interviews.

Initial list of possible themes from family therapist team IPR interviews

Focusing on the content of the therapy
Reaffirming the positive change
Constantly talking thinking about and reflecting on my position as therapist
Creating a safe space so communication can happen
Creating a shared sense of purpose and goals
Didn't have fixed idea where I was going with client
Encouraging doing things differently
Encouraging perspective taking and relational thinking
Holding multiple perspectives in my head
Non expert non judgemental
Trying to understand what they want
Using myself as an example of how things might be
Working on an agreed goal

Examples of possible data extracts examined during analysis when considering potential Theme 'reaffirming the positive change' from family therapist teams IPR interviews:

<Internals\therapist teams interviews\Family therapist team two transcription> - § 2 references coded [1.40% Coverage]

Reference 1 - 0.74% Coverage

So I suppose what we're doing is, it feels like that that is..... It's almost the idea of thickening the idea up, thickening the story about actually this would be something useful to do. We've talked about it a number of times and and it sort of gradually getting to a point where it might actually look like something.

Reference 2 - 0.65% Coverage

So saying that, and saying it was good that he had been able to say and that he'd been able to talk about it and quite openly, because that was so different from before. So again I was reinforcing the idea that there are different conversations and different things happening.

<Internals\therapist teams interviews\Transcription of family therapist team one> - § 8 references coded [9.58% Coverage]

Reference 1 - 1.48% Coverage

I was very aware that what they were doing was wonderful. They were just saying so much and thickening up all their skills strengths and resources. So I just knew that I had to shut up, whatever my agenda was. But there was a tension there, I was trying to find out where they want to get. It has a lot of what they'd said had been said previously, in other sessions. But it sounded like it was getting firmer.

Reference 2 - 1.48% Coverage

I think I was conscious that she was talking more, more than she had been in previous sessions and that it just felt like more of a conversation. And really conscious that yes, therapist one wasn't needing to say much. And the things that she was saying were just about highlighting- "well this is different". I was already conscious that it already felt different in terms of what was going on in terms of them.

Reference 3 - 1.68% Coverage

I wanted to know what they truly thought was happening and where they were on their path towards where they wanted to get and I hadn't heard clearly, I'd heard some of it where they wanted to get,. So although I want to celebrate and hear well what they're doing well I wanted to hear where they were as far as working with us and what they were worried about, what was not.... And was there stuff to still work on, and did that bear any relation to the homework or not

Reference 4 - 1.10% Coverage

But also very aware the more I say am I missing anything or is there anything else, they will always come up with something. I always want to check that I'm not cutting off. Because this is really important this is listening acknowledging and validating and it's thickening up their skills in what's working

Reference 5 - 1.25% Coverage

for me, the more they talk about how it's working, the more they reflect on what has been helpful and what hasn't and what is really good and what they're celebrating. As their talking about that they are getting more confidence and understanding about this is what has been happening and that makes it more real. Thickening up this narrative really

Reference 6 - 0.71% Coverage

I'm double checking that the kids are okay as well as maybe help them get some feedback as to their perceptions as to how the kids are functioning differently in the light of their changed behaviour.

Reference 7 - 1.48% Coverage

is also a really concrete way of being able to notice change. What is it that other people are saying, is sometimes just a bit easier. I guess also kind of conscious of it's also a way of reaffirming what they are doing differently and that that seems to be helpful. Yeah and that's often helpful I guess in terms of getting people to talk about and I guess really kind of clarify what are you doing differently.

Reference 8 - 0.40% Coverage

Certainly nonverbally I was certainly really proud of how much change they'd quickly made with very little input