An exploratory study of causal attributions made by both therapists and families attending an intellectual disability family therapy service.

by

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Volume 1: Academic and Research Dossier, plus summary of clinical experience.

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INTRODUCTION TO THE PORTFOLIO

The portfolio is a compilation of the academic, clinical and research work completed for the Doctorate in Psychology Course in Clinical Psychology (PsychD) for the University of Surrey.

The portfolio aims to show evidence of the diversity of experience and development of competence in academic, clinical and research skills during the three years of the PsychD course.

Volume 1

This volume contains the academic dossier of the site of the course portfolios, comprising of two essays; three problem-based learning reflective accounts and two case discussion group process account summaries. A summary of the clinical dossier, comprising of brief overviews of clinical experience and summaries of submitted case reports. The research dossier comprises of the service-related research project completed in the first year, a research logbook showing progress of development in and use of research skills over the three years of the course, a qualitative research project abstract and a major research project which is completed in the third year.

Volume 2

This volume contains the full competence of the clinical dossier and academic dossiers. The clinical dossier contains five formal case reports of work conducted on clinical placement along with clinical placement contracts, supervisor evaluation, trainee evaluation and clinical logbooks from four placements.
ACADEMIC DOSSIER

This section of the portfolio contains two professional issues essays, which critically
examine a diversity of psychological issues concerning theoretical and practical aspects
of psychology.
Professional Issues Essay

The course team is attempting to involve service users and carers in many aspects of the Surrey Clinical Psychology Training Programme. With reference to the evolving literature on involvement in both training and research. Explore ways of involving users and carers in the programme. What issues and dilemmas might such involvement create?

Year 1: January 2004
Introduction

When I originally read the essay titles, this essay title stuck out. Whilst working for the NHS for almost 10 years I have witnessed the impact that services can have on individuals, and these are services that I have been involved in. Having just come from working as an assistant psychologist with people with learning disabilities, I was aware of the impact that could be made to users whose voices were heard, but also when they weren’t. The subject of user involvement strikes a cord in me; I express my bias here before I proceed. I hope that in writing this essay I can explore a subject area that has meaning for me, and perhaps by arming myself with the knowledge that I sought in writing this essay, I can attempt to make changes elsewhere.

Whilst it is important to recognise that users and carers may have very different stories to tell, and may have different priorities (Perkins and Goddard, in press), I will not attempt to thrash out those difference in great detail. I will use the term ‘user’ to denote both users and carers. I am more concerned with how users can be involved in the Surrey course. I will attempt to reflect upon my experience of being a user of the clinical psychology training process, and also being someone who has worked within the mental health field for many years. I will also draw from current literature that looks at the issues of user involvement in both mental health services and training. In doing this I will first outline where user involvement evolved from, what the principles are behind it. I will then outline the practical considerations that I feel are important for the course to consider when attempting to incorporate users into the course.

Where did it begin

The user involvement movement has been around for many years, Rachel Perkins (1999) wrote a chapter entitled ‘involving service users’. In this chapter Perkins briefly details how campaigns for user rights date back to the second half of the nineteenth century. In more recent times, the user movement began in the 1970’s in the USA, slowly infiltrating the UK culture during that time. Perkins and Repper describe two clear directions within the movement (as cited in Perkins 1999). Firstly, “a radical, anti-psychiatry movement that is concerned with the right to reject psychiatric services and provide user-run, user controlled alternatives outside the
existing psychiatric enterprise”. Secondly, “a reformist user/consumer movement that focuses on improving within existing psychiatric services and campaigns for more involvement and control within these”. It is the both of these movements that has driven user involvement forward, into the twenty-first century and can be seen in the governments attempts at shifting the balance of power in favour of patients (DoH, 2000; 2002).

**What are the beliefs behind user involvement**

If I purchased goods from a shop and they were faulty in some way, I would expect a refund or an exchange. Can the same be said for the NHS. The NHS employs around 1 million people to serve a population of approximately 60 million. What recourse do users have once they consume NHS services they feel have not been satisfactory? In what way can users influence how they are treated?

Having worked in mental health services, I am consciously aware of the division between users and providers - ‘them’ and ‘us’. Having worked with People with Learning Disabilities, this is something I have become too painfully aware of. Where individuals are treated as second class citizens, where their opinions and wishes are not elicited and where abuse and neglect is often visible. For me, this is where user involvement comes from. It comes from the need to empowering the individual, for their voices to be heard, for services to deliver what users want and need, not what professionals believe is best for them. “...(it is) almost arrogant to assume the knowledge of 1 million people exceeds the knowledge of the other 59 million. People now about their bodies and therefore their health” Gay (unpublished).

The constraints are that professionals often feel they now best, remaining in a position of power (Perkins, 1999). One way of changing attitudes is to start at the beginning, by attempting to influence the beliefs and perceptions of future NHS employees - those that are training to be nurses, social worker or clinical psychologists, to name but a few.

For me this all fits in with what the Mental Health Commission (2002) in New Zealand call the recovery approach. “Recovery is not only about recovering from the actual illness or distress, but also about recovering from its consequences, and the
limiting expectations made about service users that are based on diagnostic labels. Reclaiming one’s voice is linked with recovering a sense of self. ….. self is variously expressed in hopes, dreams, goals and choices.”

The University of Manchester’s Clinical Psychology course has attempted to reflect this by producing a document, ‘Working in partnership with consumers of Health Services to improve clinical psychology training’ Allott, R et al (2004). In this document the term ‘consumer’ is used, which for the course implies ‘choice’ and ‘empowerment’.

“…. What’s in a name? That which we call a rose by any other name would smell as sweet …”

(Shakespeare’s, Romeo and Juliet; Act II; scene II).

But what is in a name, as Juliet so famously put it, if we are unable to change the true meaning of the word by changing the perceptions of whom it refers to.

**Who and How to involve**

People that access clinical psychology services do so for a number of reasons. It could be the new mother who suffers from post natal depression, the builder who has fallen off scaffolding and sustained a head injury, the women who checks obsessively and compulsively, the young boy who has started to hear voices that no one else can hear, the child who can’t seem to sit still and the mother that is anxious about her child. The list can go on and on, any of these individuals could be from a different culture, be gay/lesbian, be of different genders, class or age. They certainly can’t be viewed as a homogenous group, one size does not fit all (Forrest et al, 2000).

Trainee can potentially work in any area of clinical psychology. I believe it is vital that attempts are made to represent all voices. There are however strategic issues to this:

- Whilst ideal, how many voices need to be heard?
- Can one person possibly represent the views of many?
- What if the voices don’t agree?

Perkins and Goddard (in press) suggest that these arguments wouldn’t be used with professional members of a committee. Professionals are singled out to join certain
committees, do so because they have a "special interest, expertise or role in the area under consideration". What is suggested is that users are given the opportunity to consult those they represent for example via user forms. If as a course we assume they are unable to elicit views from other users, to give a representation of voices, then we risk undermining the mere thing that we are trying to create. We must shift the balance of power by giving responsibility to the user organisations. If voices are not represented, then it is the responsibility of the user organisations to make changes.

There is always a risk, as Forrest et al (2000) point out, that the people who are consulted may be seen to become the 'unelected representatives' of all mental health service users. However, Baresford as quoted by Forrest et al (2000) suggests if the users who are active in voicing their opinions are seen by other users and accepted as their voice, should we prevent this? Certainly many would say that Tony Blair, does not represent their views, he is however democratically elected to represent the nation, but remains accountable. As Bareford highlights, most user organisations democratically elect their representatives, as cited in Forrest et al (2000).

Trivedi and Wykes (2002) in their paper on using users in research suggest two separate approaches, firstly a more direct way by approaching users through relationships with local groups. They also suggest a less direct approach, of advertising through newspapers, magazines and newsletters. The latter perhaps possibly recruiting a "wider range of users."

Curle and Mitchell (2004) explain in their article how the emphasis of the Exeter course, has meant that over the years they have been able to engage users as teachers. "We try to ensure that users or carers contribute to all client group teaching. A natural development of that work was to invite these people to join some of us from the programme team ..... to form a user advisory group that could potentially have an influence beyond the impact of individual teaching slots". These people consisted of "three parents of children who use psychological services and six people (including one older person) who between them use services for learning disabilities, head injury, physical disability and adult mental health".
Curle and Mitchell go onto to outline the basis of the meetings. "The plan for the three meetings was to introduce ourselves, share experiences of teaching and for us to explain what help was needed; for users and carers to come back with their thoughts and ideas; and finally, for us to let them know how we had used their suggestions". They later go on to acknowledge the impact these groups had on them, "we felt humbled .... this work keeps us grounded and stops us overlooking the human aspects of training which can sometimes get lost in formal academic bureaucracy". Powerful words. For me they speak volumes as I find myself enjoying my placement days and feeling slightly disconnected when at university and in lectures.

**Tokenism**

".... the majority of ‘user involvement’ remains essentially ‘tokenistic’: rarely do users have the power to significantly influence the development of services or their own care and support with them" (Perkins, 1999).

Forrest et al (2000) points out when reflecting on user involvement in nurse training, “the challenge of achieving true involvement in the curriculum, rather than tokenistic consultation, is huge”. This is a dilemma I feel the course faces in its attempts at involving users. In order not to be tokenistic, Forrest et al (2000) suggests seeing user involvement on a continuum, and adapted a diagram from Goss and Miller to demonstrate (figure 1). When I reflect on my own personal experience of the course so far, for me it feels that we are at level 2 of the continuum. So far I have had no official contact with users or their views on any part of the teaching that has taken place to date. I am unaware whether this will happen further into the course.
I recall my first experience of being interview by service users. It was a selection interview for a job as an assistant psychologist with people with learning disabilities. Whilst the interview itself produced a respectful atmosphere in which I became aware I would be entering into, I was also aware that the process felt tokenistic. I was the only candidate for the job and the users were given money as an incentive to interview me. I wonder if they felt empowered, although on reflection can remember one of the users for sometime after saying to me, “I got you your job you know”. What a wonderful person he was and perhaps the principles of empowerment and attempts to change the perception of staff entering into the service made a difference, they certainly did for me, but was it enough? After working in that environment I became aware that the drive behind this was psychology lead. Unfortunately those who worked on the ‘shop floor’ so to speak, had very different opinions of what the role and position of a client should be, reflecting back on this still makes me quite angry; but it was that anger that gave me the energy whilst I was there to work with my supervisor in attempting to make some positive changes, which I think we did - small as they were.

With one million people working for the NHS it is vital that significant attempts be made to address the views of those that work with users. If this is not done, then the risk arises that what has been learnt at university may not be sustained when entering a culture that does not have the same ethos.
As with my experience in learning disabilities, psychology should be at the forefront and nothing less than level five - partnership will I believe make any significant impact on the service. This is the point that Trivedi and Wykes (2002) argue when considering user involvement in research, “it is important to remember that users’ responses come about largely through their experience of using services and - since it is this very experience that user involvement is trying to harness - their views, values and opinions need to be taken seriously if they are really to influence research”.

**User participation in training**

This point links in very much with the previous point on tokenism, achieving partnership means involving users at every stage of the process from incorporating users views into the handbook, through selection, training and evaluation.

Harper et al (2004) see user involvement in training as “a process involving a range of views, methods and resources spanning teaching, placements and research. It pervaded all aspects of our work, from selection of trainees to the development of therapeutic relationships with clients”. This is in stark contrast to how some courses have involved users, by invited users to “give a first person account of their experience of mental health difficulties”. Which as Harper et al point out, assumes that this is the only way users can participate in courses.

Curle and Mitchell (2004) as discussed previously were able to make changes, as suggested by service users. These changes included “user involvement in selection; include a list of good and bad qualities (that users generated) in clinical psychologists, which is included in the programme handbook; a new requirement that supervisors base their assessment both on direct observation of trainees work, and on direct feedback from users; new guidelines on consent and confidentiality” to name but a few. There are often limitations to the changes users views can make in how the course is run, particularly when the course is already up and running, “there is however, the possibility of incremental developments”, which users can be instrumental in pushing forward (Tew et al, 2004).

In involving user in training consideration must also be given to trainees. As a trainee, I often feel in a very disempowered position compared to tutors and
supervisors. Although there have been efforts to change this in some ways by giving trainees a voice, e.g. the team trainee meetings, this itself feels very tokenistic, especially when trainees are required to attend, but often only one tutor attends. Does this assume their time is more valuable than ours and if so, how can you assess that value? I could continue, but for the purposes of this essay it is not quite appropriate, the expression of my feelings should surface, I believe.

Whilst I am an advocate of user involvement in training, I am also an advocate of the users (users in this instance meaning trainees) of clinical psychology training. As Baker (2002) suggests, “Perhaps if training were to be more trainee-centred .... it might promote the development of more client-centred therapists able to recognize that clients, as adults, can make decisions about balancing what is good for them and what makes them feel good”.

Certainly when considering user involvement in training careful consideration should be given to the potential impact this may have on trainees and their feelings of empowerment and more importantly their mental health. A point certainly echoed by Forrest et al (2000), “there are inherent inequalities of power between service users and educationalists and similarly, there are inequalities of power between lecturers and students. Students often feel disempowered in relation to trained practitioners and educators. If innovations such as user involvement in selection interviews and student assessment are introduced there is a risk of disempowering students”.

**Users as Trainees**

“.... Students may also be service users but may not always make this information public. This experience should be validated and supported rather than devalued” (Forrest et al, 2000).

The new accreditation criteria for courses from the British Psychological Society (BPS), as quoted in Harper et al (2003), states that “selection procedures (for courses) must not discriminate between candidates on the grounds of gender, age, sexual orientation, ethnic origin, religion, creed or disability”.


Harper et al outline how courses can ensure that they are less discriminatory towards users as trainees. These include, being open and transparent about the selection criteria, giving those that need assistance the opportunity to do so, involving users and third year trainees in interviewing, asking interviews to reflect on their own experiences of mental health problems / services. One possible constraint of the latter is that interviews learn to “say the right thing”. Certainly when I was preparing for interviews that was something I was aware of, the need to say the right thing. Perhaps courses need to dispel somehow that there are these correct mythical answers to the questions the course seeks.

Once on the course supporting users doesn’t stop there, for me it has only begun. As someone who is going through the training process, I can reflect on how demanding and tiring it can be, certainly when it comes to handing in assignments. One possible way of supporting trainees as suggested by Harper et al (2003), is to help the trainee plan ahead by, “identifying triggers of relapse and plans for coping with these”. This is limited in itself to whether trainees want or accept help, or actual know what their limitations are.

What are the barriers to involving users?
Clinicians are often seen as the ‘expert’, having trained for many years, clinical psychologists can become imbedded in the scientist-practitioner model (Harper et al). The scientist-practitioner model allows clinical psychologists to draw on evidence to guide their practice and allows them a way of making sense out of a relative sense of chaos. The downside is that it may become the focus, limiting thinking about clients; methods may become the main sense of role and purpose. Research has been undertaken with clinical psychology to elicit courses opinions.

Curle and Mitchell (2004) cite an unpublished study by Jellico-Jones, which indicated possible resistance to the involvement of users in clinical psychology training. “Her survey of 25 clinical psychology programmes found a discrepancy between trainees’ and programme organisers’ views about service-user involvement in training, with the latter identifying more disadvantages and fewer advantages than the former.”
Harper et al also identified that the curriculum and organisation of courses can prohibit user involvement, due to the constraints on time; there is also the potential financial commitments involved to consider. They also acknowledge some of the fears expressed by members of the course team - fears of not knowing how to do 'it' or do 'it' well; doing it badly or being seen to be tokenistic; of being seen to be politically correct; also the fear that we are not in fact very different from the people we treat.

Another risk Harper et al., suggest is that of professional protectionism, this may be acted out in several ways including dismissing views that might oppose those of the professional. “Involving service users and their relatives is a straightforward matter when their views accord with those of service providers. It is when opinions diverge that problems arise. The involvement of users and relatives is meaningless if their views are disregarded as soon as they disagree with professionals” (Perkins and Goddard; in press).

There is however another very valid point made by Bowl (1996) and this is about the value given to staff. If we are to expect staff to empower users then we must empower staff. The risk is, if this is not done, that staff will then create barriers to user involvement, the empowerment of staff must come from the top - senior staff. “Few users have ever met senior staff from their local authority, although this was also broadly the case for staff too, and this lack of empowerment experienced by staff, together with the belief that their skills and opinions are under-valued, reinforces the general feeling of disempowerment amongst users” (Bowl, 1996).

**Funding**

One particular barrier to involvement is funding, but not just funding for service users in terms of payment for time, travel expenses etc., but funding for educators and support staff time and training for all those involved. There is also a need to allocate funding, not just in setting up user involvement technologies but to monitoring and researching them, ensuring that effective projects are sustained (Simspon & House, 2003).
"If user-researchers are to be closely involved then a time commitment needs to be given to this process in the research proposal and this must be costed into the project’s finances ..... service users also need to be paid for their time (as clinical academic staff are). Not only do these costs have to be included in the proposal but they are also difficult to implement, as there are limits to the payment of service users who claim benefits” (Trivedi & Wykes, 2002).

“Payment for user and carer participants were identified as essential .... Financial systems within the university and benefits issues made this problematic .... Normal lecturer rates were paid to users’ and carers’ organizations rather than to the individuals” (Masters et al, 2002).

All these points are valid and need to be taken into consideration. If funding is not available, then how can the process be sustained, if we want to move away from a tokenistic user movement, then we must as they say ‘put our money where our mouths are”. This is something that is beginning to be recognised at the government level, who are providing funding for user involvement in the new social work degree (Tew et al, 2004), but this doesn’t help clinical psychology training, efforts must be made to ear mark some form of funding for the purposes of the course. If the government requires that courses make these changes to training then they must support all courses financially. Tew et al (2004) have outlines the practicalities behind payments to individual users, but due to the limitations of this essay, I am not able to go any further than I already have.

What users need in order to participate?

It’s about finding the right balance, that is find a balance between giving too much help and disempowering and not helping enough. “.... because mental distress is debilitating this restricts the ability of many users to campaign consistently. Many are on medication which sometimes means that they lack motivation and concentration. A number of users identified this lack of inner resource as being one of the more problematic aspects of user-led initiatives, although they also acknowledged that it is important that users’ campaigns are not hijacked by organisations who represent rather than comprise people experiencing distress” (Bowl, 1996).
A systematic review by Simpson and House (2002) of studies on the effects on involving users in the delivery and evaluation of mental health services, reported that "studies suggest that users with a history of severe disorders can be involved in services. This may depend on adequate support, as all the studies we found included details of the support provided to involved users. This included training and payment for involvement .... Practical and personal support ... e.g. discussing issues of confidentiality or advising on work matters". They also add that the support provided to users was "clearly distinguished from treatment".

Along side this, user groups need to be aware of what is expected of them, otherwise when the views differ or expectations aren’t met, then this can lead to disillusionment and future reluctance to participate. Individual support when it comes to attending meetings is also important, “time should be set aside in which they can be given assistance to prepare for meetings and consult with peers, including going through the agenda and past minutes, and opportunity to meet with support staff and other users to allow for de-briefing and discussion. Such support is crucial if the experience is to be of optimum benefit” (Bowl, 1996). Trivedi and Wykes (2002) found that using a contract, although not legally binding, was felt to be important as it set out clearly how users interests were to be protected.

Bowl also suggests that consideration be made to the time of meetings to take into consideration e.g. child care and travel needs. Attention and consideration of users should also be given to location of venue, access to those with physical disabilities, pace and format of meetings. Bowl also suggests that users should not feel pressured into taking on more responsibility then they feel able to accept. He goes onto say that “they should not be made to feel any less able to miss a meeting because they are unwell or have another obligation elsewhere. Nor should they feel unable to withdraw when they feel the time is right - for example, when they feel they are well and no longer identify themselves as a service user.”

Forrest et al (2000) highlight the importance of preparing, supporting and remunerating users, just as educationalists are. They also advocate that educationalists and students alike should be given support to “enable them to respond to changes resulting from greater user involvement".
Monitoring and evaluating the process of involvement
Simpson and House (2003) have found very few studies that document user involvement and have found the evidence is not conclusive. “Of the 12 studies we found, only five were randomised trials. Each involved few users (no more than eight at one time), making it difficult to generalise results. Many outcome measures were adapted for the specific study and few were assessed independently ..... research on user involvement is not straightforward”. Simpson and House (2003) go on to discuss how “...... evidence from non-comparative research indicates few disadvantages from user involvement in service delivery and research ... although not extensively evaluated, have been reported as positive”.

Simpson and House (2003) suggest that other forms of evaluation and study be considered due to the constraints that user involvement may have on randomised control trials, for example sample size. One suggestion they make is through monitoring of routine data on user involvement within projects, but they also add that formal research evaluation should not be thrown onto the back seat, that these are still possible under the right circumstances. They argue that, building up the evidence for user involvement, they argue, “should encourage involvement to be taken seriously, as a scientifically sound method of influencing service provision”. As scientist-practitioners I believe we also have a responsibility to demonstrate good sound research to support our work, as this in itself gives credence to what we are striving to achieve.

Conclusion
I set out in the hope that writing this essay would give me greater insight into the user movement; that it certainly has. Users have come along way since the mid nineteenth century. Positive changes in government and BPS policy, means that courses must be seen to be involving users. If the course aspires to reach level 5 on the continuum of involvement, then considerably changes must take place within the culture of the course. This may take considerable time and effort on the part of the course team if they wish to achieve true involvement in all aspects of the curriculum. They may also initially require considerable funding. These are all important issues to consider and account for, to prevent tokenism from occurring.
Whilst psychologists are expert within their profession, the lives lived by users also makes them expert in their own right. Experts that need their own voices, voices that enable them to feel empowered and make positive changes, to be seen as individuals and not simply as a diagnosis or a homogenous group of people without identities. They must be feel appropriately supported with their views and opinions taken seriously. Progress has been made in several settings to involve users and this is seen within psychology, for example in Exeter where users are involved in a positive way to make an impact on the courses development.

Careful attention also needs to be given to trainees and staff who participate in the process, this includes training, support and empowerment. Users as trainees need to be made explicitly aware of the mechanisms that are in place to support them, to ensure their mental well-being remains intact.

Building up of the evaluation base to identify the best ways forward for user involvement must continue, without which services can not support good practice guidelines with the evidence they need to push forward with their ideals.

It is hoped that by making significant changes in the way health care professionals are trained and influenced, this can impact in a positive way, not only for the users of services but also those that work in them, creating an effective and respectful service. A point echoed by Simpson and House (2003), “user involvement in training may influence trainees’ attitudes, leading to a more positive attitude towards user employees, or a more individualised approach to assessment of users”.
References


Professional Issues Essay

Under the proposed reforms to the mental health act clinical psychologists will be able to assume greater involvement in the process of "sectioning" and supervising the treatment of people who are subject to compulsion.

What are the advantages and disadvantages of our profession getting involved in these processes?

What issues and dilemmas might need to be considered by clinical psychologists as they make a decision about whether or not to accept these responsibilities?

How would you decide?

Year 2: December 2005
Introduction

I chose this essay in an attempt to understand the long and somewhat heated debate that has been happening since the late 1990’s regarding the proposed changes to Mental Health Legislation. I first began to hear about the debate whilst working in secure settings, whilst I understood some aspects of the debate, my limited experience and lack of knowledge about legislation prevented me from fully appreciating the issues debated. I know relish at the opportunity to permit myself time to read and understand some of the issues that have been discussed. I hope to reflect on my personal/clinical experience throughout the essay, but acknowledge that this is a process I find particularly difficult, especially given the breadth of information I feel I need to impart. To the marker, I would appreciate your comments regarding my reflections.

When I first began researching this essay, I was very confused about the roles of the Clinical Supervisor (CS) and Approved Mental Health Professional (AMHP) and how they may impact Clinical Psychologists (CPs). Upon reflection, I wonder if this reflects how many CPs feel, however as I read on I began to understand the debate regarding the intricacy of the Bill and its impact on the profession.

This essay will attempt to give a brief synopsis of the history of events and changes in societal attitudes that led up to draft Mental Health Bill (2004) with the aim of placing in context the current legislative changes. I have chosen not to discuss the draft Bill in detail, as there is insufficient room within this essay, instead the essay outlines the key points from the proposed Mental Health Bill (2004), which I feel are pertinent to psychology and how they differ from the current Act. The essay will then outline briefly the potential advantages and disadvantage of the profession getting involved in sectioning and supervision. Finally it will look at the issues and dilemmas facing the CPs in deciding whether to take the roles on. The essay will finish with my reflections on how I might decide.
History of changes

- The Vagrancy Act 1744 saw the introduction of legislation authorising those with mental disorder to be detained. Over time, legislation has been introduced in light of concerns for the needs of those with mental health problems and the public, which include:
  - The *County Asylums Act 1808* provided asylum for those who were deemed to be too dangerous.
  - The *1828 Madhouses Act* required that each asylum and private hospital have a medical officer.
  - The Lunacy Commission was then created following the *Lunatic Act, 1845* for the inspection of standards.
  - In 1890 the *Lunacy Act* introducing judicial and medical certification of patients following concerns regarding wrongful detention.
  - During the First World War, attitudes began to alter towards those with mental health problems, as the traumatic effects of trench warfare on returning soldiers became apparent. The *Mental Health Act 1930* drew from these changing attitudes, altering how those with mental health problems were referred to. ‘Lunatic’ was discarded in preference of ‘person of unsound mind’ and ‘asylum’ for ‘mental hospital’.
  - The introduction of psychotropic medication in the 1950’s saw the emergence of the medical model of mental illness, with the medical profession directing treatment.
  - In the 1950’s, the Percy Commission reviewed mental health legislation; the conclusions of that review formed the basis of the *1959 Mental Health Act*, which demonstrated a shift in the societal view of mental illness.
  - The current *Mental Health Act (MHA) 1983* is an adjusted version of the 1959 Act, which took into account rulings within the European Court of Human Rights and the uncovering of abuse on psychiatric hospitals.
  - Since the introduction of the MHA 1983, there have been developments in human rights law and legislation and changes in societal attitudes. This includes the adoption of the European Convention of Human Rights and the emergence of the social model of mental illness (House of Lords, House of Commons, 2005; Department of Health (DoH) 2005).
In light of these changes, the government ordered, in 1998, a major review of mental health legislation. In 1999, a Green paper ‘Reform of the Mental Health Act 1983’ was published, which was later followed by a White paper in December 2000 titled, ‘reforming the Mental Health Act’. A draft Mental Health Bill was published in 2002 for consultation, after much criticism a new draft emerged, which is the current draft published in 2004.

Since its publication, the Bill has been subject to pre-legislative scrutiny by a joint committee of the House of Lords and Commons, who sought and received evidence from professionals, carers and service users. In response to its findings the joint committee published its findings in 2005 and received a response from the Government, in 2005. The Government is currently in the process of redrafting the Bill, taking into consideration the evidence set forth in the joint committee’s report.

The Bill was also announced in the Queen’s Speech at the beginning of this session of Parliament (2005-06), which suggests the government means to introduce the Bill to Parliament during this session (House of Lords, House of Commons, (HLHC) 2005).

The differences between the current Act and Mental Health Bill 2004

Unlike the current Act, the Bill proposes a much simpler framework for determining who is liable to be treated under compulsory powers. It provides a single definition of mental disorder, based on behavioural rather than diagnosis for the purposes of assessment and treatment, and does not provide any exclusion criteria. It also provides a single pathway under which compulsory powers can be used. Under the proposed legislation, services can treat Service Users (SUs) within the community where it is deemed appropriate. The courts can divert non-dangerous offenders with mental health problems away from prison. A new Tribunal system is introduced, whereby the uses of compulsory powers over 28 days have to be independently authorised by the tribunal or the courts. Certain safeguards for SUs have been introduced, these include a nominated person who replaces the role of the nearest relative, they will have more rights to be consulted about decisions and can apply to the tribunal on the SU’s behalf for discharge.
There is also the specialist independent advocacy service, which both SU and nominated person will have access to, which alongside the nominated person will act to support the SU. Care plans have been introduced; these focus on the needs of the SU, these have to be produced within five days of the compulsory powers being enacted and are under constant review. There is currently no clarity from the government about what should and should not be contained in the care plans.

There is a demarcation of certain roles, this sees the Responsible Medial Officer (RMO) role, which is held by a consultant Psychiatrist, being replaced by the Clinical Supervisor role. This role has been opened up to approved clinicians, who have received the appropriate training and experience. The Approved Social Worker role is another role that is being replaced with the AMHP role. This role is open to other professions who have undertaken relevant training in the responsibilities of the new role, who have experience in working in mental health services and have the relevant professional competencies (DoH, 2004; HLHC, 2005; DoH 2005).

Advantages and Disadvantages

There has been considerable debate about the role of the CS and AMHP and whether Clinical Psychology should take on these roles. Many argue there are great advantages to the profession having involvement in sectioning and supervision. These roles could see CPs becoming a fundamental part of this aspect of the mental health process, having a direct influence in the delivery of care and exercise of power (Diamond et al, 2005). This role could grant credence to psychological approaches which have a practice base in formulation rather than diagnosis, providing a catalyst for much needed change within the NHS as an organisation (Chisholm, 2005).

The current mental health care system is also seen by some as being inadequate, as CSs, CPs could potentially influence and change the system for the better, they would not only have the powers to detain, but conversely have the powers not to detain (Chisholm, 2005).

Taylor (2005) argues that CPs would be in a better position to meet the needs of vulnerable SUs, as CPs will act more psychologically, by replacing diagnosis with formulation this could see the advent of different conversations with and about SUs.
A shared understanding of what it is that both parties want out of the experience could see a decline in the impersonal treatment of SUs where they are passive participants waiting to see the benefits of their treatment. Within the profession, CPs often work behind closed therapeutic doors with SUs; being more transparent about what our roles are may perhaps serve to improve relationships with other professionals and SUs (Pilgrim, 2005).

Under the current legislation, the RMO makes decisions on behalf of other professionals, which is often outside their competence. This includes discharging or transferring a SU whilst they are receiving psychological treatment or the sectioning of a SU for the sole purpose of receiving psychological treatment, which a psychologist might decide is inappropriate or unrealistic (Black, 2001). Also, psychology as a profession, to give it credit, is some 4000 years younger than medicine, so when considering its position within society it is doing well considering its youth (Kinderman, 2002).

Whilst many champion the rights of the profession taking on these roles, there are some who argue that the profession should take a cautious look at the potentially drawbacks the roles bring with them. Diamond et al (2005) raises concerns that the CS role could harm the relationship between the CP and the SU, potentially changing the type of relationship CPs have with SUs. This change could see CPs being prevented from taking a lead in or even being involved in a meaningfully and trusting therapeutic relationships with SUs (BPS, 1999). CPs may also be bracketed together with other mental health professionals as agents of the state, if the assessment process is seen, as it may be by some SUs as a prelude to compulsory detention (Holmes, 2002).

There are certain resource implications; the NHS confederation (NHSC) (2003) estimates a potential increase from eight per cent, under the current Act, to 16 per cent, with the proposed changes, of a consultant psychiatrist's time being spent on duties connected to the detention of SU on their caseload. The NHSC suggest that training for AMHP position, if it is similar to Approved Social Worker (ASW), could take 60 days with additional time needed to prepare a portfolio. If CPs take on these roles, they too are likely to see an increase in their workload, possibly working...
weekends and 24 hours, there has also been no mention of a pay increase in line with these new duties. Holmes (2002) also questions how these new duties will fit in with therapy, consultation, supervision and training. With all these pressure together with pressure to deliver the National Service Framework and other policies and guidelines such as those laid out by the National Institute for Clinical Excellence, could clinicians be forced to ration out existing resources. CPs could be forced to divert treatment away from the major part of their caseload towards SUs, who are formally detained, thus disadvantaging SUs who are not subject to mental health legislation (NHSC, 2003). Chisholm (2005) suggests that along with feeling over-stretched and overburdened, CPs may also find themselves professional isolated, working within multidisciplinary teams consist of various medically trained professionals.
Issues and dilemmas

Split within the profession

The Division of Clinical Psychology (DCP) in 2001 conducted a survey of its members to ascertain their views on the proposed changes; there was a 16 per cent response rate. Of those who responded, 71 per cent felt that the profession should be open to the development of CPs as CSs, whilst the 29 per cent felt the profession should resist the development (Cooke, 2002b). Whilst this survey provided some support for the proposed changes, there are some within the profession who are opposed to the proposed changes in legislation. They go so far as to suggest that there are many others within the profession who also oppose the changes, but have not been given the opportunity to voice their opposition. These professionals suggest there is a need for an official ballot, believing it will provide a somewhat more democratic process than the current executive decisions being made by the Chair of the DCP (Diamond, et al 2005).

Diamond et al raise some important issues, which I hope to reflect on in this essay, however whilst it is important to bear their points in mind, it is also important not to get swept away in fantasy, that is, believing the profession is being forced in a direction it does not wish to go in. After all, the chair of the DCP is a democratically elected representative of the DCP and for those who really object to the legislation, they can lobby their MPs who represent our views in Parliament, where proposed legislation is subjected to reviews and scrutinise (Gillmer, 2005). It is also important to remember that to date; the DCP has taken a proactive part in providing warning and protection against the Bill, championing the views of psychology both independently and as part of the Mental Health Alliance.

Whilst remaining realistically cautious, some would question the potential impact on those in the profession who do not wish to take on this role, will NHS Trust employ them (Holmes, 2002). There is however currently no evidence to support the belief that CPs will be obliged to act as CSs in cases where the clinical team agrees that their skills would be most usefully used as therapists (Taylor et al, 2003). The government has also suggested that whilst consultant CPs may be appropriate for the role of CS, in most cases the CS will continue to be a psychiatrist (DoH, 2004d)
Increased workload
As mentioned earlier, there is an indication that the proposed legislation will lead to an increase in workload. The NHSC (2003) suggests that the proposed legislation will produce an immediate increase of 60 to 100 per cent in the number of tribunal hearings, as everyone at 28 days will have a tribunal. With these duties, there will be an increased number of reports to be written. One suggestion is that report and hearing may have to be shorter and more straightforward to enable all sufficient tribunals to be heard. However, the NHSC highlight that due to changes in advocacy, and the rights of SUs to appeal against their detention, tribunals could become more complex and time-consuming. They go onto argue that the number of detentions may have to be reduced in order to cope within the resources currently available.

Additionally, for those taking on the AMHP role, training if similar to that of the ASW could mean 60 days of training, plus additional time to prepare a portfolio. If this is the reality, who will deal with the psychological assessment, therapy, consultation, supervision and teaching, that CPs are contractually obliged to do (Roberts, 2005). A potential cure could be changes to the career structure and training of applied psychologists which would produce different levels of qualified psychologists within the profession (Kinderman, 2005). This would enable different responsibilities to be conferred to those at the appropriate level, with the potential effect of reducing the workload of anyone individual CP.

Changing the system from within
Having worked within inpatient settings, I have been shocked and upset by the environments that SUs are expected to live in, they are often at best containing and at worst, dirty and harmful to their health and recovery, with very little to do (Chisholm, 2005). My experience of inpatient forensic settings, illustrated the dominance of the medical model of mental health, fighting against this was often difficult as I was often the only representative from psychology. As an assistant psychologist (AP), there were several parts to my work, which included both in and outpatient work as well as work within the probation system, this was also the case for the CP who supervised me. On the inpatient ward, I worked alongside a CP, an occupational therapist, a social worker, nurses and two RMO’s together with other members of their team including Specialist Registrars and Senior House Officers. Chisholm (2005)
highlights how working within a multidisciplinary team comprising of many medically trained professionals can lead to professional isolation. As an AP, even with close supervision (bearing in mind my limited experience and training) I often felt powerless in affecting change, frequently feeling unable to air thoughts as they were usually disregarded. Although I also worked as part of a larger psychology department, I fear I have now taken a passive aggressive stance as this experience as left me wanting to steer clear of inpatient settings. If however, others within the profession take the same course of action, steering clear of the CS role, this position may only serve to disenfranchise the profession, with the effect that their opinions will either not be taken seriously or as was my experience, continue to be ignored.

Changing existing legislation so that CPs become an essential part of the process may force many out of complacency, give credence to psychological approaches and provide a means by which to engender much needed organisational change (Chisholm, 2005). In 1999b, the BPS commented on the move within services towards multidisciplinary assessment and intervention and that responsibility should rest on the most appropriate professional within the team, rather than the RMO. If CPs are to take on this role as supported by the BPS, the profession has a duty to protect SUs from harmful or negligent practitioners, in order to do this, the profession has a duty to become statutorily regulated body.

Holmes (2002) suggests that due to our limited numbers and ever increasing workload, we may be better placed concentrating on what we are experienced and trained in doing, rather than attempting and failing to change other professionals practice. However, we may be in a better position as a minority in-group at exerting change than attempting to manoeuvre from outside (Chisholm, 2005)

**Power and the relationship with SUs**

While some CPs may wish to distance themselves by suggesting that they do not work in inpatient settings or have contact with SUs that may be detained, they are still part of the same system that employs forms of social control. In essence, the NHS and government pay their salaries; they are therefore liable because of their presence within the system (Pilgrim, 2005). It is therefore important to acknowledge that power exists whichever position we take as professionals, if we choose to
acknowledge, recognise and work through our thoughts and beliefs, we are far less likely to abuse that power (Jones, 1993).

Roberts (2005) argues that if CPs take on the CS role it could drastically change the type of relationship we have with SU. Diamond et al (2005) suggesting that there is ample research evidence (e.g. Stanford Prison Experiment) which shows that the roles people take are crucial to the way they behave and they question whether once we have the CS role, our profession will not act any differently than psychiatry.

In a study by Hurley et al (2005), they attempted to understand how detention might compromise the role of the mental health nurse. They questioned Approved Social Workers (ASW) to ascertain whether the therapeutic relationship between ASW and SUs was impaired as result of the ASW seeking compulsory detention of the SU. Three different themes emerged from the research, the first was that the relationship was strengthened through mutual open discussion about the ASW’s and the SU’s experiences of the application of compulsory care. The second theme was that the relationship was irrevocably damaged, so much so that an alternative key worker had to be allocated. The third theme indicated that the experience of being placed under the MHA meant that the relationship required rebuilding to regain its therapeutic value. All respondents indicated that detention was seen as a last resort measure, where the risks to the SU or others outweighed the impact on the therapeutic relationship.

The type of relationship CPs currently enjoy with SUs, which is seen as fundamental to the CPs role, is open, autonomous and based on self-acceptance and mutual goodwill. If we as a profession use this relationship as a basis of our work there are strong arguments to suggest that we can continue to provide a safe and therapeutic environment, not a prison. Chisholm (2005) argues that there are psychologists who work within the prison system, who are able to work in a non-threatening way, whilst bettering the surroundings they work in.

The CS role has potentially different consequences on the therapeutic relationship depending on the settings. In an open setting where therapeutic progress is dependent on the building of trust, the CS role may endanger this trust, possibly leaving the SU
feel betrayed, damaging the relationship and hampering progress. Within closed settings, the relationship is slightly different. Whilst working as an assistant psychologist in forensic services I often felt pressure within the therapeutic relationship around the outcome of the work. Some clients feared saying things that might incriminate them in someway, preventing or delaying their discharge, whilst others would acquiesce throughout the work believing it would facilitate their discharge (Black, 2002).

**Coercive Social Control**
As CSs, CPs will have the ‘powers to detain people and force treatment on them against their will’ Diamond et al (2005)(pg.3). No matter how it is dressed, mental health law is about the social control of those deemed mentally ill, and it is argued until it is abolished, then all professional involved within the system are implicated in social control (Pilgrim, 2005).

I doubt very much that we will be seeing the abolishment of mental health law in the near future, but by acknowledging our implication within the system, we can begin to view the mental health system from a different position. In particular, recognising the forces that have shaped it over the last 50 years, that is decisions made by RMO’s.

When viewing the system in this way, I find myself being curious about how a system based on formulation rather than diagnosis may look like. Could it lead to a better life for all involved, where SU become active participants in their treatment, forming contracts with professionals about their care rather than being passive participants who are plied with drugs in the hope they might work (Pilgrim, 2005).

Concerns have been raised regarding the compulsory treatment of SUs in the community, in particular if SUs are forced to use medication with potentially lethal side-effects against their wishes without inpatient supervision (BPS, 1998). Under community section, SUs will also have certain requirements placed on them for example, having to attend outpatients for treatment at specified times.

While the government has suggested that treatment cannot be imposed within an individuals home, if a SU does not follow any of the requirements stipulated in their
care plan, it may be necessary to compulsorily detain them in hospital (DoH, 2004c). This raises concerns, as there is evidence to suggest that SUs choose not to take medication for entirely rational reasons, mainly because they are ineffectual in a large number of cases. Two-thirds of people who take medication regularly are likely to experience a recurrence of their psychotic experiences within two years (Cooke et al, 2002a).

There is also some limited evidence to suggest that the act of entering hospital under a section makes people less likely to view their hospital treatment as helpful or benevolent. The process by which SUs are identified as needing the control of others and the admission itself should be seen as interventions with a costs and benefits profile (Ross, 2003). Ross suggests that as soon as people can be forced to accept psychological intervention, then it will be impossible to assure anyone that the choice is theirs, is this social coercive power at its worst? It could however be argued that the authority and powers to detain SUs are reviewed and ultimately held by the MHRT, which is hardly unhindered power. Black (2001) suggests that power without accountability is corrupting; however responsibility without power is debilitating and undermining. It is also important to acknowledge that whilst we can make every effort to ensure we do not abuse our powers, it may be the case that some individuals due to their early life experiences, may perceive any intervention by mental health services as intrusive and abusive (Pilgrim, 2005).

Canvin et al (2005) conducted a survey of SUs who had been subject to compulsory powers, to ascertain their view on the proposed Bill. The views presented in the paper suggested that the SUs felt that the use of compulsory powers was acceptable depending on whether they respected privacy and autonomy. Participants also acknowledge that mental health problems might lead people to lose sight of their needs, therefore justifying intervention. However, it could be argued that the proposed community treatment orders would in effect threaten SU's autonomy, going against every notion of deinstitutionalisation.

**Defensive Practice**

Whilst creating new possibilities to break the medical mould of the past, where resources are over-stretched, CPs may find themselves, like psychiatry defaulting to
conservative decision making to avoid false negatives, in doing so they may use lawful compulsion cautiously for self-protection. There could potentially be an abuse of power, whereby SUs could possibly be pressurised into complying, which could be recorded misleadingly as being ‘voluntary’. However if we continue working as reflective practitioners, being open and honest about what are roles are, it may perhaps serve to improve relationships (Pilgrim, 2005). Taylor (2005) also argues that we may not be any more philanthropic or benign than psychiatry, but we will act more psychologically in the CS role and so the needs of vulnerable group of SUs would be better met. However, until the legislation is enacted and a code of practice is developed and staff are trained in the use of the legislation, and clinicians start using it in their clinical practice, it may be hard to be certain of the true consequences of the legislation (BPS, 1999).

**Dangerous and Severe Personality Disorder (DSPD)**

There has been much debate about the term DSPD. Personality Disorder, as opposed to mental illness, is often view by psychiatry as untreatable, which places psychiatry in an uncomfortable jailer role. Under the current Bill, SUs with DSPD can be treated under compulsion providing all five conditions are met (DoH, 2004b). CP, as I have previously discussed tend to formulate, exploring with the SU what their difficulties are and then collaboratively working with the individual to reduce their unhelpful behaviours, in the hope that it will improve their lives and the lives of others. Could the very nature of CPs work be the reason the government has invited them to take on the CS role (Pilgrim, 2005). Kinderman (2002) argues that mental health legislation is an inappropriate way of treating dangerous individuals who are deemed to have unimpaired judgement and should be treated under the criminal justice system.

**Discussion**

Had I been approached a year ago and asked whether I thought CPs should take on the role of CS, I believe I may have answered no. On reflection, I feel this may have been an uneducated response and based on my limited experience within forensic services. I naively entered the field of psychology perhaps not fully understanding the influence the medical profession had within the system; I had a very rude awakening as an AP in forensic services.
Having had the opportunity to review the literature and gain a better understanding of the proposed legislation, I am not too sure that I would be so quick to say no. There are, I believe, some valid reasons for taking on the role of the CS, namely our skills, framework of knowledge and understanding. These skills help us to understand what is happening for the individually, placing them in the context of their life experiences, positions and roles within society. I entered the profession hoping that I could help engender change, not just for the individual but also the systems they exist in, which includes mental health services.

Having the opportunity to develop care plans, which are based on the personal and human needs of the individual, rather than the artificial categorisation of psychiatry, would go partway to this ambition. On the one hand I feel uncomfortable with the position of detention, but I have also become frustrated by a system in which SUs are passengers in a vehicle steered by the psychiatric profession, where they are placed in seats according to their diagnosis and treated accordingly.

I do not presume to believe that the CS role will be free of problems, and may even engendering hostility in some, but these are issues I am willing and prepared to work through, if the ultimate goal is to change the system in which we work and treat in. Whilst I may cheer at the prospect of being in a position to make changes, I also appreciate that I would have to be cautious and reflective in my practice, so as to prevent the abuse of power. On reflection, I also find myself slightly daunted by the enormity of the role; however, in reality it may be that I have few opportunities to take on this role. I also imagine this role would not be conferred upon me until I became a consultant CP and I hope that by then I will be wiser and more experienced than I currently am.
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Problem Based Learning

Reflective Account

Relationship to Change

Year 1: June 2005
We have been asked to write a reflective account of the whole problem based learning (PBL) exercise, or part thereof (including the original problem, the group process, the presentation) from the vantage point of subsequent clinical experience on placement and with the benefit of hindsight. For the reflective piece I have chosen to focus on my thoughts and feelings at the time of the PBL exercise and my subsequent thoughts and feelings, having now been on placement for several months.

**Coming together as a group**

As a member of a PBL group, I came together with the other members of my group to exchange our stories. These stories represented what we saw as our individual journeys in our ‘relationship to change’. Reflecting on and telling my own experiences of change, I began to notice similarities in our stories. These similarities were the experience of change from being an undergraduate student to now being postgraduates, also from being assistant psychologists to trainee clinical psychologists. It is difficult to say whether being on the course and having similar journeys, we consciously decided to bring stories that we felt the others could connect with. In attempting to make connections with the other members of the group, I chose to bring what was perhaps a familiar topic to discuss. Certainly for me it only felt natural to discuss change in this way; it felt safer. Reflecting back on this now, whilst on placement, it feels somewhat like the process of therapy with a client, where time is spent establishing trust and rapport. As with my PBL colleagues, this was done by showing that we cared about each other by listening, showing warmth and empathy when we individually shared our stories. I have also begun to notice that within therapy, clients have been able to explore and be more frank about very deep and personal issues. When I asked one client what she thought has enabled her to make positive changes in her life, her response was “having my feelings validated for the first time”. This is something that can only be done once the therapeutic relationship is further established, with confidence in the process, and in the security of the therapeutic relationship.

**The Pace of the Process**

Reflecting back on my feelings at the time of the PBL, it felt strange being thrust together with a group of people I was only beginning to get to know. I recall experiencing fear, fear of the expectations placed on me by other group members, and
also by myself. The process initially felt very fast paced; I recall thinking that we didn’t have much time to prepare the presentation. It felt like I didn’t have time to think about what we were doing. I was also conscious that others within the group worked to a faster pace. Reflecting on this, it certainly touches on my own need to achieve and not to fail. The process meant I had to just let go and go with the flow. Feeling rushed during this process makes me mindful of working with clients and the importance of working collaboratively. One of the underlying principles of cognitive therapy encourages collaboration and active participation of the client, with this in mind; sessions are tailored to suit the needs of the client and at the pace of the client. Although it could be argued that there are limitations placed upon us as therapists (trainee or qualified) with the current health care system, as we are sometimes only able to offer time limited sessions.

The Creation of Betty

In deciding to focus our presentation on the change from an assistant psychologist to a trainee, we set out to explore different psychological concepts that we felt related to our experiences of change. These concepts included self-efficacy, confidence, goal setting, responsibility and control. Armed with these concepts and our experiences, it felt natural to create a character that could portray the truly human aspects of our experiences. This process and the creation of Betty felt very enjoyable. It felt imaginative, drawing us away from a formal presentation where we might have perhaps read off an overhead, or presented ideas. I recall feeling energised by this change in direction. Betty and her presenting difficulties enabled us to make connections between theory and practice, as we ourselves were embarking on doing at the commencement of placement.

The assessment of Change

What stuck out mostly for me about my own change is, how do you assess change, how do you know you have changed? Having the opportunity to sit and reflect on this within the group, it became apparent that we often need frames of references by which to assess change. It is sometimes hard to assess change, until we have made that all-important step forward. Once we have done this, we can then look back at where we have come from. This is something I have experienced with clients, who come to therapy expressing a wish to make changes in their lives.
When I begin work with a client, I often ask clients to complete objective measures of mood, which help me by not only giving me objective scores but also providing a baseline measure (or frame of reference). In addition to this, I may also ask a client to monitor behaviours or cognition's in the form of thought diaries. These frames of reference allow the client and me in a collaborative way, to explore how our work together is progressing and whether we are achieving the goals of therapy.

For myself, having been on placement for several months and having made that step forward, I can now look back at where I once was. In seeing where I once was, I can really appreciate that the PBL exercise created a frame of reference that I can refer back to over the next three years, perhaps even my entire lifetime.

**Drawing parallels with my clinical work on placement**

To draw a parallel with the therapeutic process, some of the issues for me at the beginning of the PBL exercise included starting a new course; coming together with new people that I needed to work with and get to know. I also came wanting to learn about becoming a competent clinical psychologist and all the associated skills needed in order to do that. Now several months into placement, the University feels like a secure base from which I can go off and explore, like a child leaving the secure base of its caregiver in order to explore the world around it. I certainly know my PBL group better and I feel I can bring slightly more personal issues to the group. I have also become more confident in myself and my abilities, I am learning from my experiences through my work with clients and in supervision that putting into practice what I have learnt does on most occasions work.

The skills and knowledge I am acquiring on this course are somewhat comparable to the skills I am teaching clients whilst on placement. During our sessions together, clients learn a range of self-help skills that they can implement both in and between sessions. In this way, they can become their own problem solvers. In my experience, I have found that client although highly motivated, may find this difficult at first needing encouragement and support in what they are doing. As they become more confident and competent in what they are doing, they begin to take the lead, until a time where it is mutually agreed that therapy should begin to end.
This process feels familiar to how I have felt on placement, and is encapsulated in the course handbook, 2004-05 (pg. 195). The handbook discusses the various stages through which a trainee may progress. The first of these stages is the ‘Novice’ stage where, “the trainee needs basic facts and skills, needs to establish a professional role. There is initial anxiety but high motivation; a high level of insecurity in the role”. It goes on to say “in the early days of the programme the trainees may feel de-skilled as they establish themselves in a very different role of that previously. This may occur even though the trainee may have worked in the same speciality in a different job, say as assistant psychologist. This is an important stage in allowing the trainee to become open to new learning. However it can lead to a high level of anxiety”. I certainly feel I am still at this stage, although there is also a growing part of me that is beginning to progress to the next stage. As I reflect back over my first few months I felt anxious about my skills, but have been nonetheless motivated to learn new skills, techniques and ways of thinking.

In my experience as an assistant psychologist, I experienced a similar process of change. I recall having to administer a psychometric test for the first time. I recall being anxious days before, whilst it continued during the testing process, the intensity reduced. From that experience, I learnt to overcome the anxiety, realising that the process was not as difficult as I had imagined. I also had a somewhat objective measure of my abilities, my supervisor, who was encouraging and supportive. Just as I provide that objective, encouraging and supportive voice to my clients. Understanding the struggles that I have gone through, the creation of Betty as a symbol of the groups experiences, allowed us in a way to get in touch with our own selves, the patient within us.

Self-Discovery

In undertaking the PBL exercise and writing this account, I am beginning to explore and become more aware of what I as an individual bring to my work. I am not simply my job title, a trainee clinical psychologist; I am also a daughter, a sister, a cousin, and a friend, the list is endless. Just as a client is an individual and not simply a diagnosis. During placement, I have begun to learn to look past the diagnosis and understand the individual in the context of their life experience. Just as my life experiences have influenced the way I see the world, they also influence my value.
system and how I relate to others. This is something we saw in Betty; we learned to understand her presenting difficulties in the context of her life experiences (Stedman et al 2003).

I feel in a privileged position working with clients, earning their trust and respect. Being given the opportunity to hear their stories and understand their current difficulties in the context of their life experience. The PBL exercise has opened a door through which I have begun to discover how my own experiences influence the creative ways in which I work with clients, making connections with them. For example, understanding the different ways in which I am able to learn, I can be creative in the ways I choose to teach new skills to the clients I work with. I find myself reflecting on these experiences in supervision, learning from my experiences with clients and the meaning they hold for me.

Placement
Finally, joining the multidisciplinary team on placement felt similar in many ways to coming together with the PBL group, new faces, names and personalities to get to know. What was different was that the team was already established and I had to get to know new people and understand the dynamics of how the team functions. I was also away from the secure base of the University, and unlike the PBL group, I was the only new person, coming into an already established team. Whilst working with my PBL group, I was able to appreciate and learn from the group about the importance of team working, where emphasis is placed on collaborative working, with a common aim. This is something I was certainly mindful of when I began working with the team, appreciating and respecting their work ethics and team culture.
References


Problem Based Learning

Reflective Account:


Year 2: March 2006
My aim for the reflective account is to write a free flowing narrative, reflecting on my experience of the PBL exercise, the presentation, content and the group process. I will attempt to reflect throughout on how my experience of the exercise has influenced me since both personal and professional, in particular the connections I have made between the exercise and my clinical experience whilst on placement within a learning disability (LD) service. This is the second PBL reflective account we have been asked to write. Much has changed within a year; I hope to be able to reflect upon this at certain points throughout the account, highlighting the changes within myself and those around me.

For the PBL task, we were given a case study concerning a family composed of a married couple with twin daughters. The mother was identified as having a LD and the twins had been taken into care following child protection proceedings. Other issues highlighted within the case study included domestic violence and parenting. The group task was to decide “whose problem is it? Why?”

Within the first meeting I recall feeling somewhat confused, as there had been some confusion over the exercise and when it would be taking place. Some of the members of the group had come prepared, whilst others had not. This meeting was also the first with our new facilitator. Our previous facilitator had been a male, whom I experienced as being very dominant within the dynamics of the group. I recalled feeling slightly uncomfortable with our new facilitator, a female from a psychodynamic background. On reflection, I feel I was concerned about what she might think of me. I wanted to make a good impression, believing perhaps that with her all-seeing psychodynamic eye, she might see the fraud within me. I was also nervous about how I might compare to those in her first group, would I be good enough. This is something I also recall feeling when starting my second year placement, on reflection I wonder how my supervisors experienced the change in trainees. I also wonder how service-users (SU) experience this, especially within a LD service where there are often multiple professionals involved in an individual’s care over many years.

One of the first tasks was to appoint a scribe; however we chose not to appoint a chair. This on reflection was very different to the first PBL exercise. Whilst we had
been very directed in taking these roles on, we had also sought comfort in them. I feel that this change reflected a positive strength within the group, we felt comfortable expressing our views within a collaborative atmosphere. Through discussions we were able to bounce ideas off each other, exploring the issues presented to us whilst also remaining focused. On reflection, this draws a parallel with the therapeutic relationship, where an atmosphere of collaboration can take time to foster and develop (Beck, 1995).

In terms of the case study, I recalled feeling unclear about what was expected; also the information we were given felt sparse. Sometime after the first meeting we received an email from Arlene, I expected this email to contain more information and insight into the case, however, it simply confirmed what I had already understood. On reflection, I can appreciate how pertinent the information was in relation to the exercise. In my experience within LD services, referrals are often made to the service with very little information; the exercise allowed me to build confidence in my own intuition together with the professional and theoretical skills I had amassed over the years.

I recall feeling overwhelmed by the exercise; it brought up a lot of issues I knew very little about such as child protection. There were also terms I had not heard of before and did not understand, such as ‘children’s Guardian’ and ‘rehabilitation plan’. I was also the only trainee within my group on a LD placement, I recalled feeling overwhelmed with the responsibility of championing the voice of those with a LD. However on reflection, the exercise highlighted the importance of team working, drawing on the skills that others within the group had. Working within a LD service is very different to adult mental health; casework is much more reliant on multi-disciplinary team working rather than individual professionals working independently, alongside each other. This has been particularly evident when conducting assessments within LD services, I have found myself working with speech and language therapists, community nurses and care staff in assessing and understanding an individuals needs.

In brainstorming and exploring the issues that the case study raised, we found ourselves trying to find a balance between the needs of the parents and the needs of the children. Balancing different needs is something I continue to find challenging.
and is reflected in the battle I had at the time and continue to have, in finding a balance between course work, placement needs and my own personal needs. Discussion in and outside of the PBL group helped me appreciate that I was not alone in this struggle. Whilst my commitment to the work felt no different to the first years PBL exercise, I found my enthusiasm was not as great, I did what was necessary. This perhaps demonstrates maturity, being able to acknowledge that I have done enough and what I have done is good enough (meaning best of my abilities). Also within the group, we were aware of the expectations placed on us as we had already presented twice before. Whilst on placement I have noticed a change in my ability to acknowledge this, not only with reports and reading pertinent material, but also when working with SUs. In the past, if an intervention had not worked, I sought to find an intervention that did; I feel this tapped into my desire to be a good clinician. If an intervention did not work it meant that I had not been a good clinician. I have begun to notice that I am more able to acknowledge when an intervention has been good enough, also acknowledging that the responsibility for an intervention does not solely lie within me, but within the therapeutic relationship (Beck, 1995).

Within PBL meetings, I found our facilitator took more of the observer position within discussions, reflecting back at certain points. This then allowed me the opportunity to take a reflective position on the issues she highlighted, something I appreciate and utilise within my supervision. We were also able to utilise our facilitator's knowledge and experience of psychodynamic theory, which excited me. She was however also able to acknowledge her lack of knowledge of learning disability and child services, which was something I found both daunting, refreshing and liberating. The not knowing position is something I find myself becoming more comfortable with (Sinason, 1992). Over the last year and a half, I have found my ability to tolerate not knowing change, at first I felt as if I had to know everything and have all the answers, if I did not, this would somehow mean I was an incompetent clinician. My experience especially within LD services has helped me feel more comfortable within this position. I have found that with some SUs, who have for the majority of their lives, been told what to do, when and what to think; not having the answers and normalising the anxiety provoking experience of not knowing, consequently liberates the SU to begin to think for themselves.
In researching the different areas that we had brainstormed, we had amassed a wealth of information that we needed to condense and convey within a short period of time. As with our first PBL exercise we chose to communicate our ideas through a role-play. I noticed that as we began to develop our ideas and ways of conveying the information, we used a certain amount of humour. Whilst being respectful to the subject and the content of the presentation, the humour appeared to lie in how we portrayed ourselves as "professionals" and the subjects we individually spoke about. We chose names for ourselves which were a play on words for the subjects we spoke about, e.g. Professor Connie Geetive was an expert in cognitive development and Professor Anna Tachment was an expert in attachment. We had also taken funny pictures of ourselves to show on the overheads, our objective was to create laughter. I wonder if our attempts to make the audience laugh helped us dispel the feelings of anxiety we felt about the subject material and may in a way have acted as a defence whereby we degraded ourselves before others might (Lemma, 2000).

I felt happy with the presentation we had put together, whilst it had been a struggle to condense and edit what we wanted to say, I was also excited by what I thought was a novel and exciting way of portraying our presentation. On the day of the presentation I recalled feeling let down, I had expected more tutors to be present at our presentation, instead there was only one course tutor and three visiting tutors. This left me feeling that our efforts had not been important enough to warrant the attendance of the course team, I felt angry and abandoned. On reflection, I imagine that workload prevented tutors from attending, but I also wonder about the topics we were presenting. It portrayed a population within our communities, who are predominately voiceless, and who are marginalised and discriminated against. I wonder if the poor attendance reflected a defence against this, if they do not witness the presentations then these issue cannot exist (Sinason, 1992). These issues draw parallels with and highlight a SU I have been working with who describes experiencing rejection, abandonment and great loss in her life. Not only did her family rejected her for not being the perfect child, but when at the age of 22 she became pregnant she was encouraged to abort the child, being persuaded as she politely put it, that she would be "better off" without it. This amazing woman continued to mourn the loss of her unborn child, but was not able to express this as there had been denial by those around her of her feelings and theirs. As if by not
speaking about it, the issue would go away, be forgotten, or no longer exist. Had I more space, I might consider transference and counter-transference issues for both the presentation and the SU.

Finally, working within LD services has given me the opportunity to reflect upon the skills I have developed and how they give me power and control over my life. The skills I utilised in completing the PBL exercise included, working independently as well as part of a team, communicating and sharing information, organisational and problem solving skills. I have developed these skills over many years; but they are also skills I have taken for granted. It has made me reflect on how a SU with a LD might deal with the same information, would they necessarily understand it. Within our group, we were able to ask several professionals to explain things we did not understand, we used the internet, we read research papers and books on the subject area. Working within LD services I have become aware of the power differential between professional and SUs, with SUs in some instances being over reliant on the professional, and being trapped by their secondary handicap (Sinason, 1992). Whilst others, who lack the capacity in the many areas we may take for granted, relying on others to do for them and be their voice.

At the start, this exercise felt nebulous, however on reflection I think it was a subtle way of highlighting the potential issues that face us as clinicians. Writing this account has given me the opportunity to appreciate and make the connections not only with the exercise, my current placement and my experience to date, but has also provoked thoughts about the type of clinician that I want to be.
References


Problem Based Learning

Reflective Account:

Working with Older People

Year 3: February 2007
My aim for this reflective account is to write a free flowing narrative, reflecting on my experience of the PBL exercise, the presentation, content and the group process. I will attempt to reflect throughout on how my experience of the exercise has influenced me since, both personal and professional, in particular the connections I have made between the exercise and my clinical experience within a Community Mental Health Team for Older People. This is the third and last PBL reflective account we have been asked to write. Much has changed over the three years of this course; I hope to be able to reflect upon this at certain points throughout the account, highlighting the changes within myself and those around me.

For the PBL task, we were given a case study concerning a 72-year-old man (Mr Khan), who had migrated from Pakistan in his mid 30’s. Mr Khan’s wife had recently died of cancer; he also had two daughters, Shazia who lived in Pakistan with her own family and Maya who lived in the UK with her European husband. Maya had contacted social services regarding concerns about her father’s health and memory. Other issues highlighted included cultural and religious difference, loss and risk. Unlike previous years, there was no specific task or question to answer.

The first Case Discussion Group (CDG) was not only the first opportunity we had as a group to discuss the PBL exercise, but was also our first opportunity to meet with our new facilitator. I recall the conversation we had about what we appreciated most about our previous facilitator and the way we worked. Our new facilitator then informed us how he liked to work and the particular framework/model he utilised. I appreciated the opportunity to be able to work within a different model, but also felt frustrated that our voices were not listened to. This made me reflect on the way we work with service users (SU) and the choices we give them, in particular the NICE guidelines which recommend certain therapies over others (NICE, 2004). Reflecting now on the process, I am drawn back to the first meeting with our second year facilitator. I do not recall having the same feelings of frustration; on the contrary I was pleased and happy to be working within a psychodynamic framework. It felt natural and suited my style. I recall feeling apprehensive wondering how she might compare us to her previous group. This is not something I experienced with our new facilitator, however I found myself comparing our new facilitator to our old facilitator and wishing her back, often when new members join an already established group,
there are feelings of hostility and tension towards the new member (Yalom, 2005). This makes me wonder how it is for SU’s when members of a team they have been working with leave (Werbart, 1997). This highlighted the issues of ending and loss, something I have found to be particularly pertinent whilst working within older people services; I hope to reflect on this later.

I recalled leaving the first PBL session feeling we had not achieved much, as a group we are quite task focused usually assigning different areas to research, then bringing our findings back to the group. This was something that had worked for us previously allowing us to individually balance our workloads, we also live some distance away from each other, so meeting up to discuss the PBL was not often practical. This time we left the session with no plan of action. I recalled having mixed feelings, those of frustration that we did not have a plan of action, but also relief that I had space to do some other important pieces of work. This was also something that other members of the group experienced, so we were able to share our experiences and talk about how this made us feel. This makes me wonder how it is for SU’s and how they might juggle the various demands of their lives whilst also fitting in the homework exercises we negotiate with them. Over the last three years I have found myself appreciating much more the pressures individuals face. I have noticed that I am more able to have an open discussion about what is realistic for the SU to do, which places greater emphasis on the collaborative nature of the relationship (Beck, 1995).

During the second PBL meeting, I recall the process feeling quite problem saturated (Dallos, 2004). We struggled at the beginning wanting to find the answers to what could be wrong with Mr Khan. We had conversations about how we could detect and treat his depression, dementia or grief and how we would go about assessing these. On reflection this felt quite medical, something not very dissimilar to how the process feels on my current placement. I am aware on placement that the medics are the gatekeepers to the service; all referrals go through them in one form or another. The majority of treatments are centred on physical health, with very little time being spent on acknowledging the psychosocial aspects of someone’s difficulties. I recall attending a ‘ward round’, a weekly meeting were professionals working on the ‘geriatric ward’ would sit around discuss ‘in-patients’ care, before inviting them in for discussion. On this particular occasion there was a discussion within the team
concerning a female in-patient due for discharge. There were concerns that this woman may relapse and return into hospital, discussions around preventing relapse, centred on ensuring she continued to take her medication. Not wanting to be challenging, I decided to take a curious stance (Cecchin, 1987) and ask about social support and activities that were available to her. I was surprised and saddened by the apparent revelation this appeared to be to staff present. I wonder if this lack of consider for the psychosocial aspects of ageing is a defence on the part of those working in the area, that somehow if they deny the unhappier realities of ageing, they themselves might be protected from the prospects of becoming old themselves (Scrutton, 1999). I am also aware that my supervisor, who works part-time within the team, covering a large geographical area, is the only qualified psychologist within the team, compared with six psychiatrists. I wonder what wider message this sends out to the team and community about older people’s emotions and feelings. If you can give someone a tablet that takes away their depression then that in itself avoids the time-consuming process of looking deeper into the cause of someone’s distress (ibid), therefore perpetuating the idea that they are ill because they are old and that any difficulties they have are medical.

Our facilitator in the second PBL encouraged us to take a step back from our problem saturated conversation and suggested we do a role-play, each taking on the role of a member of the Khan family, including the deceased Mrs Khan. My first reactions were that of dread and bemusement, how was the role-play possibly going to help us figure out what was wrong with Mr Khan. As the narratives developed, I recall these feelings melt away, the role-play gave me the space to reflect on the narratives of those within the story; the role-play helped bring their stories to life. By the end of the role-play I was left wondering how to keep these stories alive whilst also balancing the factual aspects of the presentation which we as a group felt needed to be portrayed. As a group we were able to acknowledge the need for a balance between reflecting and action, we therefore each took topics we felt were pertinent to the exercise to research. Within myself there was also a pressure to do a good presentation, a presentation which was just as dynamic and humorous as our previous presentations. This highlights for me the ongoing struggle I have to acknowledge when I have done ‘good enough’. I have noticed my ability to acknowledge this more as the three years have gone by. I have found that supervisors over the years have
helped me cope with the uncertainty of whether I have done something 'good enough' as well as exploring these feelings within the context of transference and countertransference (Lemma, 2006).

During a telephone conversation with another member of my group we discussed our thoughts about the role-play; it was at this point that we hit upon the idea of continuing the narrative theme. We had both used narrative therapy in our child placements and had found that the externalising of the problem had been a useful technique which was respectful, curious and non-blaming (Vetere & Dowling, 2005). As there were many possible causes for Mr Khan’s difficulties, it felt important not to attach anyone particular label to him. To my excitement and relief the other members of the group liked our idea. Each taking the areas we had previously chosen, we went away to create our respective narratives.

The area I chose to research and present was natural ageing. When we came together as a group to share our narratives, I was struck by how humorous mine was in comparison to the others in my group, I wonder if I had used humour as a defence against all the unpleasant aspects of getting old (Lemma, 2000). In an attempt to bring my narrative in line with others within the group, I decided to tone-down the humour. I was concerned that there be a certain amount of humour, but I was also mindful of the need to remain respectful to the subject and content of the presentation.

On the day of the presentation, I was struck by how diverse the presentations had been, some very factual, others using role-play, whilst others using a similar narrative approach. Whilst I would not volunteer to do another PBL exercise, I was struck that this would be the last time we would come together as a year to present. This takes me full circle to the beginning of my account where I touched upon the issue of endings and loss, something that is very pertinent on my current placement. Being born into a family from a non-Western culture, I am struck by the different social expectations placed upon older people within Western and Eastern cultures. Within my culture of origin older people are revered and respected, they are central to the family. Whilst in more Western cultures, there is an expectation that older people withdraw from society and take time to reflect on their lives before dying (Scrutton, 1999). This is reflected in some health services who decide that at the age of 60, an
individual comes under an ‘older people’s service’. For many people that I have worked with, the loss of their role within society, the socially constructed views of ageing they take on have left them feeling vulnerable and oppressed. Personally, I do not want to reach the age of 60 and be expected to disengage from society and accept what is coming to me. Taking a narrative perspective on the PBL exercise has allowed me to appreciate the many narrative that surround us all and that whilst it is important to acknowledge what may be physically happening to someone, it is vital that we do not define them and label them according to those views.

I think this exercise has helped me question my views and perceptions of old age and how as a psychologist I can help individuals negotiate change within their life, without accepting the socially constructed view; developing their own individual narrative. On reflection, this free flowing narrative appears to have taken me full circle to the first year presentation on the ‘relationship to change’. As a final year trainee, how do I approach the inevitable process of change from a third year trainee to a qualified clinical psychologist? Will I have the courage to continue to create my own narrative, or will I perpetuate the socially constructed view of a psychologist?!!?
References


Case Discussion Group

Process Account Summary

Year 1: September 2005
Process Account Summary
This is the second reflective account we as trainees were asked to write on our experiences over the last year within our Problem Based Learning / Case Discussion Groups (CDG).

The CDG was formed at the beginning of the first year; its objective as laid out by the course team, was to provide a safe environment through which trainees could reflect on their clinical work, with reference to personal and professional learning. The discussion groups would also provide a basis from which the scientist-practitioner and reflective practitioner approaches could be integrated (Course Handbook, 2004).

As a group of five trainee clinical psychologists, with the addition of the course facilitator for the group, we met for approximately fifteen sessions over the course of our first year. This process account is a personal account of my experience within the group and how this has changed and developed over my first year of clinical psychology training. I have attempted to reflect on my contribution to the group and the discussions we had, the group process, and how these have influenced my personal and professional development.

The aim of the CDG was to allow us to reflect upon the therapeutic relationship, formulation and themes arising from the cases we brought for discussion. As a group we were able to explore and learn from each others experiences, in particular I was able to reflect on issues of diversity, psychometric assessment, forensic and legal issues, and confidentiality to name but a few. However, I feel this was limited by the groups inability to fully explore the dynamics of the therapeutic relationship, in particular neglecting the emotional aspects of the relationship, choosing to focus our efforts on the practical aspects i.e. what questions to ask, who to write to and what course of action to take.
Case Discussion Group

Process Account Summary

Year 2: July 2006
Process Account Summary

My aim for this reflective account was to write a free flowing narrative, reflecting on my experience of the Case Discussion Group (CDG). I attempted to reflect throughout on my experience of the CDG and how it has influenced me both personally and professionally, in particular the connections I made between the CDG and my clinical experience whilst on placement within a learning disability (LD) service and a child and adolescent mental health service. I reflect on the changes I experienced around me and within myself over the first two years whilst on the course; this is an issue I reflected upon at certain points throughout the account.

As a group of five trainee clinical psychologists (four female and one male), with the addition of the group facilitator, we met for a total of eleven sessions over the course of our second year. As a CDG, we had been artificially placed together at the beginning of our training, two years ago. I recall my experiences of this process and how it felt to be with a group of strangers talking about quite personal issues. I go onto explore the ways in which we as a group developed and grew, becoming more reliant on each other for support and friendship over the two years.

I reflect on the experiences of one of the group members during one of her placements and how this impacted on the group and the nature of our discussions. I also reflect on a change in theoretical orientation during the CDG’s, that is in the first year our facilitator came from a Cognitive Behaviour theory base, whilst our facilitator in the second year came from a Psychodynamic theory/practice base. I reflect on how I as a trainee and individual respond to this.
CLINICAL DOSSIER

This section of the portfolio contains a brief overview of the experience obtained on five clinical placements and summaries of five formal case reports conducted during the three years of clinical training.

Placement contracts, supervisor evaluations, clinical logbooks and the full versions of the five case reports are presented in Volume 2.

All names and other identifiable information have been removed to ensure confidentiality is adhered to.
SUMMARY OF CLINICAL EXPERIENCE

This section of the portfolio contains details of experience on five clinical placements, including placement details and summary of clinical skills and expertise obtained.
Adult Mental Health Placement Summary

Placement Details

Dates: November 2004 – September 2005
Supervisor: Dr Peter James
Setting: South West London and St. Georges Mental Health Trust
Base: Sutton South Community Mental Health Team (CMHT) and inpatient ward

Summary of Experience

The placement provided experience of working with a cognitive-behavioural/psychodynamic and schema therapy framework with a variety of adult mental health problems in the context of a community mental health team. Clinical work comprised of assessment for treatment interviews, intervention work for presenting problems of anxiety, depression, obsessive-compulsive disorder, eating disorders, phobia, multi-impulsive behaviour and psychosis. A ward based group for anxiety management based on cognitive behavioural therapy was also conducted. The CMHT placement enabled experience of working with a multi-disciplinary team, whilst the inpatient placement enabled experience of working with a psychiatric inpatient team.

Clinical Skills and Experience

Assessment consisted of semi-structured interviews with psychometric measures (i.e. Beck Anxiety Inventory and Beck Depression Inventory). Experience was gained in developing therapeutic engagement skills, understanding patient confidentiality and formulation within cognitive behavioural, psychodynamic and schema therapy frameworks. Experience with a variety of Neuropsychology measures was also gained, including WAIS-III, WMS-III, Rivermead Behavioural Memory Test. A service-related research project (audit) was also conducted investigating the clinical need for family work and CBT for service users with psychosis and their families.
People with Intellectual Disabilities Placement Summary

Placement Details

Supervisors: Geetha Langheit and Dr Julie Nixon
Setting: Surrey and Boarders Partnership NHS Trust
Base: Epsom Community Learning Disabilities Team

This was a joint one year placement with child and Adolescent Mental Health

Summary of Experience
Clinical work consisted of working with adults with mild to severe learning disabilities in the community (e.g. in residential homes, day centres and as outpatients at the team base). Opportunity arose to work with a diagnosis of Aspergers and Down’s syndrome. The placement provided experience of working directly with individuals, their families, carers and professional systems including residential, secure services, day care, and special needs school staff. The psychological models/theory used included attachment theory, grief counselling, cognitive behavioural/behavioural and systemic frameworks.

Clinical Skills and Experience
Experience was gained of working with a range of presenting problems including bereavement, anxiety, issues related to sexual abuse, identity and sexuality, dementia, depression and challenging behaviour. I was able to develop my psychometric assessment skills, using the WAIS-III, Leiter, BPVS, an in-house dementia assessment and Asperger’s in-house assessment. I also had the opportunity to train residential staff on assessing co-morbid mental health problems, with individuals with intellectual disability.
Child and Family Placement

Placement Details

Supervisors: Penny Bebbington and Dr Rebecca Scarth
Setting: Surrey and Boarders Partnership NHS Trust
Base: Epsom Child and Adolescent Mental Health Team

Summary of experience
The placement provided experience of working with children, families and professional systems using, attachment theory, developmental, behavioural, cognitive behavioural and systemic frameworks. Opportunity rose to work with a child with an emotional disorder and intellectual disability, direct work with families and their children, indirect work with parents and schools. I worked with children and young people from the age of 18 months to 17 years.

Clinical Skills and Expertise
Experience was gained of presenting problems including specific phobia-parcopresis; conduct disorder, attachment related problems, eating disorders, ADHD, behavioural difficulties and developmental delay. A range of assessment tools were employed including WISC-III, WPPSI, WIAT, Conner’s, Spencer Children’s Anxiety Scale, Fear Anxiety Scale and BAI. School observations were also conducted in a nursery and in a special needs school. Group work was conducted at a local primary school with parents; this was a psycho-educational group with the aim of helping parents manage their children’s anger. Visits were also conducted to local services to gain insight into resources available to families within the area. I also attended clinical psychology meetings and worked with other professionals within the team i.e. community nurse.
Older People Placement Summary

Placement Details

Dates: October 2006 – March 2007
Supervisors: Ron Bracey
Setting: Surrey and Boarders Partnership NHS Trust
Base: Kingsfield Resource Centre, Redhill Older People Community Mental Health Service and East Surrey Hospital

Summary of Experience
The placement provided experience of working with people over the age of 65 years. It was situated in both an outpatient community service and an inpatient medical setting. I conducted in-patient work with individuals with dementia and depression. The community work consisted of working with individuals adjusted to life-cycle changes as well as mental health problems such as anxiety, depression, and functional assessments for dementia.

Clinical Skills and Experience
Neuropsychological assessment skills were developed using a variety of psychometrics including the RBANS, WMS-III, WAIS-III, MMSE, FAS, Trail Making, WTAR and Grading Naming Test. Skills were developed in working with this population using psychological models used included CBT, Schema Focused Therapy and Mindfulness. I was able to reflect on life-cycle change and the role of older people within society. There was also opportunity to discuss ethical issues around consent with people with a diagnosis of dementia and the use of medication to treat specific dementia in line with new government guidelines on their administration. The limitations of services in provide adequate support and respite for this population was also discussed. Visits to day services for people with a diagnosis of dementia allowed an understanding of service provision for this population.
Advanced Competencies Placement Summary

Placement Details

Supervisors: Dr Anna Manners, Fiona Clarke, Dr Mary Hill and Dr Darren Lombard
Setting: West London Mental Health NHS Trust
Base: Broadmoor Hospital, Crowthorne

Summary of Experience

This placement provided experience of working with in-patients within a high security hospital. The work involved forensic assessment, such as assessments for risk of Arson, generic risk assessments as well as neuropsychological assessments. Therapeutic work involved using Narrative, CBT, mindfulness and systemic theories with individuals and nursing team. Individuals within this setting presented with a variety of problems including forensic history (e.g. sexual/relationship difficulties, emotional control issues such as anger and violence, substance misuse and fire-setting behaviours), personality disorders (e.g. antisocial and borderline) and mental health issues (e.g. psychosis and schizo-affective disorder).

Clinical Skills and Experience

I was able to conduct forensic assessments using the Historical Clinical Risk Assessment (HCR-20) to examine risk management issues, Arson Assessment, and an admissions assessment. I conducted individual work with a sex offender the focus of this work was exploring issues around empathy and how this impacted on his interactions with those around him. I had the opportunity to work with an individual who had been in Broadmoor for seven years and not engaged in any therapeutic work, the focus of the work was around constructing a cohesive narrative and using motivational interviewing techniques to increase motivation to change. I also had the opportunity to run a ward based group exploring issues around strong emotions, this was based on the high dependency unit, with individuals who are experienced as challenging and need a high level of nursing support. This placement provided an
opportunity for me to explore and develop my learning in systemic organisations and the influence they have on service users (e.g. the power dynamics between nursing staff and service users). It also gave me opportunity to develop my understanding of the Mental Health Act and other legal issues that pertain to the detention of individuals within this facility.
SUMMARY OF CASE REPORTS

This section of the portfolio contains summaries of the five case reports conducted on clinical placement.
Adult Mental Health Case Report Summary 1

CognitiveBehavioural Therapy with a 25-year-old female with anorectic symptomatology with chronic low mood and low self-esteem

Reason for referral
Ms Mary Simpson a 25-year-old female was referred to the local Community Mental Health Team by her General Practitioner for assessment and treatment of depression, partly triggered by certain life events.

Assessment
A semi-structured interview was conducted to ascertain the presenting problem and Mary also completed the Beck Depression Inventory – Second Editions (BDI-II), her self-report produced a score of 20, which indicated mild to moderate level of depression.

History of Presenting Problem
Mary described a difficult relationship with her mother, where she always sought for her approval. At the aged of 10, she began being bullied at school. The bullying continued into secondary school and was mainly verbal. Mary began to self-harm at the age of 14, starting with scratching her arms with her fingernails and progressed to cutting with razor blades. At the age of 15, Mary had a horse riding accident and was placed on strong medication for the pain, which resulted in a loss of appetite and weight loss. She felt better due to the weight loss and started to be “sneaky” about her meals.

Mary described using both the self-harming and restrictive eating continually since the age of 15, to cope with difficult feelings. The longest period she went without self-harming or restrictive eating was approximately six months, whilst settled into a new flat and new relationship, but she relapsed when the relationship ended.
Formulation

Mary’s early experiences as a child are of significance, the experiences of feeling unlovable, inferior, worthless and unattractive are factors, which led her to develop core feelings of low self-esteem.

Her attempts to overcome these feelings were futile, trying to get her parents attention by self-injuring and telling her parents and teacher about the bullying failed. In an attempt to gain her mother’s approval, she developed over-evaluated perfectionist standards that she would continually strive to attain. Mary then developed unhealthy coping strategies to deal with these feelings, such as cutting.

Falling off her horse, taking strong medication and subsequent weight loss resulted in Mary receiving positive reactions from her peers. In her aim to remain thin and in control, Mary would restrict her eating, exercise excessively and take amphetamines to suppress her appetite.

Further interpersonal difficulties with the break up of a serious relationship, after she confided in her partner about her behaviour and feelings of depression, again reinforcing feelings of low self-esteem. This led to feelings of loneliness and isolation which she coped with by cutting and restricting her eating.

Restricting her eating to 800 calories per day led to feelings of low mood, tearfulness and de-motivation. She would also feel tired, going to bed by 9pm and gets up around 6.15am. When she experienced times like this, she would self-isolate, minimising contact with friends and family. This would precipitate feelings of low self-esteem and feeling of being unloved.

Intervention

At the time of writing the case report Mary was seen for a total of 21 treatment session. In setting the goals of therapy with Mary, she chose to focus on her eating disorder, as she felt that this was a priority over her self-harming behaviour.

The intervention incorporated psycho-education about the effects of anorexia nervosa, rational for restoring normal nutrition with emphasis on weight gain, weekly
monitoring of food intake and the prescription of a normal eating pattern. Weekly weight checks were conducted by the therapist. Work also centred on identifying dysfunctional thoughts, schemas, and thinking patterns. Whilst developing more adaptive ways of being, this included modifying self-concepts. Relapse prevention and maintenance issues were also identified.

Outcome
It was difficult to assess outcome as the work was still ongoing, however, Mary’s BDI-II scores part way through, decreased from 20 to 4, which place her responses within the normal range. Mary made positive steps towards changing her eating habits, and at the time of writing the report was eating three suitable meals per day; this still continued to be the focus of our work. Her weight had not gone up, remaining within the normal range, however, her reported energy levels, socialising and time to bed had all increased. Although self-harm was not the focus of our work, she reported no incidents of self-harm over the last three months. Mary reported feeling happier with her life, although she expressed the belief that it could not keep going well, that it would eventually go wrong and everything would fall apart.

Critique
This was my first experience of working with someone who had an eating disorder. I found the process daunting and challenging, anorexia nervosa can take between one and two years to treat and then there is no guarantee that treatment will be effective in the long-term. Reflecting in supervision, about the strength and determination Mary came with, motivated me, especially at times when Mary herself becomes demotivated. I found supervision an endless support as I attempted to think through the complexity of Mary’s difficulties. Although I had the formulation to guide me, I often felt lost trying to piece the pieces together, I wonder if this was a reflection of how Mary herself felt?
Adult Mental Health Case Report Summary 2

Cognitive Behavioural Therapy with a 22-year-old male with a diagnosis of Schizophrenia

Reason for Referral
Mr Sanjit Magoon is a 22-year-old man who was verbally referred by his Community Psychiatric Nurse (CPN) within the Community Mental Health Team (CMHT) to Psychology for Individual Cognitive Behavioural Therapy for Schizophrenia.

Assessment
Sanjit was assessed in a joint session with the trainee clinical psychologist and her supervisor. As Sanjit was already known to the team, the focus of the assessment was to gain a better understanding of Sanjit’s current experiences and whether he wished to engage in individual work to address these issues. In addition, I read his case notes and had a discussion with his care co-ordinator. The Psychotic Symptoms Rating Scales (PSYRATS) for auditory hallucinations and delusions were conducted two months into therapy, once greater rapport had been established.

Presenting Problem
Sanjit reported that he continued to hear voices, which he found distressing and off-putting. This prevented him from achieving things he wanted to in his life such as attending Music College. He described hearing two voices, the first being the voice of a famous movie star and the second the voice of his father. Both voices commented on Sanjit’s physical appearance, making derogatory comments about him such as, “you’re fat” and “you’re ugly”. Sanjit also reported the belief that everyone in the world was telepathic with the exception of himself and he found this distressing. He reported not feeling “in control” of his life and it not being how he wants it to be; this left him feeling very unhappy and he found it difficult to enjoy things in life. Sanjit reported that he had previously done work with a clinical psychologist from an early intervention team around his voices and the delusional thoughts he held, but reported that he found it hard to believe in the strategies and the ideas now. Sanjit reported that he was keen to have individual work with the aim of
reducing the distress he experienced from hearing the voices and the delusional thoughts he holds.

**Applying a CBT formulation to Sanjit’s experiences**

Sanjit’s early childhood was characterised by his mother being the main, and for the most part, only caregiver within the home. When his father returned home, this was often marked by violence towards Sanjit’s mother, which was witnessed by Sanjit. Bringing up three small children on her own and experiencing violence at the hand of her husband may have placed Mrs Magoon under significant stress. This may have affected her ability to relate to and attend to the needs of her children. Witnessing the violence towards his mother and not having his needs adequately met may have influenced Sanjit’s beliefs about himself the world and other, perhaps that the world is a violent place, where his needs and emotions are not met.

Sanjit left school within six months of starting his A-levels, which conflicted with the family rule that placed great emphasis on achievement. Upon leaving school, Sanjit became increasingly isolated, as he no longer socialised with his school friend. He began working at weekends as a telephone operator, which he found increasingly boring and he became frustrated that he could not find a weekday job. Increased isolation and stressed at not being able to find meaningful employment, these critical incidents may have been contributing factors to Sanjit’s first episode. Due to physiological changes in neurochemistry, Sanjit began to hear a woman’s voice. Attempting to make sense of the experience, he constructed a delusional belief around the voice. Having intimate contact with a woman may have increased his self-esteem, making him feel special and wanted. Having limited social contact and no girlfriend may have influenced this belief. The attempted suicide a year after first hearing the voice indicated the strength of his belief in the voices and the delusional beliefs he constructed about them.

Since having contact with mental health services and receiving neuroleptic medication, Sanjit continued to experience residual symptoms in the form of voices and unusual beliefs.
**Intervention**
Sanjit was seen on 22 occasions over five months, once for a Care Programme Approach review another to visit a music project for people with mental health problems. We met weekly for the other 20 sessions, which usually lasted between 30 and 50 minutes. The sessions centred on engaging with Sanjit and building a therapeutic relationship. Cognitive Behavioural Therapy was used as a framework which allowed the trainee to socialise and encourage Sanjit to think and make links between his thoughts, feelings and behaviour. Enabling Sanjit to examine the evidence for and against his distressing beliefs about the self, world and others, enabling him to go onto challenge his thinking patterns about his beliefs and find realistic and accurate interpretations of situations.

**Outcome**
Sanjit came to therapy with the explicit request for help in getting rid of his voices. However the use of techniques such as subvocalisation as a means of blocking out the voices proved to be too threatening for Sanjit. He explained that if he gained some control over the voices, it would mean that he had schizophrenia, which made him feel very depressed. This gave greater insight into Sanjit’s difficulties and demonstrated the utility of the therapeutic relationship in giving Sanjit the space to explore and discuss these issues. With this new insight the trainee arranged a visit to a music project for people with mental health problems; Sanjit was a keen drummer but did not have the outlet for it. It was hypothesised that doing an activity he enjoyed would have a positive effect on his self-esteem.

**Critique**
It became apparent during our work together that Sanjit was not able to look at his beliefs, as the alternative was that his experiences’ were a symptom of his psychosis, something which was unacceptable for him. Reformulation highlighted the need to provide activities that could boost his self-esteem in a more healthy way, before interventions seeking to help him modifying his beliefs.
Intellectual Disability Case Report Summary

Extended Assessment of a 16-year-old adolescent male with Down’s syndrome presenting with challenging behaviour

Reason for referral

Antonio a 16-year-old British adolescent male with Down’s syndrome was referred by his schoolteacher. The teacher the Community Team for People with Learning Disabilities (CTPLD) requesting that a team member attend an urgent meeting at Bee School to discuss increasing concerns regarding Antonio’s behaviour.

Presenting Problem

Due to the stated emergency of the referral, little was known about Antonio and the identified problem. Antonio was described as increasingly challenging, acting out violently towards staff and students as well as being non-compliant with requests to join in with group activities, which disturbed the whole group.

Extended Assessment

An extended assessment was conducted with Antonio over a period of seven sessions, using semi-structured interview with teaching staff, observations of Antonio within the classroom and psychometric assessments (Leiter, and BPVS).

Results of Psychometric Assessment

With regards to the BPVS, Antonio’s score fell within the extremely low score range. His age equivalent score was three-years-one-month; the confidence intervals for the age equivalent score were two-years-nine-months to three-years-seven-months. The results of the LIPS indicate that Antonio’s score fell within the severe impairment of intellectual functioning range (BPS, 2000). His age equivalent score was at the four year eleven month level.
Formulation

Antonio's challenging behaviour was formulated within the context of operant behavioural theory. When applied to Antonio's situation, observations within the school environment highlighted a number of issues. In terms of antecedents, at times the tasks expected of Antonio were not suitable for his level of ability. He was sometimes given complex and lengthy sentences, which were non-directive and often not given face to face. He appeared to work well in one-to-one situations where he was given simple instructions and positive verbal praise. Activities he enjoyed included arts and crafts and working on the computer. Although on one occasion Antonio was difficult to engage in the computer work, once engaged he subsequently refused to move onto another activity. This can either be viewed as positive reinforcement, i.e. the consequence of the challenging behaviour was that Antonio was able to continue with the activity or negative reinforcement; the challenging behaviour resulted in the withdrawal that is demand avoidance. Due to Antonio's communication difficulties, others around him found it difficult to understand what he was trying to communicate, this may have lead Antonio to withdraw from social interaction (negative reinforcement) or 'act out' as a means of communication. In addition, as a consequence of his hearing loss, when there was a lot of activity or noise around him and/or he was unable to hear or understand the instructions being given to him, Antonio may not have understood what was expected of him and not respond appropriately.

The results of the psychometric assessment and subsequent conversations and observations of Antonio in the classroom, suggested that there was an overestimate by staff of his cognitive ability. This may have confounded difficulties as staff set tasks or have expectations of Antonio, which are beyond his cognitive abilities.

Recommendations

Due to Antonio's receptive and expressive communication difficulties, instruction were given on more suitable ways to communicate with Antonio that ensured he understood what was expected of him. Antonio's expressive language appeared to be at a one or two-word level; his speech was also unintelligible to most people.
Suggestions were made about how staff could improve communication with Antonio such as communication cards or makaton.

It was recommended that Antonio could benefit from one-to-one support for a specific period of time to help teachers to re-engage Antonio in activities. Introducing a structured programme at school, tailored to his level of ability, would give Antonio a sense of what was expected of him. Antonio was also referred to a drama therapist, with the aim of exploring further the cause of his behavioural difficulties.

Critique

The extended assessment appeared to provide the pertinent information to answer the assessment question, that is: why was Antonio acting in a challenging way? Due to the complexities of the case and the current status of the process, it is difficult to be certain which of the hypotheses were correct. Feedback from the school however indicated that they were already developing strategies in line with informal recommendations made. The school had taken a more proactive and systematic approach towards rewards and this seemed to have had a positive effect at reducing the challenging behaviours.
Child and Adolescent Mental Health Case Report Summary

Behavioural Therapy with a 17 year-old female presenting with a specific phobia – parcopresis

Reason for Referral
Annabel Stevenson a 17-year-old female was referred to the Child and Adolescent Mental Health Service (CAHMS) by her General Practitioner. The referral letter stated that Annabel was suffering from anxiety symptoms which prevented her from using any toilet to open her bowels apart from the one at home.

Assessment
The initial psychology assessment was conducted in a community clinic with Annabel and her mother, Liz present. The assessment comprised a one-and-a-half hour session and was conducted by the trainee and her supervisor. The outcome of the assessment was presented to Annabel and her mother and was fed back to the referring GP. The Beck Anxiety Inventory was used to measure the severity of Annabel's level of anxiety. Annabel's self reported experience of anxiety was 25, which fell within the moderates range

Presenting Problem - History and Development
There appears to have been a number of factors which led Annabel to experience anxiety regarding the use of public/other toilets. Annabel’s mother explained that she herself has never like using public/other toilets. Annabel recalled a number of incidents in her childhood regarding the use of “stranger” toilets to defecate. The first at the age of three. Annabel recalled a further two incidents, which she felt impacted on her current problem. Attending a sleepover at a friend’s house, Annabel and her friends consumed alcohol, she subsequently felt sick and was given salt-water to drink, which resulted in an urgent need to defecate. She reached the toilet in time, however after this incident the girls spread a rumour at school that she was ‘caught short’. These rumours caused Annabel to feel dirty about herself. More recent incident in 2005, Annabel was caught short whilst visiting her sister’s college. Annabel felt this recent incident precipitated her current anxieties around using a public/other toilet.
Annabel felt that if she used a toilet to defecate, it would be obvious by the noise and smell what she was doing. She worried that others would think she was disgusting, these beliefs were having a significant impact on Annabel’s life preventing her from attending college and engaging in social activities with friends.

**Formulation**

Having a mother with the same phobia may have predisposed Annabel to fear using public/other toilets. Early unpleasant and distressing experiences’ whilst a young child, may have reinforced this early learnt behaviour. The experience of being caught short at her sister’s college may have reinforced the feelings of anxiety Annabel had regarding defecating in public toilets, as well as being a precipitant to her current difficulties. Annabel's overt manifestations of her experience of anxiety (i.e. refusing to leave the home environment) elicited attention and care from both her mother and sister. This may have increased the likelihood that these behaviours would occur in the future and reinforced the notion that leaving the home environment would be distressing as it would lead to the need to defecate in a public toilet. Annabel’s inconsistency at leaving the home environment further helped to maintain the fear of using public/other toilets, in that it prevented her from experiencing the feared situation.

There were a number of protective factors which could potentially influence the probability that a treatment programme for anxiety would be effective, these included Annabel's apparent motivation to change together with a supportive social and family network.

**Action Plan**

The main goal of therapy was for Annabel to be able to use a public/other toilet without experiencing debilitating anxiety. This would also include being able to leave the family home without feeling anxious about needing to use the toilet.

**Intervention**

Annabel was offered a total of 10, one-hour-sessions using a behavioural approach, with a number of behavioural experiments/exposure work being undertaken in the
community, in three stages. The initial stage of therapy worked on building rapport, psycho-education and normalisation, i.e. informing Annabel that others present with similar anxiety difficulties, and how their treatment was approached. The following stage comprised a further conceptualisation of Annabel's phobia, a construction of an exposure hierarchy and the introduction of relaxation training. The final phase of our work together comprised working through the exposure hierarchy, helping Annabel overcome her anxiety at each stage and building up the belief that using public/other toilets was not an aversive experience.

**Outcome**

At session 10 Annabel completed the BAI, her overall self-reported experience of anxiety was 6, which fell within the normal range. This score was consistent with Annabel's self reported experiences of anxiety and shows a marked reduction in her reported level of anxiety when compared with the baseline measure. Also of importance was Annabel's success at completing the number of significant steps in her exposure hierarchy, with decreased post exposure anxiety. Due to time limitations on placement, Annabel's care was transferred to the trainee's supervisor to enable Annabel to capitalise on the work she had already achieved and to ensure they were maintained.

**Critique**

The work conducted was successful, measured by the reduction in Annabel's anxiety. In retrospect, it may have been beneficial to have commenced self-esteem work at an early stage. Limited evidence base in this area meant the intervention was based on experiential knowledge. It was important however for the initial intervention to work specifically on Annabel's phobia, as this had severely restricted her life and its quality. Given the reformulation, I feel less confident about the long-term effects of this work. Perhaps additional time or a referral to Psychodynamic services may have given Annabel the opportunity to resolve any feelings of conflict she experienced towards her parents.
Older People Community Mental Health Case Report Summary

A Neuropsychological Assessment for Dementia in a seventy-two year old male

Reason for Referral
Darren Williams was referred to the Community Mental Health Team for Older People by his GP, following concerns about his memory, delusional beliefs and a fall. The team psychiatrist met with Darren for an initial assessment and referred him for a psychometric assessment in order to clarify his cognitive profile and aid diagnosis.

Presenting Problem
At the initial assessment Darren described word finding difficulties as his main concern, for example when having a conversation with someone he would find it difficult to find the word he required and therefore finds it difficult to end his sentence. He also described noticing that he jumped from topic to topic, to the point that his conversations with people did not appear coherent. Darren also described forgetting where he placed things. He felt that this was partly to do with his "visitors", who were moving things around and hiding his money from him. In an attempt to catch them out, he would either, hide the money and then have difficulty finding it later, or he would lie awake all night trying to catch them out.

Hypothesis
Given Darren’s presenting problems, medical history, MMSE score the following hypotheses were considered:

Darren’s neuropsychological profile will be consistent with:
1. Alzheimer’s disease (AD), specifically cognitive decline, memory loss, word finding and naming difficulties and difficulties with tasks that require visuospatial and executive functioning.
2. Dementia with Lewy Bodies (DLB), including deficits of attention, executive functioning and visuospatial abilities. Other symptoms present include visual hallucinations and delusions, fluctuation in cognitive functioning and repeated falls or loss of consciousness.
3. Vascular Dementia (VD), including deficits in attention and visuospatial functions, poorer performance on tests of recall and executive functioning.
4. Darren may be suffering from depression, his profile would not be consistent with that of a dementia and would fluctuate dependent on attentional difficulties and mood.

Assessment
In line with the literature, the following tests were administered together with a semi-structure interview:
The Wechsler Test of Adult Reading (WTAR, Wechsler, 2001).
The Repeated Battery for the Assessment of Neuropsychological Status (RBANS, Randolph, 1998).
Verbal Fluency (VF) was assessed using the Controlled Oral Word Association Test (FAS).
The Trial Making Test (TMT) (Reitan, 1958).
The Graded Naming Test (GNT) (McKenna & Warrington, 1983).
The Clock Drawing Test (CDT.)
The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983).

Results of Assessment
Darren’s neuropsychological profile was impoverished across multiple domains. Premorbid estimates of Darren functioning using the WTAR placed him within the Average range of functioning. When compared with his performance on the WAIS-III, this suggests a deterioration of his general intellectual functioning. The results of the WMI-III indicate that whilst Darren had difficulty acquiring new information, his memory difficulties were further compounded by problems with retrieval.

The results suggested that Darren did not have significant difficulties in Attention for auditory-based tasks. His difficulties appeared to be with visual based tasks, in which he was required to manipulate information. Darren’s performance on Visuospatial/Constructional tasks was also variable. The assessment indicates that
Darren had difficulties above those expected in Vascular Dementia, which are more in line with an AD/DLB profile.

DLB shares many features of AD, with DLB often being confused with AD. Darren’s performance and presenting symptomatology supported a diagnosis of probable/possible DLB.

**Recommendations**

Following the assessment, a report was written detailing the findings together with recommendations. I also met with Darren to feedback the assessment, whilst also gaining his perspective on the report before it was finally sent out. I also gave him some information on DLB and the local Society.

It was recommended that Darren may benefit from being referred to the memory service for support and counselling. That with Darren’s consent, his son and daughter could be contacted and provided with support/carer information. He may benefit from an Occupational Therapy assessment to assess his current level of daily living skills, which could help identify areas he needs support with, whilst also providing a baseline measure for future monitoring of change. With Darren’s permission, it was recommended that a risk assessment be carried out by the Psychiatrist to ensure Darren did not place himself or others at risk when driving.

**Critique**

It is important to note that there were limitations to the assessment as there is no definitive anti-mortem test which diagnosis dementia and this is why a ‘probable’ diagnosis can only be given. It may have also been helpful to assess Darren’s activities of daily living.
RESEARCH DOSSIER

This section of the portfolio contains evidence of research work conducted throughout the three years on the PsychD course, including a service related project undertaken whilst on the adult mental health placement, a major research project completed in the third year, and a record of research experience presented in the form of a research logbook.
SERVICE RELATED RESEARCH PROJECT

Measuring the need for Cognitive Behavioural Therapy (CBT) and Family Intervention (FI) for service users with a diagnosis of Schizophrenia in a Community Mental Health Team (CMHT) caseload.

Year 1: July 2005
Abstract

Title: Measuring the need for Cognitive Behavioural Therapy (CBT) and Family Intervention (FI) for service users with a diagnosis of Schizophrenia in a Community Mental Health Team (CMHT) caseload.

Aims: To identify all users who have a diagnosis of schizophrenia. To develop a questionnaire in line with recommendations by NICE guidelines for schizophrenia (2002) to determine and prioritise the need for individual CBT and FI for each service user with a diagnosis of schizophrenia. To enable care co-ordinators to complete the above questionnaire and to collate the data in a format that is usable to the team to aid them in providing interventions to those with greatest need.

Participants: All team members who have a caseload that includes service users who have a diagnosis of schizophrenia.

Results: The caseload comprised 296 users; care co-ordinators identified 68 service users (23%) as having a diagnosis of schizophrenia. With 52.9% (n=36) identified as living or having close contact with their families. No service users or their families had been offered family intervention, whilst seven service users (10.3%) had previously received individual CBT.

Conclusions: The NICE guidelines have provided services with a framework to set standards and highlight the importance of psychological interventions. However, this study has shown that there are limitations in implementing this into practice i.e. funding and resources. This study has considered the implications in providing psychological interventions for service users with schizophrenia, in a CMHT.
Acknowledgements

All the staff within the CMHT, in particular my clinical supervisor for his support and guidance in undertaking this project. Thanks also to my SRRP supervisors for their support and guidance.
Introduction

In a bid to modernise the NHS, the Labour government brought about changes by introducing new organisations and structures. One of the new systems introduced was the National Institute for Clinical Excellence (NICE). Their explicit aim was to provide, with some degree of authority, advice to the NHS on the cost effectiveness and clinical appropriateness of new and existing technologies (Walley, 2004). This would be done by developing national standards for clinical practice for those within England and Wales, thereby reducing the very publicised and embarrassing variations in clinical practice, known as 'postcode prescribing' (White, 2004). Along side this, another aim was to continuously improving the quality of treatment and care provided throughout the NHS (Kendall, Pilling, Pettinari & Whittington, 2004). On The 1st April 2005, NICE joined with the Health Development Agency to become the new National Institute for Health and Clinical Excellence (also known as NICE).

In December 2002, NICE published the first of its mental health guidelines, for core interventions in the treatment and management of schizophrenia in primary and secondary care. These guidelines identified good practice points and recommendations for psychological, pharmacological and service-level interventions, in both primary and secondary mental health services. These along with subsequent publication i.e. NICE guidelines for the treatment of Alzheimer’s disease (2001), NICE guidance on the use of electroconvulsive therapy (ECT) (2003) and NICE guidelines for Depression (2004), did not pass without comment. Comments included concerns about institutional discrimination (Stewart, 2001) in the eligibility criteria for the use of medication in the treatment of Alzheimer’s disease. The potential over-stretching and under investment of services in the treatment of depression (Whitty & Gilbody, 2005) and the conflicting advice offered by NICE and the Royal College of Psychiatrists in the use of ECT (Carney & Geddes, 2003). There are also concerns around the impact on other services who have not been assessed by NICE. With a ‘general pot’ of money from which to run the NHS and priority given to NICE assessed areas, there are concerns that resources will be freed from non-assessed areas and given to assessed areas (Walley, 2004).

In order to understand the impact of NICE at a clinical level, this study is interested in the implementation of the good practice points and recommendations for
psychological interventions within a particular Community Mental Health Team for people with a diagnosis of schizophrenia. NICE guidelines for schizophrenia highlight two main psychological interventions i.e. individual Cognitive Behavioural Therapy (CBT) and Family Intervention (FI). NICE suggest that these treatments should be an "indispensable part of treatment options".

There is at the time of this study no formal way of assessing the unmet needs within the CMHT. Whilst some service users (from here in called users) are being offered individual CBT, there are currently no form of FI offered to users and their families within the CMHT. Alongside CBT, NICE stipulate the importance of FI for those who live with or are in close contact with users with a diagnosis of schizophrenia. One suggestion made by NICE for potential future research, is the research into the methods for identifying which users would most benefit from FIs and methods for promoting their effective implementation should be undertaken (pg. 160). The first part of this study addresses this suggestion.

FI grew from work carried out in the 1960's and 1970's on family environments, Expressed Emotion (EE) and the possible affects these have on the course of schizophrenia. Studies have suggested that users, who experience environments where there are high levels of EE, were at greater risk of relapse (Cutting & Docherty, 2000). Vaughn & Leff (as cited by Kuipers & Raune, 2000) developed the Camberwell Family Interview (CFI), which is a five-scale measure of Expressed Emotion (EE). The significant predictive features of EE, as indicated by the CFI are critical comments, hostility and emotional over involvement (Kuipers & Raune, 2000).

One objective for an audit suggested by NICE (pg. 53) is the identification of the appropriateness of treatment being offered to users with a diagnosis of schizophrenia. In order to be able to implement this, the CMHT needs to identify those with a diagnosis of schizophrenia. NICE recommend the development of case registers in primary care for people with severe and long-term mental health problems. The development of some form of register would enable the CMHT to quickly identify and assess whether needs are being met.
The Trust in which the CMHT sits, currently operates several IT systems such as Clinical and Management Information System (CMIS) and Electronic Care Programme Approach (eCPA). The CMHT is also required to provide monthly caseload reports, they therefore have another document, which is held and updated monthly in an MS Word document. One way of developing a register would be to extract information from these systems to identify users with a diagnosis of schizophrenia and then to prioritise them according to their needs.

**Aims of the Study**

1. To identify all users who have a diagnosis of schizophrenia.
2. To develop a questionnaire in line with recommendations by NICE guidelines for schizophrenia (2002) to determine and prioritise the need for individual CBT and FI for each user with a diagnosis of schizophrenia.
3. To enable care co-ordinators to complete the above questionnaire and to collate the data in a format that is usable to the team to aid them in providing interventions to those with greatest need.

**Methods and Procedures**

The CMHT serves a geographical area of approximately four square miles with a population of approximately 55,000. It is part of a large mental health trust, which provides services for South London Boroughs in the South West London area. At the time of the study, the Community Mental Health Team had the following establishment. 1.0 full time equivalent (FTE) Consultant Psychiatrist, 0.4 FTE Specialist Registrar, 0.5 FTE Associate Specialist, 0.8 FTE Senior House Officer, 3.0 FTE Community Psychiatric Nurses, 1.0 FTE Occupational Therapist, 0.8 Clinical Psychologist, 1.0 FTE Team Manager and 2.0 FTE Social Workers.

The CMHT caseload record is updated monthly and is held as an electronic document by administration staff. Data for one calendar month were extracted from the electronic document, thereby providing a snapshot of the CMHT caseload. Care co-ordinators were given a list of users on their caseload and asked to identify who had a diagnosis of schizophrenia. To establish the accuracy of the diagnosis and most time-effective way of determining diagnosis, data from CMIS were extracted and compared with care co-ordinators responses.
NICE (2002) stipulate a number of ‘circumstances’ in which FI should be offered. These include whether a user lives with or is in close contact with their family, if the user has experienced a recent relapse, if they are considered at risk of relapse and if they experience persistent symptoms (pg.54). A questionnaire was developed from the ‘circumstances’ outlined in the guidelines to measure the needs for both CBT and FI (see appendix A). NICE also state that if a user with schizophrenia is not able to participate in an informed discussion and an advocate or carer is not available; they should not be offered individual or family intervention. These exclusion criteria were also added to the questionnaire. Whilst the guidelines give ‘circumstances’ in which FI and CBT should be offered and criteria for which users would be excluded; they do not give guidance on how to prioritise those that may need FI. Questions assessing the level of High Expressed Emotion within the family were therefore added to aid with the identification and prioritisation for FI.

Once data had been extracted from CMIS this was then compared to care co-ordinators own responses of diagnosis for their caseloads. Care co-ordinators were then asked to complete a questionnaire for users that had been identified as having a diagnosis of schizophrenia. Care co-ordinators were asked to base their responses to the questionnaire on their experience of the users and their families. The approximate time taken to complete each questionnaire was one minute. Other information extracted from CMIS for users with a diagnosis of schizophrenia were date of birth, gender and ethnicity.

Responses to all the questions were coded, with possible maximum scores for FI being nine and for CBT four. In order to prioritise users for the interventions, scores were summed, with priority being given to those achieving higher scores.

A register was produced prioritising according to scores obtained on FI and individual CBT scales of the questionnaire. To determine those that had previously received individual CBT or FI the CMHT Clinical Psychologist went through the register, identifying those that had received these interventions.
Data for this study were analysed with SPSS for Windows Release 11.5 (SPSS, Chicago, USA). Missing data were coded and descriptive statistics were calculated.
Analysis and Results

Demographics
There were 301 users on the CMHT caseload; five of the users were excluded from this study as they lived out of borough. Whilst the team held care management responsibilities they would not offer individual CBT or FI to the users or their families. After exclusions, the caseload comprised 296 users; care co-ordinators identified 68 users (23%) as having a diagnosis of schizophrenia.

In attempting to extract diagnosis from CMIS, it became apparent that these were only entered into the system if a user had been discharged from a psychiatric ward. This information was only accessible by viewing the discharge reports provided by CMIS per calendar month. Information was extracted for two calendar months; thirteen users were discharged over the two months, 30.8% (n=4) had their diagnosis entered into the system. Out of the four users whom had their diagnosis entered into CMIS; one had a diagnosis of schizophrenia.

Of those 68, 26 (38.2%) were female and 42 (61.8%) were male. The mean age for females was 56.28 years (age range 30 – 75) with the mean age for males being lower at 44.28 years (age range 22 – 77), the overall mean age was 48.87 years. Table 1 below provides the frequency of the ethnicity of users with a diagnosis of schizophrenia.
Table 1 Ethnicity of users with a diagnosis of schizophrenia

<table>
<thead>
<tr>
<th>Ethnic Groups</th>
<th>Frequency of those with a diagnosis of schizophrenia</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>49</td>
<td>72.1</td>
</tr>
<tr>
<td>Any other Asian</td>
<td>3</td>
<td>4.4</td>
</tr>
<tr>
<td>White Irish</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Any other White</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Indian/Asian</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Not stated</td>
<td>2</td>
<td>2.9</td>
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<tr>
<td>Black</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Any other Black</td>
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<td>1.5</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>mixed white and black Caribbean</td>
<td>1</td>
<td>1.5</td>
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</table>

Descriptive results

Of the 68, 52.9% (n=36) were identified as living or having close contact with their families. These 36 cases were then prioritised according to the total score obtained from the questionnaires completed by the care co-ordinators. The highest number of cases 19.4% (n=7) receiving a score of three (out of nine) and 22.2% receiving a score of four. One case received a maximum nine, two cases scored eight, and three cases scored seven. There were five cases, which scored a total of two or six.

As suggested by NICE for schizophrenia (2002), users would be excluded from receiving FI or CBT if they met both of the exclusion criteria. These criteria were questions to elicit whether the user is able to participate in an informed discussion and an advocate or carer is available. Of the 36 cases identified as living or having close contact with their family, one case met the exception criterion; this user had a total score of four out of a possible nine for family intervention.

Scores were prioritised for CBT, 17.6% (n=12) received a maximum score of four, with 27.9% (n=19) receiving a score of three, 32.4% (n=22) receiving a score of two and 22.1% (n=15) receiving a score of one. Six cases met the exclusion criteria.
Three had a maximum score of four, one a score of three, one a score of two and one a score of one.

To determine users in need of both FI and CBT, comparisons were made between scores obtained for FI and scores obtained for CBT for users who lived with or were in close contact with family. Table 2 summarises these results, with the exemption of the case that met the exclusion criteria for family intervention.

Table 2: Comparison of CBT and family intervention scores for those identified as living with or being in close contact with family.

| Sum for Individual Work out of 4 |
|-----------------|---|---|---|---|
|                 | 1 | 2 | 3 | 4 |
| Sum for family  |   |   |   |   |
| intervention    |   |   |   |   |
| scores out      |   |   |   |   |
| of a maximum    |   |   |   |   |
| score of 9      |   |   |   |   |
| 5               | 5 | 0 | 0 | 0 |
| 2               | 2 | 5 | 0 | 0 |
| 4               | 2 | 1 | 4 | 0 |
| 3               | 0 | 1 | 3 | 0 |
| 2               | 0 | 2 | 3 | 0 |
| 1               | 0 | 1 | 1 | 2 |
| 0               | 0 | 0 | 1 | 1 |
| 0               | 0 | 0 | 0 | 1 |

No users or their families had been offered family intervention, whilst seven users (10.3%) had previously received individual CBT. Table 3 summarises scores for users that have previously received CBT.

Table 3: Scores for CBT for users who have previously received CBT

<table>
<thead>
<tr>
<th>Sum for CBT out of a maximum score of 4</th>
<th>Frequency</th>
<th>Percent</th>
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<tr>
<td>2</td>
<td>2</td>
<td>28.6</td>
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<tr>
<td>3</td>
<td>5</td>
<td>71.4</td>
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Table 4 provides a summary of the allocation of cases within the CMHT.

Table 4: Allocation of cases per Care co-ordinator discipline

<table>
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<th>Care co-ordinator discipline</th>
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<th>Percent</th>
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<td>Psychiatry</td>
<td>22</td>
<td>32.4</td>
</tr>
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<td>Occupational Therapy</td>
<td>3</td>
<td>4.4</td>
</tr>
<tr>
<td>Team Manager</td>
<td>4</td>
<td>5.9</td>
</tr>
<tr>
<td>Social Work</td>
<td>6</td>
<td>8.8</td>
</tr>
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</table>

Discussion

The overall aim was to assess the need for CBT and FI within a CMHT. Reflecting on these aims set, the majority of these were achieved, however there were several limitations to the work carried out, together with implications for the service in which the study was performed. These will be discussed successively.

The identification and development of a register for all users with a diagnosis of schizophrenia

The study attempted to do this by extracting data from CMIS and by giving care co-ordinators a list of their caseload and asking them to identify who had a diagnosis of schizophrenia. Despite the information system in place, CMIS did not provide an accurate record of user’s diagnosis and so extracting a list of users with a diagnosis of schizophrenia was not possible. This study therefore relied on care co-ordinators to identify users on their caseload with a diagnosis of schizophrenia. Whilst this may be a suitable way of identifying users with a diagnosis of schizophrenia; due to the limitations of this study, its accuracy could not be established. If a service is not able to identify with any degree of ease or certainty, the overall needs of its users then this has implications for the overall provision of care. One positive outcome from this study has been the introduction of a system where by all users diagnosis can be added to the information systems updated monthly by the administrative staff. If this is
maintained, it should ensure an easier and more effective way by which care provision can be assessed in future.

NICE guidelines for schizophrenia also recommend that Primary Care Trusts develop a case register for people with severe and long-term mental illness. A development of a joint register between primary and secondary care could help by enabling follow-up as users progress through health system with the positive result of improving quality of care. However, amongst other things, this could have cost implications, as this would necessitate the need for specific case register staff to manage the register (Garnett & Bean, 2003).

**Questionnaire Development to prioritise the need for CBT and FI**

Whilst the questionnaire proved to be a useful but crude way, of eliciting the information required for this study, due to limitations, it was not possible to establish the reliability and validity of the questionnaire. This has particular relevance to questions aimed at eliciting EE, which was assessed using care co-ordinators subjective interpretations of the users and their families. As a crude method of assessing the need for a particular intervention, it does have its benefits. The questionnaire takes approximately one minute to complete and the information it captures is not used to exclude users from receiving interventions; it merely provides a rudimentary way of prioritising them.

Future work could look at ways of developing the questionnaire or using a measure such as the Five Minute Speech Sample (FMSS; Magaña et al., 1986) to assess levels of EE and prioritise users accordingly. In the FMSS assessment of EE, parents are asked to speak for five minutes about the user, the tapes are then rated producing a dichotomous EE index, which is comparable to the CFI. This would however have cost implications in terms of staff training in this technique as well as time taken to complete the measure. It could equally provide a suitable pre and post intervention measure of EE.

**Service Implications**

After exclusions, 62 users require CBT and an additional 35 require FI, when coupled with the NICE recommendations that both interventions last for over 6 months and
including more than 10 sessions, this has potential service implications. If the team Clinical Psychologist (CP) were to exclusively treat this user group and their families, this may take several years to complete. With only a 0.8 FTE CP working within the service, how should resources be deployed? There may be a need to prioritise those who have higher scores on the questionnaire; however, what could the potential implications be to users, their families, and the service if such a system were implemented?

There may need to be a review of who provides or is most appropriate at providing CBT and FI and the training needs within this remit. One option could be to train CPNs in these techniques, as the results indicate they hold the largest caseload of users with schizophrenia. This could however have long-term implications for CPNs and CP’s, in terms of workload and professional identity. Another important point highlighted by Walley (2004) is the impact of funding for the provision of CBT and FI, and the other potential implications this may have on other important services that may not have been assessed by NICE.

The NICE guidelines have provided services with a framework to set standards and highlight the importance of psychological interventions. However, this study has shown that there are limitations in implementing this into practice i.e. funding and resources. This study has considered the implications in providing psychological interventions for users with schizophrenia, in a CMHT. The limitations this study has highlighted suggest a systematic and collaborative approach in implementing these interventions, and a need for a realistic idea of the resources available.
References


Appendices A

Questionnaire for Individual CBT / Family Intervention
Questionnaire for Individual CBT / Family Intervention

1. Does the service live with or is in close contact with family members? (If NO, go to question 3) Yes  No

The most predictive of the five scales for High Expressed Emotion (HEE) within a family, from the Camberwell Family Interview, are critical comments, hostility and emotional over-involvement.

- Criticism is defined as unfavourable comments about the client.
- Hostility is defined as either generalisation of criticism or hostility.
- Emotional over-involvement consists of over-protective behaviour, devoted behaviour and exaggerated emotional responses.

2. With the above definition in mind, in your opinion is there high expressed emotion within this service user’s family? Yes  No

- Is there a member of the family who is overly critical or angry towards the service user? Yes  No
- Is there a member of the family who expresses feelings of hostility towards the service user? Yes  No
- Is there a member of the family who is over involved or over-protective of the service user and does too much for them? Yes  No

3. Has the service user experienced a recent relapse? Yes  No

4. Is the service user considered at risk of relapse? (The term ‘at risk’ refers to following an acute episode, or if a person has had 2 or more episodes in the last year). Yes  No

5. Does the service user have persistent symptoms? (The term ‘persisting symptoms’ refers to positive or negative symptoms, which persist, with limited or no response to antipsychotic medication). Yes  No

6. Does the service user take medication regularly as prescribed? Yes  No

7. Is the service user able to participate in an informed discussion? Yes  No

8. Is an advocate or carer available? Yes  No
Appendix B

Ethics Scrutiny form
The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust's ethical committee.

Name of Field/Placement Supervisor: 

Signature of Field/Placement Supervisor: 

Name of Trainee: 

Title of SRRP: 

Date: 

8/7/05
Appendix C

Email from supervisor confirming feedback of SRRP
Dear Suzanne,

I am writing as requested to confirm that you did feedback to Sutton South CMHT the findings of the SRRP you conducted whilst on placement with me. The team found the feedback extremely useful and indeed the project has been very helpful in identifying people with schizophrenia that need psychological interventions.

Kind regards,

Dr.

Consultant Clinical Psychologist

### Research Log Checklist

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<td>2 Carrying out a structured literature search using information technology and literature search tools</td>
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<td>3 Critically reviewing relevant literature and evaluating research methods</td>
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<td>4 Formulating specific research questions</td>
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<td>5 Writing brief research proposals</td>
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<td>7 Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
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<td>11 Collecting data from research participants</td>
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<td>21 Summarising results in figures and tables</td>
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<td>25 Interpreting results from quantitative and qualitative data analysis</td>
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<td>29 Submitting research reports for publication in peer-reviewed journals or edited book</td>
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<td>30 Applying research findings to clinical practice</td>
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**Qualitative Research Project**

**Abstract May 2006**

**Title:** The Beliefs, Thoughts and Experiences of Believers of the Paranormal: An Interpretative Phenomenological Analysis.

**Aim:** To explore ‘believers’ experiences of the paranormal through their thoughts, beliefs, interpretations and personal paranormal encounters. Further the researchers wondered how participants’ beliefs in the paranormal had developed and what function(s) did their beliefs serve for them?

**Design:** Focus group (consisting of four participants), which lasted approximately one and a half hours.

**Participants:** To access ‘believers’ in the paranormal, participants were recruited via a local psychic circle.

**Analytic procedure:** The focus group was transcribed and analysed using IPA. IPA was chosen because it is a method that aims to understand individual subjective accounts of experiences, and to explore the ways in which those experiences are meaningful.

**Results:** Following the analysis the researchers identified three main themes.

1. Interpretation of paranormal experiences - the stories participants told and their interpretations of their experiences seemed to support their beliefs about whether paranormal phenomena was part of normal reality or not.

2. Belief development and maintenance – beliefs in the paranormal appeared to be developed and maintained through storytelling. Shared storytelling was an example of social learning and had the function of validating/providing support for individuals’ beliefs in the paranormal.
3. Functions of believing – all participants agreed that they gained something positive from their experiences/beliefs, including comfort, reassurance surrounding death and communication/messages obtained through their paranormal experiences.

**Conclusion:** Despite the small sample size the study succeeded in obtaining an in-depth exploration of the beliefs and experiences of a homogenous group of believers in the paranormal. The research helped us to illuminate some of the ways in which paranormal beliefs are shared and transmitted between members of social groups, and has highlighted the importance of such processes in enhancing a sense of group cohesion and belonging. The research was also innovative in using focus groups and IPA simultaneously. By using focus groups the research was able to draw out the social factors in paranormal beliefs.
MAJOR RESEARCH PROJECT

An exploratory study of causal attributions made by both therapists and families attending an intellectual disability family therapy service.

Year 3: August 2007
ACKNOWLEDGMENTS

I would like to thank all the therapists and families involved in this study for taking the time to participate, in particular to the therapists involved who shared their experiences and insights.

I am grateful to all the individuals involved, for their hard work and effort in helping me recruit volunteers for this study.

I am indebted to Professor Arlene Vetere for all her invaluable advice and support. I would also like to thank Dr Julie Nixon for help and support in making this research possible.

I would also like to thank my fellow trainees for all their support in particular during our conversation within research meetings to discuss the IPA analysis.
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ABSTRACT

Objectives: To investigate the causal attributions of families and therapists within the first session of family therapy attending an intellectual disability family therapy service. The study goes on to explore the therapist’s perspectives on the first interview with respect to how family members made attributional statements and how this fitted with the findings of the attributional analysis.

Participants: Four families and two therapists were recruited through an intellectual disability service.

Design: A mixed method was employed using the Leeds Attributional Coding System (LACS) to code causal attributions made during the first family therapy session. Interpretative Phenomenological Analysis (IPA) was used to analyse and interpret interviews with therapists.

Results: The results were presented as case studies. Overall analysis was also conducted to explore similarities and differences across the cases. Mothers in this study made most of the attributional statements, with fathers making approximately half those of the mothers. Children made few attributional statements. Parents within the study tended to make statements that exonerated the children. Both therapists involved in the study made few attributional statements and these did not appear to be either blaming or exonerating in nature. The IPA analysis appeared to support the findings of the LACS as a clinically useful tool.

Conclusion: The relevance of the analysis for systemic theory and practice was examined and ethical and methodological problems discussed.
1. INTRODUCTION

The research based on family therapy with families with children with intellectual disability (ID) is extremely limited. To work effectively with families with ID children, therapists need to understand the unique needs, resources, and stresses common to these children and their families. This research hopes to draw upon research within a range of fields such as attributional theory, family therapy and the field of ID. In drawing together these different fields of research, the researcher hopes to develop a coherent narrative within which the current research sits.

1.1 What is Intellectual Disability

ID is a life-long condition resulting from genetic or developmental factors or damage to the brain, which often occurs at birth. ID can affect people in different ways including a person's level of intellectual functioning (usually permanent) and sometimes their physical development.

Whilst much can be done to help individuals with an ID and their families live full and happy lives, their disabilities are often fixed and cannot be treated and/or controlled with medication and/or other therapies. The Department of Health (DOH) (1995) defined ID as:

- reduced ability to understand new or complex information, to learn new skills (impaired intelligence); and
- reduced ability to cope independently (impaired social functioning), which started before adulthood with a lasting effect on development.

1.1.1 Prevalence

Producing precise information on the number of people with ID in the U.K. population is difficult. In the case of people with severe and profound ID, it is estimated that there are about 210,000: around 65,000 children and young people, 120,000 adults of working age and 25,000 older people (DOH, 2001). Most live, initially, in their family homes and later on in appropriate residential accommodation (DOH, 2002). In the case of people with
mild or moderate Intellectual Disabilities, lower estimates suggest a prevalence rate of around 25 per 1,000 population, about 1.2 million people in England (www.intellectualdisability.info).

Evidence suggests (DoH, 2001) that the number of people with severe ID may increase by around one per cent per annum for the next 15 years. There are a number of factors contributing to this increase, including an increase in life expectancy, in particular among people with Down's syndrome and the growing numbers of children and young people with complex and multiple disabilities who now survive into adulthood. There has also been a sharp rise in the reported numbers of school age children with autistic spectrum disorders, some of whom will have ID and a greater prevalence among some minority ethnic populations of South Asian origin. These changes are likely to have an impact on the home environment, meaning radical adjustment to family life and routine (Vetere & Dallos, 2003). New and innovative services are being developed to meet the needs of this population including family therapy.

1.1.2 Loss, Guilt, Protection and Exoneration

Common reactions to news of disability include protectiveness, revulsion, grief, anger, shock, guilt, embarrassment and inadequacy of reproduction and rearing (MacKeith, 1973; Sinason, 1992). Families are often faced with how to grieve for what was hoped for and is now lost: often referred to as ‘the perfect child’ (Sinason, 1992). At each lifecycle stage (Carter & McGoldrick, 1989) each of the family members is again forced with the loss of previously held expectations. Feelings of protection towards the person with ID from perceived consequences of their disability can often lead to counter-productive patterns of behaviour, this can often be seen when parents have different standards or expectations for their ID child and other children within the family (i.e. leaving home, sexual relationships) (Goldberg et al., 1995). Patterns of relationships within families with ID members are often related to, as in other families, to inter-generational patterns of relationships (Byng-Hall, 1985).
1.2 Systemic Family Therapy

Family therapy is also referred to as couples and family therapy, and family systems therapy. What follows is a very brief overview of systemic theory; it is beyond the scope of this research to outline in any depth the core ideas of systemic therapy. For a more comprehensive overview, the reader is referred to Vetere & Dallos (2003) and Carr (2006).

Family therapy is a relatively recent development, the 1950s saw the simultaneous emergence of family therapy in a number of different countries and in a number of different disciplines, movements, therapeutic and research traditions (Carr, 2006). Family therapy is a branch of psychotherapy that works with a wide range of adult-focused and child-focused problem. The main aim of family therapy is to helping to nurture change and development with regards to the presenting problems and promote healthy family development. This is done by focusing primarily on the relationship between the person with the presenting problem and significant members of his or her family and social network. It tends to view these problems in terms of the systems of interaction between family members. It emphasizes family relationships as an important factor in psychological health. As such, rather than blaming individual members, family problems are understood in terms of relational dynamics at many levels of contextual understanding. When individuals/families present, their individual circumstances will determine the level of importance that is attached to the individual, relational, group, cultural, and societal levels of explanation (Vetere & Dallos, 2003).

A systemic analysis involves understanding the connections between patterns, behaviour, and beliefs at a rational level of description and explanation. Vetere & Dallos (2003) suggest the evolution of systemic practice, which they have conceptualised as paradigm shifts or phases by which these changes have occurred. The three phases proposed by Vetere & Dallos (2003) suggest three phases in which systemic therapy has progressed:

The first of these included the central idea that a symptom displayed by one member of a family served a "function", an idea shared by both behavioural approaches and
psychodynamic therapies. Families were also understood in terms of behavioural sequences and patterns and in emphasising the function of a symptom in maintaining the stability of a family system. For example, an unwell child could be seen to serve the function of keeping the parents together, who had previously spoken about separation. Such behaviour was deemed a form of communication; these forms of unconscious communication were often given more emphasis then other more explicit forms. The types of theory that focus on behaviour patterns include structural, strategic and brief therapy.

The second phase saw a move in other areas of psychology, such as the cognitive revolution, which focused on cognition, meaning, and personal beliefs, rather than behavioural principles. The idea of the therapists as an objective observer was questioned. This was replaced with the idea that like others within a family system, a therapist will form personal and subjective views, which is influenced by their own assumptions and prejudices. The types of theories that focus on belief systems include Milan, family construct psychology and brief therapy/solution-focused therapy.

The third phase represented a change within sociology and psychology, in particular social psychology. There is still recognition of the importance of the intra-psychic experience, however there is also a recognition that it was impossible to disentangle the families and individuals from the wider cultural context began to emerge. There was also a growing realisation of the importance of language and the assumptions and experiences that are rooted in the cultural meaning of language, for example gender, race and class. The types of theory to focus on context included Feminist, narrative and Post-Milan.

There have also been more recent attempts at identifying ways in which different models of psychotherapy can be integrated; this for example includes Vetere and Henley (2001) integrating group analytic psychotherapy and systemic psychotherapy, for a more comprehensive list the reader is referred to Vetere and Dallos (2003).
Other central ideas in the development of systemic therapy include the issue of power at all relational levels and within society, patterns in relationships (Bateson, 1980) and over time, such as generational issues and life-cycle change (Carter & McGoldrick, 1989) to name but a few. Systemic family therapy has been slower to develop in ID services for families.

1.3 Working Systemically with Intellectual Disabilities

ID services have in the past tended to medicalise or pathologize the person with ID. These services have often seen the individual's difficulties as being inherent to them, that is, they are mainly deficit-based, ignoring the individual's abilities and resources (Baum, 2006). Halliday and Robbins (2006) explore the use of family therapy with individuals with ID and note that the approach is something people with ID benefit from and feel comfortable with. However, Fidell (2000) argues that care must be taken when including people with ID in family therapy, that their presence is not seen to be “tokenistic”. Baum and Walden (2006) highlight the importance of being aware of the use of language within sessions so as to ensure that conversations are accessible to all present.

When working systemically with adults who have ID and their families, Goldberg et al., (1995) highlight the importance of the therapist and reflective team in allowing families to think about and explore issues of loss and grief, which can often involve prolonged, repetitive processes. Goldberg et al., discuss the concept of ‘helplessness’, which is described as an area in which nothing is expected to change. Exploring helplessness enables families and therapists in turn to think about and concentrate efforts on areas in which everyone agrees change is possible.

Families may also be faced with shrinking social networks, perhaps in response to concerns about other peoples’ reactions to their children. However, whilst their social networks shrink, their professional networks expand (Vetere & Dallos, 2003). In an attempt to understand professional networks and their impact on the care of individuals with ID, Snow et al., (2007) conducted a study exploring the attributional styles of care staff towards self-injurious behaviour by adults with ID. The results of this study
suggested that staff made causal attributions about self-injurious behaviour that were internal, uncontrollable, unstable and specific. In other words staff believed that the behaviours were caused by factors that originated within the individual, but were beyond the individuals control, that is the behaviour, was caused by factors that were short-term, transitory and specific in outcome. Although Stratton (2003) expresses caution in generalising the findings from such research, it does pose a very interesting question about how families with children with ID might attribute their difficulties.

Case (2000) explored the social concerns of parents of disabled children and found parents to be dissatisfied with professional information before, during and after diagnosis of disability. Case highlights the need for on-going research to understand the experiences and perspectives of parent of disabled children in order to avoid a mismatch between parental and professional goals and needs.

1.4 Attribution Theory
Attempts to explore individual's perspectives can be linked back in some part to attribution theory. Attributional theory can be traced back to Fritz Heider (1958) who noted a similarity between the goals and activities of scientists and those of people in their everyday lives. Heider postulated that on the basis of observation, people form beliefs or theories about what is occurring around them in order to understand, predict and control events that concern them.

Heider believed that individuals are motivated to see their social environment as predictable and hence controllable, and that they apply the same kind of logic to the prediction of social events as to the prediction of physical events; they look for a necessary and sufficient condition for such events to occur (Eiser & Van der Pligt, 1988). Since Heider's original formulation, a vast literature has been spawned in which ever-increasing number of dichotomies and dimensions have been identified and studied, including the expansion and development of the theory by Jones & Davis (1965) and Kelley (1967). It is beyond the remits of this study to explore the literature and development of attributional theory, however an outline of the relevant dimensions and
their development will be briefly discussed. Although these are subject to debate (Bell-Dolan & Anderson, 1999), the five dimensions outlined below are reported to be the most important attributional dimensions (Stratton, 2003):

1. Internal versus External
In his attempt to differentiate between causal factors Heider sought to differentiate between those that originate within the individual and those that originate within the environment, which came to be termed "internal" and "external" (Weiner, 1986). This dimension is also known as ‘locus’ as it has been associated with the concept of locus of control. This dimension has been tied to several emotional and behavioural adjustment outcomes, for example, depression and loneliness is associated with making internal attributions for negative events (e.g. failing an examination) but external attributions for positive events (e.g. getting a job). Aggression is associated with making a particular kind of external attribution for a perceived injury (e.g. “He did that on purpose”).

2. Stable versus Unstable
Weiner (Weiner, 1979; Weiner et al., 1971) again referred to Heider (1958) when he differentiated causes according to whether they are perceived as being stable (unchanging overtime) (e.g. intelligence) or unstable (changing) (e.g. luck). Stability of attributions is related to expectations of success and achievement motivation (Weiner, 1986).

3. Global versus Specific
Globality refers to how consistent across situations a causal factor is expected to be (Abramson, et al., 1978). So at one end of the scale (global), causes are placed that have a broad-spectrum of effect, while the other end, ‘specific’ attributions, mean attributions that only relate to a narrow, special field.

4. Personal versus Universal
The more the internal factors that led to the negative outcome are seen as personal (or idiosyncratic) to the individual, as opposed to universal (all generally applicable), the
more that individual will be held to blame for the negative outcome of their actions (Brewin & Antaki, 1982; Janoff-Bulman, 1979).

5. Controllable versus Uncontrollable
The more the factors that led to the negative outcome seem controllable by an individual the more that individual may be seen to be to blame for that outcome (Brewin and Antaki, 1982; Shaver 1985; Smail, 1993). Controllability is also associated with emotions such as guilt and shame (Weiner, 1986)

1.5 Measures Used to Explore Attributional Style
Traditionally attribution theory has been researched using questionnaires (i.e. Attributional Style Questionnaire, Peterson et al., 1982) and other intrusive techniques to elicit patterns of attributions. Often these methods coerce the participant to make attributions, which they ordinarily might not be inclined to do. These methods do not allow the exploration of when or whether attributions are made without the request of the experimenter (Thomae, 1986). The reader is directed to Bugental et al., (1998) for a selective review of measurements of parental attributions.

The Leeds Attributional Coding System (LACS) was developed in response to growing dissatisfaction with questionnaires. The LACS is a method of coding attributions occurring naturally in therapeutic encounters (Stratton et al., 1986). Stratton (2003a) suggests that ‘recording and coding the attributions made during family therapy is an effective way of gaining insight into the habitual but sometimes unproductive explanations used by some families’ (pp.137).

The LACS has generally been used by researchers to code all causal statements, regardless of their subject matter. It can be used to code only certain categories of attributions that are of interest to researchers. What the LACS provides is a way of identifying and coding attributions occurring in natural settings with the suggestion that the dimension's employed can be modified depending on the aim of a particular research project.
1.6 The Application of Attributional Theory within Therapy

Research within marital and family therapy has demonstrated the utility of attributional theory in offering some tools with which to understand and improve interpersonal relationships. Kelley (1979) has pointed out that causal attributions are among the most important factors which determine how we feel about, behave towards and interact with individuals close to us. He suggests that couples may have a tendency to use their partners’ behaviour to make inferences about the partner’s disposition. The actor’s attributions about the partner’s behaviour will influence the feelings and evaluations with regard to the specific behaviour of a partner and in addition the satisfaction that they experience in the relationship.

A study of the attribution styles in marital couples found that more maritally adjusted couples were less likely to attribute negative relationship events to either themselves or their partners and were more likely to see these events as unstable and specific (Baucam et al., 1989). The maritally adjusted men were also more likely to attribute these negative events to outside circumstances with positive events being attributed to either themselves or their partner.

Attribution theory has also been applied to parenting behaviour. Bolton et al., (2003) found a link between parental high expressed emotion and causes that were attributed as personal to, controllable by and internal to the child, in a study amongst mothers of young children with behavioural problems referred to a clinical psychology service. Peters et al., (2005) explored maternal attributions and high expressed emotion, and found that there was a tendency for mothers to provide causes that were internal to, controllable by and personal to their children: a pattern they described as child-blaming.

Freeman et al., (1997) indicated that mother’s of children without problems employ the positive attributional bias for their children. That is they view pro-social behaviour by their children as due to internal characteristics of the child that are stable in nature. At the same time, they see deviant behaviour as situational and temporary. Such parents typically believe they have control over parent-child interactions because of their own
competence and skills. Conversely, mothers of children with behaviour problems and parents who maltreat their children display an opposite pattern. They explain their child’s deviant behaviour as due to disposition or stable causes within their children and that their children have control over their behaviours. These mothers appear to attribute lack of control on their part for their child’s behaviour. As a consequence of believing they have no control, these mothers may find that feelings of apathy, depression, and hopelessness follow (Gotlip & Abramson, 1999). Corcoran & Ivery (2004) suggest that as a result of having children with behavioural problems, mothers show increased stress and depression, they also tend to blame their children, become angry, and use harsh discipline.

When a family is referred for family therapy, it is usually one member of the family (often the child) who is seen to be/have a problem such as fear of school, an inability to sleep etc. It is this “blame frame” which has sparked off a number of studies exploring the issue of blame within family therapy (Bowen et al., 2002; Wolpert, 2000; Stratton, 2003a/b). Stratton (2003a), exploring causal attributions during family therapy, found that parents attributional styles tended to present their children as agents more often than themselves, seeing themselves as targets more often than their children. These parents saw causes as more likely to be internal to their children but external to themselves, and that the causes are more controllable and more personal for the children over the parents. Stratton goes on to suggest that the combination of these attributional dimensions is an effective way of identifying incidents of characterological blaming.

Stratton (2003b) whilst exploring the causal attributions of reconstituted families within family therapy found that biological, step- and adoptive parents differed in their attributional styles. Step parents tended to allocate more responsibility to the child and the effects the child had on the family, stepfather's tended to see causes as internal and controllable. Adoptive parents allocated a similar responsibility to the child as stepfather's, but were more able to attribute both good and bad outcomes as well as global causes for a child’s positive outcomes. They were less likely to make internal and controllable attributions to their children. Biological parents showed the least tendency
to attribute causality to their children, although they were more likely to see their children as agents. The children’s descriptions tended to be more internal to themselves than to their parents, which Stratton suggests may be a direct result of hearing their parents using attributions about them, but could also be a strategy by which they can avoid trouble.

Munton et al., (1999) in study investigating the attributional style of mother’s with children diagnosed as failure to thrive (FTT) noted four different attributional patterns.

1. Mothers attributed FTT to causes located within their children, but over which the children have no control.
3. The third attributional pattern concerned body size.
4. The fourth regarded attributions by mothers regarding their own behaviour.

In this study, therapists were able to tailor the intervention according to the mother’s attributional style, with positive effect.

These studies have allowed a better understanding of how families attribute causality within family therapy; there has however been a paucity of research specifically within the family therapy ID field.

1.7 The Use of Attributional Theory in the Process of Change in Family Therapy

In a study comparing the attributional styles of families attending family therapy and families recruited from the local population, Munton et al., (1999) found that families in therapy had a greater tendency to make attributions for unpleasant events they experienced as stable and global causes, which the researchers interpreted as “pessimism”. They also found families tended to make attributions involving causes which were both, internal and personal; this was interpreted as “trait-based” that is attributing causes to some unique trait or characteristic, rather than circumstances. Understanding specific familial attributional styles enable therapists to formulate interventions towards shifting attributions.
In a study looking at families rated by therapists as having changed/not changed during family therapy and comparing the attributional patterns of these families at the beginning and end of therapy, Munton et al., (1999) reported a number of interesting findings. Families rated by therapists as not having changed during therapy had a tendency to perceive the causes of their difficulties as more stable in nature compared with the other group of families. Families more resistant to change appeared to have more entrenched beliefs about the extent to which the causes of their problems were unchangeable and so family therapy appeared to have little impact on these particular causal beliefs. All families when compared to their first sessions tended to use more trait explanations in their final sessions – trait explanations for unpleasant events have been associated with low self-esteem, and have consequently been labelled maladaptive. This puzzled researchers who hypothesised that trait explanations might be less maladaptive if they are perceived as changeable. This study however failed to demonstrate any consistent change in attributional styles over the course of therapy, irrespective of whether the families were rated as having undergone positive change by therapists.

Family therapist's have to negotiate complex family systems, often dealing with families with competing accounts of their difficulties. How therapists respond to family systems can have an impact on a family's engagement with therapy. Wolpert (2000) explored the relationship between drop-out after the first meeting of family therapy and levels of blame by either family members of the child and/or blame of parents by the therapist. In a proportion of families who dropped out there was a high proportion of blame by family members of the child and therapist blaming of parents in the intervention.

1.8 Discourses of therapist's experience
How therapists engage and respond to families is a central feature of systemic practice, the concept of neutrality has been challenged in the literature (Stancombe & White, 2005). This poses the question of how therapists respond to families, what are their experiences of being in therapy with families. There is a lack of empirical studies which investigate therapist discourses of therapy and the therapeutic process. There have however been a number of studies exploring discourses around the issue of blame.
Stancombe & White (2005) have explored the discourses therapists engage in, both with families and therapy teams, in response to blame. They found therapists made accountability-neutral versions of the families' difficulties, and that therapists were forced to make choices between competing versions of events. However, in constructing these accountability-neutral versions, the therapists relied on both their own and the team's implicit and explicit practical-moral judgements. The authors go onto highlight the need for therapists to be aware of their prejudices and how these impact on therapy. The authors suggest the analysis of therapist's talk as a process of encouraging greater reflexivity.

In a study exploring therapists understanding of blaming events in systemic therapy, Bowen et al., (2005) found that therapists tended to categorise families current difficulties in terms of fear and control issues from past relationships and consequent underlying beliefs. They also described the resulting negative outlooks as a direct challenge to therapist idealism. Two of the dominant themes to emerge in the interview were the unbalanced allocation of responsibility within families and the difficulties negotiating difference and change within the family, both implicated by therapists in the process of blame. Bowen suggests that in understanding the complex family processes involved in blaming events, specific therapeutic techniques can be used to target these events.

Burck et al., (1998) explored therapist's discourse within the process of family therapy. Discourses to emerge included the challenging of participants thinking, this was done by introducing alternative discourses in relation to process, examining how the family's account for their difficulties as well as exploring therapists relationship with the family. This involved repositioning the family discourse with the therapist noting and elaborating ways in which they could take charge at a number of different levels in their lives, whilst also affirming the families own accounts and experiences. This study was helpful in exploring and understanding ideas of change within family therapy together with therapeutic skills and competencies required by the therapist.
1.9 Objectives

The aim of this exploratory study is to use the Leeds Attributional Coding System (LACS) to gain a better understanding of the attributional styles of families who attend an ID family therapy service. As a means of validating and expanding on these findings, the study aims to use a qualitative research method to explore the therapist's perceptions of the families who attend family therapy. The main areas of investigation in the second stage of the research are to gain an understanding of how the therapist's view the families and their attributional styles, what are their assumptions of the family and how did these influence their interaction with them. Whilst there has been research looking specifically at blame, this research has not been conducted within the area of ID. We therefore cannot be certain that other issues will not arise from the research. The research will then explore how the LACS fits in with the therapist's perceptions of the families and how the findings can be used for future work with these families. Using a case study approach, the utility of the LACS as a tool to aid the therapeutic process will be explored.

There are several reasons for carrying out this study. The Government White Paper "Valuing people" (2001) highlighted the need for research among people with ID. Alongside this the Department of Health (2005) has drawn attention to the fact that disabled children have many needs and often use many services. The Government wants children and their families to have services that meet their needs. Whilst there has been research looking at the attributional styles of families who are not affected by disability, there has been no such research within the field of ID and family therapy. Understanding the needs of these families means that services can adapt, plan and set up services which best meet the needs of this population.

Aims

1. Explore the attributional styles of families who attend an ID family therapy service.
2. Explore the lead therapist's perceptions of the same families and how this fits with the LACS data.
3. Explore the clinical utility of the LACS.
2. METHODOLOGY

Diagram one, below, illustrates the analytic process by which this research was conducted across the four case studies, a full description of the process is provide later on in this section.

<table>
<thead>
<tr>
<th>Case Study 1</th>
<th>Case Study 2</th>
<th>Case Study 3</th>
<th>Case Study 4</th>
</tr>
</thead>
</table>
| a) Family One – 1st Family Therapy session  
LACS – numerical analysis Quotes | a) Repeat for Family Two | a) Repeat for Family Three | a) Repeat for Family Four |
| b) Lead Therapist (Clive) interview for family one  
IPA - Themes | b) Lead therapist (Clive) interview – family two – IPA Themes | b) Lead therapist (Jill) interview – family three – IPA Themes | b) Two lead therapist interviews (Clive & Jill) – family four - IPA Themes |
| c) Comparison between analysis a and b | c) Comparison between analysis a and b | c) Comparison between analysis a and b | c) Comparison between analysis a and b |

Comparison across families

Pooled IPA analysis across therapist’s interviews

Discussion across four case studies

Diagram 1: Illustration of analytic process across case studies for this study
2.1 The Qualitative Vs Quantitative Debate

This study has used a mixed methods design. Quantitative and qualitative methods are often viewed at opposing ends of the methodological spectrum, with schools of research providing sound evidence to support their own positions.

Quantitative research is usually associated with a deductive approach where the concept of science is seen as objective truth or fact. Starting with a theory, a hypothesis is developed and subsequently tested. The ontological position is that there is one true reality which exists independent of human perception. It is based on positivism, which states that all phenomena can be tested and quantified; aiming to prove causal relationships. From an epistemological position, this approach holds that the subject under investigation can be studied without being influenced by the investigator. The approach allows the reactions of many people to be measured, but is limited to the number of questions it can ask (Sale et al., 2002) (Green et al., 1989).

Qualitative research is based on inductive reasoning whereby observations are made, usually in order to develop a new hypothesis or contribute to new theory (Casebeer & Verhoef, 1997). From this position science is often viewed as lived experience and therefore subjectively determined. It usually begins with open-ended observation and analysis, most often looking for patterns and processes that explore "how and why" questions. The ontological position is that there are multiple realities or multiple truths based on different construction of social reality. From an epistemological position, there is no access to reality independent of our minds; we negotiate a shared reality. The investigator and the object of study are interactively linked so the findings are co-created within the context of the specific question being asked which postulates that reality does not exist prior to the question being asked and ceases to exist when the focus of investigation is taken away. Qualitative research focuses on the process of meaning. Research using qualitative methods produces detailed information regarding small groups of people, giving a deeper understanding of that particular group; so the findings can only be generalised to theory and not to populations (Sale et al., 2002).
2.2 Combining Methods

As has been outlined above, both paradigms come from quite different epistemological, ontological and methodological positions. Sale et al., (2002) argues that the methods are shaped by and represent paradigms that reflect particular beliefs about reality and therefore, the quantitative paradigms are based on a worldview not represented by qualitative paradigm. These contrasting views can trap researchers into believing that their methodology is the only way in which to conduct research (Casebeer & Verhoef, 1997).

Reichardt & Rallis (1994), propose that as a first step towards reintegrating the two methods, researchers should ignore the limitations of the other tradition, whilst attempting to minimise the faults of their own tradition. They go onto argue that whilst they accept that both traditions differ, they both have a common research purpose: to understand and improve the human condition. Paradigm relativism (Taskakkor & Teddlie, 1998) take this point further and argues a more pragmatic approach, where the purpose of the research and the research question drive methodology rather than a particular world view.

Green et al., (1989) outline ways in which mixed method research have been used in the literature and demonstrate the strengths of combining these approaches:

- seek convergent results (triangulation);
- explore interconnected and/or distinct aspects of a phenomenon (complementarity);
- examine similarities, contradictions, and new perspectives (initiation);
- use methods in a ways that complement one another (e.g., interviews used to inform the development of a survey instrument);
- add breadth and scope to a project

Health researchers (i.e. psychological therapies and nursing) investigate complex phenomena which often require multiple perspectives. Similarly it has been argued that the complexities of most public problems or social interventions such as health education,
health promotion programs require the use of a broad spectrum of qualitative and quantitative methods. Whilst others claim that researchers should not be preoccupied with the quantitative vs. qualitative debate, as it will not be resolved in the near future and epistemological purity does not get research done (Caracelli & Green, 1993).

Haase & Myers (1988) argue that both approaches can be combined because they share the goal of understanding the world in which we live in. (King et al., 1994) claim that both qualitative and quantitative research share a unified logic and the same rules of inference apply to both. Casabeer and Verhoef (1997) postulate that researchers should view qualitative and quantitative methods as part of a continuum of research with specific techniques selected based on the research objectives. They go onto question the similar results found in research using the two paradigms and argue the possibility of this if they are supposedly looking at different phenomena.

2.3 Quantitative Measures – The Leeds Attributional Coding System

Attributional style was measured using the Leeds Attributional Coding System (LACS) (Stratton et al., 1988). The LACS provides a method of analysing and coding attributions, it is a powerful tool enabling the exploration of processes within families. In particular it provides a tool for clinicians, which enables a greater understanding and increased awareness of the ways that even mundane events are explained. Exploring this aspect can give insight into descriptions to which the children and adults in a family are continually exposed, and by which they frame their behaviour; expectations, sense of identity and self-esteem. The LACS also provides a way of exploring how therapists respond to the attributions made by family members and how they might reframe the issues that the family bring to therapy.

The LACS provides a framework for identifying attributional beliefs in verbal material and for coding these attributions as binary data on five categories, stable-unstable, global-specific, internal-external, personal-universal and controllable-uncontrollable. Binary refers to whether or not the attribution belongs to a category or not. Using the LACS allows qualitative material to be used in two ways, either quantified in a way that makes
statistical analysis possible; which requires a large sample, or alternatively, to look systematically at the content of attributions, exploring the unique way in which individuals explain different events. Whilst the LACS is described as a quantitative tool, the processes by which attributions are coded are subject to the skill and interpretation of the rater. Patterns of attributing cannot be interpreted as ‘normal’ for a given population; therefore conclusions can only be drawn between and within group comparisons and not population norms (Stratton et al., 1988).

To ensure reliability, attributions were extracted and coded from one transcript using the LACS by the research supervisor at the University of Surrey. These were compared to attributions extracted and coded by the researcher to validate the attributional coding conducted by the researcher.

The LACS is thought to have higher validity than some forced choice questionnaires as the ratings are performed on the actual speech used by the participants, allowing for the collection of data which are more complex and representative of individual attributions (Stratton, 1988).

2.4 Qualitative Measures – Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith et al., 1999; Smith & Osborn, 2003) is rooted in the phenomenological approach, which is interested in how individuals see and make sense of their social relational world and the meanings they attribute to their personal experiences (Dallos & Vetere, 2003). The approach is also constructionist in that, as it attempts to gain an insiders perspective, the researcher and the participant co-construct meaning in an attempt to make sense of these experiences. IPA acknowledges that this is not a direct or complete process. The researcher, in an attempt to get close to the participant's personal world, will be dependent on their own conceptions, which are required to make sense of the participant's world; this is done through a process of interpretation.
To aid this process, "self-reflexivity" is an important component for the researcher when interpreting and analysing the data. Understanding their phenomenological stance and how this may influence their interpretation, so as to ensure the findings reflect the participant's views as much as is possible, and not the researcher's, is an essential part of the process (Shaw, 2001). To ensure that interpretations were as close to the views of the participants as possible, validity checks of themes were carried out by a group of three Trainees on the Doctoral Clinical Psychology programme at the University of Surrey, who were also conducting research using IPA and one research tutor. They each read through one transcript and were able to validate themes identified by the researcher.

Although IPA was chosen for this study, I am aware that there are other qualitative methods which share similar techniques to IPA, such as Discourse analysis (DA) (Willig, 2001) and Grounded Theory (GT) (Charmaz, 2006); however there are several reasons why IPA was selected instead of DA and GT. Central to the process of IPA is the investigation of mental process and social cognition (Smith & Osborn, 2006). Both IPA and DA acknowledge the importance of language; but differ in their perception of the importance of cognition. DA is more concerned with the discourse and conversation, because this is where meanings are created and negotiated. GT was developed as a method of studying social processes, whereas IPA was developed to gain insight into an individual's personal experience. IPA was therefore deemed the most appropriate qualitative method to investigate the meanings associated with therapists experience's of families' attributional styles.

2.5 Procedure

2.5.1 Ethical Approval

Ethical approval was obtained from the Local Research Ethics Committee, the local Research and Development Ethics Committee and the University Ethics Committee (Appendix-I). Confidentiality of personal details and anonymity were assured to participants along with the right to withdraw.
2.5.2 Participant Involvement

Following ethical approval, two families were consulted to gauge their views around appropriateness and clarity of the information pack. This involves the lead therapist approaching two families at the end of a therapy session, showing them the content of the information pack to gauge the families' views of the forms. Both families gave verbal feedback and reported that the information provided was written in a clear and sensitive manner. Neither family felt there was a need to alter the pack.

During a consultation meeting with the family therapy team, both the family information pack and the therapist information pack were presented to gain the therapist's comments around appropriateness and clarity. Feedback from the therapists indicated that the packs were written in a clear and sensitive manner and did not require alteration.

2.5.3 The semi-structured interview

The construction of the semi-structured interview followed the guidelines laid out by Smith & Osborn (2006), an interview schedule (Appendix-II) was used to facilitate exploration of the subject area. This included prompt ideas around the themes of reason for referral, initial hypotheses, the therapist's experience of the family, therapists' response to the family, the therapist's response to the LACS feedback, potential utility of LACS for future therapy.

Draft questions for each theme were then constructed. A literature search was conducted to aid the construction of the interview, however no literature was found to aid this process. The interview schedule was constructed from discussion with the research tutor. A pilot interview was then conducted with the field supervisor to gain her comments around the clarity, appropriateness and sensitivity of the interview schedule. Feedback from the field supervisor included concerns about saying the right thing in the right place or not answering the question correctly. As a consequence of this it was explicitly explained at the beginning of each interview that there were no right or wrong answers as the interview was looking to explore the therapist's experience. One other change to the schedule included changes to a prompt question which asked about the therapist's
assumptions and expectations. The word assumption was dropped as this was found to be too confusing along side expectations. General feedback from the field supervisor indicated that she found the questions interesting and thought provoking.

2.5.4 Sampling: Constructing a Theoretical Sample
Families who attended the ID family therapy service were approached regarding the research within a six month period. Families who attend the service have at least one child within the family who has an ID diagnosis or developmental delay, which local services believe warrant a referral to this specialist team. When referred to the service, letters are sent out offering an appointment. At this stage families were also sent out an invitation pack, containing a letter of invitation to take part in the research together with an information sheet, written consent form and a demographic information sheet (Appendix-III). A section of the information sheet encouraged parents/guardians to discuss the research with their child. All therapists within the family therapy service were also given an information pack containing a letter of invitation to take part in the research together with an information sheet, written consent form and a demographic information sheet (Appendix-VII). Only those therapy cases where both the family and therapist have given their written consent were included in the study.

Smith & Osborn (2006) argue that there is no right answer to the question of sample size, refer to studies that have used one, four, nine and fifteen participants. They suggest that five or six participants is a reasonable sample size when conducting IPA analysis, and is enough to note and examine similarities, but not too many to overwhelm the researcher with data. Due to the time constraints of the study and the in-depth nature of the analysis involved (using both attributional analysis and IPA), those selected to participate in the study were based on the first four families to agree to participate in the study together with the lead therapist. Families were excluded from the study if they or the lead therapist did not give consent or withdrew consent at a later date. Non English speaking families who would require an interpreter were also excluded as translating speech would confound the analysis.
Where a family and lead therapist consented to participating in the research, no direct contact was made with the families unless the family requested it. The first session of a family therapy was then recorded onto DVD. There were a number of reasons why the first family therapy session was used. Firstly, it was felt that the first session would provide the richest data of causal attributions, as families explained the reasons for attending therapy (Stratton, 2003b). Secondly, therapeutic interventions near the end of the session and in subsequent sessions, may impact on later causal attributions. Lastly, using the first session of family therapy would ensure that the study would not be affected by subsequent drop-out from therapy.

2.6 Characteristics of Participants Present during the Therapy Session

Table 1 briefly outlines the characteristics of family members who attended the family first family therapy sessions; these are detailed further at the beginning of each case study.

<table>
<thead>
<tr>
<th>Family One</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Occupation</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louise Smith (Mother)</td>
<td>40-49</td>
<td>Female</td>
<td>White British</td>
<td>Part-time</td>
<td>BTEC/GNVQ</td>
</tr>
<tr>
<td>Peter (Father)</td>
<td>40-49</td>
<td>Male</td>
<td>White British</td>
<td>Full-time</td>
<td>BA</td>
</tr>
<tr>
<td>Joanne</td>
<td>13</td>
<td>Female</td>
<td>White British</td>
<td>School</td>
<td>-</td>
</tr>
<tr>
<td>Timmy</td>
<td>9</td>
<td>Male</td>
<td>White British</td>
<td>School</td>
<td>-</td>
</tr>
<tr>
<td>Billy</td>
<td>4</td>
<td>Male</td>
<td>White British</td>
<td>Pre-school</td>
<td>-</td>
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</tbody>
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<thead>
<tr>
<th>Family Two</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Occupation</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna Jones (Mother)</td>
<td>30-39</td>
<td>Female</td>
<td>White British</td>
<td>Part-time</td>
<td>A-levels</td>
</tr>
<tr>
<td>Rob (Father)</td>
<td>30-39</td>
<td>Male</td>
<td>White British</td>
<td>Full-time</td>
<td>HNC</td>
</tr>
<tr>
<td>Alice</td>
<td>5</td>
<td>Female</td>
<td>White British</td>
<td>School</td>
<td>-</td>
</tr>
<tr>
<td>Helen</td>
<td>3</td>
<td>Female</td>
<td>White British</td>
<td>Pre-school</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Three</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Occupation</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heidi Watts (mother)</td>
<td>40-49</td>
<td>Female</td>
<td>White British</td>
<td>Unemployed</td>
<td>BA</td>
</tr>
<tr>
<td>Cara</td>
<td>15</td>
<td>Female</td>
<td>White British</td>
<td>School</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Four</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Occupation</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karen Harris (mother)</td>
<td>30-39</td>
<td>Female</td>
<td>White and Asian</td>
<td>Housewife</td>
<td>BA</td>
</tr>
<tr>
<td>Tara</td>
<td>2</td>
<td>Female</td>
<td>White and Asian</td>
<td>Pre-school</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 1: Characteristics of participants present during family therapy session

1 All names have been changed to preserve anonymity
2.6.1 Participant Therapist Characteristics
Two therapists (Clive and Jill) were involved as lead therapists for this study and were subsequently interviewed. Both therapists worked as part of a larger reflecting team (Anderson, 1987). Clive, who is male, was a qualified family psychotherapist, working in a Child and Adolescent Mental Health Service. He described his theoretical orientation as eclectic (Vetere & Dallos, 2003). Jill, who was female, was a qualified Clinical Psychologist working within adult ID services.

2.6.2 Family Therapy Service
The family therapy service, in which the research was conducted, was a relatively young service, having been established approximately one year before the research commenced. The team was led by Clive (family psychotherapist) and included a community nurse, a clinical psychologist (Jill), a music therapist, a drama therapist, and a speech and language therapist. Families attending the service were offered a range of different approaches such as music and drama therapies, through to suggestions about changes within the home environment and routines, to advice about resources in the community. The team took a holistic approach to therapy sessions, with the main aim of facilitating communication between family members, to identify their strengths and new ways of approaching some of the difficulties they had been experiencing.

In the sessions within this service, one therapist usually interviews the family, whilst his or her co-workers (reflecting team) sit behind a one-way mirror. At times during the therapy session, it was the practice of the team to send a member of the reflecting team to knock on the door of the main therapy suite, to speak with the therapist or the family. The purpose of this was to either relay a question from the reflecting team, or to engage members of the family in drama or music therapy.

After approximately one hour, members of the reflecting team would enter the main therapy suite and openly discuss their thoughts, concerns and possible interventions in front of the family. Following their discussion, the reflecting team would leave the

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2 All names have been changed to preserve anonymity
therapy suite, allowing the family and lead therapist to discuss what they had heard. At the end of the consultation families would be offered another appointment. The above description provides a very brief account of the therapeutic process within this particular service; the reader is referred to Andersen (1987) for a fuller description of reflective team practice.

2.7 Quantitative Analysis

The DVDs from each family therapy session were transcribed (x4 transcripts each averaging 27 pages) (see Appendix-V for a sample copy) and analysed using the LAC (Stratton et al., 1988) a tool developed by a group of researchers and clinicians working in the Leeds Family Therapy and Research Centre. This process involves extracting the attributions from the qualitative data. A definition of attribution as defined by the LACS was used, “any statement in which an outcome is indicated as having happened, or being present, because of some identified event or condition”.

The next stage of the analysis was to separate cause and outcome elements of the attribution, and then identify Speaker, Agent and Target. Attributions were then binary coded on causal dimensions – stable-unstable; global-specific; internal-external; personal-universal and controllable-uncontrollable. Binary refers to whether or not the attribution belongs to a category or not, definitions for each category are outlined in table 2 below.
### Table 2 definitions of dimensions using the LACS (Stratton et al, 1988) (adapted from Snow, Langdon, & Reynolds, 2007)³

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaker</td>
<td>Who is speaking and providing the attributions</td>
</tr>
<tr>
<td>Agent</td>
<td>The person group or entity nominated in the cause of the attribution</td>
</tr>
<tr>
<td>Target</td>
<td>The person, group or entity mentioned in the outcome of the attribution</td>
</tr>
<tr>
<td>Stable – Unstable</td>
<td>This dimension is applied to cause element of attributions as to whether the cause of the outcome was due to stable or unstable factors. Stable factors are things that are unchanging about a person or set of circumstances, or factors that will continue to affect future outcomes (e.g. being stupid). Unstable factors are short-term or transitory (e.g. being exhausted).</td>
</tr>
<tr>
<td>Global – Specific</td>
<td>This dimension is applied to the cause element of attributions as to whether the cause of the outcome was due to global or specific factors. Global causes are coded when causes are likely to have a significant impact on several different outcomes (e.g. having a poor relationship with siblings or parents). Specific causes are found in one off events and are unlikely to have repercussions beyond the one identified in the attribution being coded (e.g. having chickenpox).</td>
</tr>
<tr>
<td>Internal – External</td>
<td>Internal causes are factors that originate from within the individual, such as a person's emotions, beliefs or personality characteristics. External causes are factors that originate within the environment, or as a result of circumstance, or as a result of the actions of other people (e.g. a family member failing to visit)</td>
</tr>
<tr>
<td>Personal – Universal</td>
<td>Personal factors must demonstrate that there is something special, unique or different about the speaker, agent or the targets of the attribution (e.g. the person has difficulty making friends, they are experiencing a certain emotion). Universal factors are when nothing in the cause, outcome or link between the two suggest anything distinctive about the person, that is the speaker gives no reason to believe that his/her behaviour is any different from any other person in the reference group.</td>
</tr>
<tr>
<td>Controllable – Uncontrollable</td>
<td>The attribution is coded as controllable only when the person could have realistically affected the outcome without having to exert some exceptional effort. Attributions are rated controllable when there is an indication that the person has chosen to act in a particular way. The behaviour is thought to have been carried out due to factors that are beyond the person's control, the attribution is rated as uncontrollable.</td>
</tr>
</tbody>
</table>

Once the data were coded, they were entered and analysed for patterns by frequency using a computer software package SPSS v14.

³ A pull-out copy of this table can be found in Appendix VI
2.8 Qualitative Analysis

Once the attributional analysis was completed for one session of family therapy, the second part of the research involved inviting the lead therapist for a semi-structured interview. This interview explored the therapist's perception of the family therapy process and the causal attributions made during therapy. Using and feeding back the findings of the LACS, the study explored the results with the lead therapist, including if and how the result could be used clinically and their potential utility and influence on the therapeutic process. The semi-structured interviews were recorded and transcribed verbatim (five interviews with two therapists, each transcript approximately 20 pages).

The analysis used for this part of the study was Interpretative Phenomenological Analysis (IPA). IPA attempts to understand how people make sense of lived experiences and the meanings these experiences hold for them. These are usually examined using semi-structured interviews. In order to understand the person’s perspective, the transcripts themselves are subject to interpretation by the researcher. IPA recognises that this process of interpretation is itself subject to the researcher’s own perspective and interpretation, so any outcome is the product of the interaction between the participants and researchers perspectives (Smith & Osborn, 1999). The IPA process involves the transcript of the interview being read and re-read in order for the researcher to become familiar with the data. As the researcher does this, they note in the left hand margin anything that strikes them as interesting or significant. Repeated reading of the transcript may produce summaries, interpretations or connections with other comments in the transcript. The right hand margin is then used to note emerging themes or qualitative analysis can be undertaken using a software package such as NVIVO. Interpretative connections are then made between emerging themes. The same process was repeated for subsequent transcripts.

2.9 Self-Reflexivity and Ethical Concerns

Smith (1995) reports that the researcher should reflect on their “interpretative phenomenological position” (p.24) through questioning the dynamic relationship the

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4 A sample copy of a therapist interview can be found in Appendix VII
interviewer has with the participant and exploring how the interviewer's preconceptions may influence their interpretation and analysis. To aid in this process of self-reflexivity, a colleague conducted two reflective interviews pre- and post- interviewing the therapists, this helped me establish what my views and opinions were, how my interest in this phenomenon developed, and made me more aware of the potential biases and assumptions that could influence my interpretation and analysis (King, 1996).

As I enhanced my self-awareness of my phenomenological position, I became aware of a number of issues that may influence my interpretation and analysis. Firstly, before clinical psychology training, I had worked for two years within learning disabilities services, which involved working with service users, families and carers. I am aware that I am inclined to view this service user group as being marginalised. I am aware that my assumptions about this service user group may be influenced by my previous experience that families may attribute difficulties to the system or the disability the service user has been diagnosed with rather than the service user. In an attempt to stay true to the families and therapists experiences I was mindful of these assumptions when analysing data and interviewing therapists.

I was also aware of my beliefs around power, having undertaken a first year training of a three year course in systemic therapy, I was aware of my lack of experience within this setting. I was conscious of the dynamics this could introduce when interviewing a therapist with years of experience, whilst having information which the therapist was not aware of, namely the attributional coding. I was aware of my concerns about relaying the attributional coding in a way that would not offend, whilst also remaining curious within the interview, listening to what the therapist had to say, but also being mindful of the need to be sensitive in my questioning to free myself from the fear of offending. I am aware of the views that I hold around diagnosis, that whilst they can be helpful to enable access to services, they can also be restrictive.

During a validation process, I became aware of these last two points. Whilst analysing one of the transcripts I had found it difficult to note times when I noticed the therapist
using medical terminology/diagnoses e.g. ADHD. In discussion with my peers, I was able to acknowledge my concerns regarding the identification of the therapist involved, due to the number involved in the study. The discussion with my peers enabled me to reflect on ways in which I could report the themes in a way that would be helpful for the research and its participants. Reflective practice has enabled me to recognise my reactions and to take them into consideration when analysing and reporting the research findings.
RESULTS

Diagram 1 is presented again here to remind the reader of the analytic process of this study.

Diagram 1: Illustration of analytic process across case studies
3.1 Case Study 1 – Smith Family

3.1a Genogram of the Nuclear Family

Diagram 2: A genogram of the Smith Family

3.1b Reason for Referral

The Smith family (please see genogram above) were referred to family therapy, following concerns regarding the difficult behaviour of the youngest child Billie, the identified patient. Billie had been given a diagnosis of Worster-drought syndrome, which is a form of cerebral palsy, resulting in damage to the cortical grey matter of the brain and is marked by cognitive impairment, speech delay and language impairment. Billie had also attracted a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). Billie had not received an ID diagnosis; however, it was the policy of the ID team not to begin to diagnose children with ID until they had reached school age. The team were also aware that Timmy, Billie’s older brother, had an Autistic Spectrum Disorder and an ID diagnosis and had undergone psychosurgery for retractable epilepsy. Joanne, the eldest child attended a local secondary school.

All names have been changed to protect anonymity
3.1c The Process of the session

The research was conducted on the first session of family therapy. Family members present were Mr and Mrs Smith, Joanne, Timmy and Billie and the lead therapist was Clive. During the first part of the therapy session, whilst the family were meeting with Clive, James (drama therapist) entered the therapy room to relay a question to the family and Clive, from the reflecting team. He also provided some additional toys for Billie to play with. The reflecting team entered the therapy room part way through the therapy session, to have a discussion in front of the family and Clive, during this part of the consultation, James (drama therapist) engaged in “play” with Billie. Liz and Viv were also present and contributed to the reflecting team discussion.

3.1.1 LACS Analysis

Participants in this case study made a total of 115 attributions throughout the one and a half hour session. Mrs Smith made the majority of attributions (n=64) with Mr Smith making 35 attributions. Joanne made seven attributions, with the other two children in the family making no attributions, this does not mean that they were not engaged in conversation, or did not speak, Billie chose to express himself through play and Timmy chose not to speak unless spoken to. The lead therapist (Clive) made six attributions and one of the reflecting team (James) made three attributions (see Table 3).

Table 3: LACS: Number of attributions made by participants in the First session of Family Therapy

<table>
<thead>
<tr>
<th>Name and role</th>
<th>Number of attributions</th>
<th>Percentage of attributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter (Father)</td>
<td>35</td>
<td>30.4</td>
</tr>
<tr>
<td>Louise (Mother)</td>
<td>64</td>
<td>55.7</td>
</tr>
<tr>
<td>Joanne (Daughter)</td>
<td>7</td>
<td>6.1</td>
</tr>
<tr>
<td>Timmy (Son)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Billie (Son) (Identified Patient)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clive (Lead Therapist)</td>
<td>6</td>
<td>5.2</td>
</tr>
<tr>
<td>James (Reflecting Team Therapist-RTT)</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>Liz (RTT)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Viv (RTT)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 4 illustrates the percentage of the speaker’s attributions which fell within each dimension. Further analysis was undertaken to explore each individual’s attributions, that is, who they identified as agent and the dimensions along which they made their attributions. Due to limitations in word count these cannot be include in the results section, but are included in the appendices. Due to limitations in word count the following descriptions provide a general overview of these results providing insight into whom some members of the family and team saw as agents and targets. 6

Table 4: Percentage of attributions made per LACS dimension

<table>
<thead>
<tr>
<th>Speaker and N=attributions</th>
<th>Percentage of Speakers Attributions with regards to Agent per dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unstable</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Father (n=35)</strong></td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Mother (n=64)</strong></td>
<td>3.1</td>
</tr>
<tr>
<td><strong>Joanne (n=7)</strong></td>
<td>57.1</td>
</tr>
<tr>
<td><strong>Clive (n=6)</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>James (n=3)</strong></td>
<td>66.7</td>
</tr>
</tbody>
</table>

6 This process has been repeated for each case study.
Mr Smith saw himself, his wife, and Billie to be the agents in 57% (20/35) of his attributions. He also saw himself, his wife, and his family to be the targets in 80% (28/35) of the attributions made. It is worth noting that Mr Smith saw himself as the target of 31.4% (11/35) of his own behaviour (Appendix-VIII).

For example Mr Smith attributed the majority of Billie's behaviour to be persistent into the future (stable) and have substantial effects (global). That they are part of his disposition (internal), they happened because he was involved (personal) and were within of his control (controllable) e.g. "...Normally I'd be up and down flapping about making him sit down and that will take all my attention and Louise's attention so we're deliberately letting Billie do what he does ..."

In the analysis of Mrs Smith attributions, she saw herself, Timmy and Billie to be the agents in 53% (34/64) of her attributions. She also saw herself, Timmy and maternal grandmother to be the targets in 64% (41/64) of the attributions made (Appendix-VIII).

Mrs Smith attributed Mr Smith's behaviour to be persistent into the future (stable) and have substantial effects (global). That they are part of his disposition (internal), they happened because he was involved (personal) and were out of his control (uncontrollable) e.g. "...Peter invariably phones when I'm in the middle of this stressful time and so he will, get an angry wife at the end of the phone...."

Joanne made seven attributions. She attributed the children's (her and her siblings) behaviour to be specific to a given situation and not to persist into the future (unstable) and have substantial effect (global), that they are not part of their disposition (external) and the event could have happened to anyone (universal) and were out of their control (uncontrollable) e.g. "...When Billie was born they [mother and father] stayed home and looked after us...."

Further analysis was undertaken to illustrate how Clive attributed the behaviours of those

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7 This study is using conventions used by other LACS based research articles.
he identified as agents in his conversation within the family therapy session. For example, Clive attributed Billie and Timmy’s behaviour to be persistent into the future (stable) and have substantial effects (global). That the behaviour was part of their disposition (internal), it happened because they are involved (personal) and were out of their control (uncontrollable) e.g. "... Your brothers tend to just talk to each other so they got each other...”

Within case study one, the attributions made during the first session of family therapy, tended to be stable, global, internal, personal with approximately 60% of the attributions being seen to be within the agents control and the 40% as uncontrollable.
3.1.2 Therapist Interview

Summary of IPA Themes
The superordinate themes together with their themes are detailed below. As the analysis progressed, some themes identified initially seemed less central to the aims of the study or were not well supported in the data and were therefore not presented. An attempt has been made to order the themes so that they present a clear, coherent narrative. Inevitably some themes are a reflection of the questions employed in the interview schedule (Coyle & Rafalin, 2000). As can be seen below three superordinate themes emerged from the analysis, these together with their emergent themes are discussed in turn.

3.1.3 Superordinate Themes

3.1.3a. Therapist’s perception of family

Emergent Themes
i) Family Dynamics
ii) Family’s Attributional Style

3.1.3b. Impact of family on therapist

Emergent Themes
i) Therapist’s Prejudice
ii) Therapist’s Feelings of Empathy

3.1.3c. Therapist’s response to the family

Emergent Themes
i) Therapist and Family being - Defended
ii) Incongruence in session
iii) LACS Feedback

3.1.3a. Therapist’s perception of family

Clive (lead therapist) gave a rich description of his perception of the family and how he understood how the family saw the problems that led them to attend family therapy. These have been clustered into two themes, dynamics and attributional style, which are detailed below.

i) Family Dynamics

Noting dynamics between members of the family, Clive notes his perception of the
parent's relationship with their daughter "...She's [Joanne] clearly got a closeness with her mother which felt solid and good .." he goes onto say " ...But the connection with the father wasn't very nice, I think he should be taking joy in her and helping her feel twelve a bit more."

In talking about the relationship between the parents, "Mum wasn't being sufficiently supported by Dad to have space to relax and get more playful she always had to be busy with the task, erm, that, yeah, that Dad just didn't, he tended to want to read magazines about wine ..." and "I thought Mum presented as very nice and rather desperate for a more collaborative parental relationship with her husband .."

Clive notes Mr Smiths' absence from the family and its impact, "His...absences do play a large part in making family life very difficult, because Mum is very stressed looking after two boys with, erm, well, with problems that have had autistic-type diagnoses given to them"

Clive commented on how he saw the nature of the family dynamics "...So he [Father] was being very polite and nodding and agreeing, but I couldn't see him going off and playing more with the kids, erm, and I could see him continuing not to be, be there very much, so I couldn't see Mum playing with them, so I couldn't see Joanne, er, becoming more playful and childlike, and I couldn't see Timmy getting out of his rather depressed presentation"

ii) Family's Attributional Style
Clive was asked where he felt the family attributed their difficulties, "I felt that it was attributing autism and Wooster-Drought Syndrome to the little one, that was, as I saw it, actually serving to maintain the dysfunctional elements in the family."

He also attributed it to "...Dad's absence..." and that the family wanted to medicalise and "pathologies" their difficulties.
He goes onto describe family members failed attempts of freeing the family “... Billie, playing with things all the time, and feeling free to do what he liked, he was, taking a lead and showing the family that there could be another way but he was up against being pathologised for so doing...”

3.1.3b. Impact of family on therapist

Clive gave a rich description of how the family members impacted on him, these have been outlined in two themes prejudice and empathy.

i) Therapist’s Prejudice

Clive described himself as being “Prejudiced” towards the family, but acknowledges that it was unfair of him “...Timmy had had brain surgery for his epilepsy which I thought, well I felt prejudiced about it ...which I think was unfair of me...”

Clive spoke about how his prejudice changed during the session: “But as you know beforehand it had been a sort of generalised one towards both parents for having the child’s brain cut up, afterwards it was more towards Dad.”

Clive goes onto describe his prejudice towards the father, “...Yeah, the erm, the dad, my prejudices remained I’m afraid, ...., I felt he was, too sort of nice and defensive, an articulate, intelligent man.”

ii) Therapist’s Feelings of Empathy

Clive expressed feelings of empathy towards various members of the family, his thoughts about Jessica were, “...I thought, you poor girl, you know, she’s so prematurely mature and developed, sensible and articulate ...”

In empathising with Mrs Smith, Clive paralleled his experience of the lack of reflecting team involvement with Mr and Mrs Smith’s relationship, “...I dunno whether I was feeling like Mum in feeling that, feeling a bit abandoned with the children...”
Clive found it easy to relate to Timmy, "That he wasn’t erm identifying with that misery in a sort of neurotic way, he just did come over as a sort of flat, depressed but well meaning little boy and who I found him easy to relate to."

3.1.3c. Therapist’s Responses to the Family
Clive’s description of how participant’s responded within the session and feedback have been outlined below in three themes, defended, incongruence and LACS.

i) Therapist and Family being Defended
Clive spoke about how defended he became in the session and how this paralleled with Jessica, "...But just her presentation was so grown-up and to that extent I felt so defended and so entrenched in how she had defended herself and coped with living in this family situation."

This was contrasted with his experience with Timmy, "... Well I just thought, you know, what a sweet boy and poor thing..."

In terms of how Clive felt the session progressed, "... I was still left with the feeling that it hadn’t been a very brilliant session on my part and the team hadn’t got as involved as they usually do ... I didn’t think it was very effective."

In the interview Clive spoke about how he felt the family responded to the therapy session. "...They responded to it academically ...."

ii) Incongruence in Session
Clive expressed a sense of incongruence between his feelings within the session and the families feedback, "... I’m a bit sort of, gloomy about it all, because they were so positive, but, well they said they were."

Clive explains his feelings about how useful the session was and the families response, "I don’t, I don’t know Interviewer, because as I say, they said it was helpful, they
subsequently said to their referring psychiatrist that it was helpful, my experience was that it made no difference at all.”

He goes onto explain how his feelings did not correspond to the families account, “...I don’t want to knock it and I don’t want to um, disagree with what they’re saying, but my instincts and feeling, I find, yeah, don’t run along with what they were saying.”

iii) LACS Feedback

Once the LACS analysis had been fed back, Clive was asked how useful the information was, “...It’s fascinating and helpful ..” he goes onto to say how he might have used the information, “I would want to be asking erm questions of Dad that would enable him to make more attributions” “... So I think I might have found it helpful to erm, to have got more active about wanting to help them be clear, what was expression of feelings, and what was actual, actual blame, whatever actual blame is.”

In terms of the future utility of the LACS, Clive said, “...I think it really, really could be useful, erm, if it was kept nice and simple...” and that it would be helpful to have a member of staff trained “...a sort of permanent erm, LACS person on the team...”

Clive spoke about how he would use the LACS “...almost I would like to have members of the team sort of er, helping me think about agency”. .... “... maybe every twenty minutes of so, summing up, you know, what the scores are, who’s seeing each other”.

In terms of the feedback, Clive felt that it agreed with his thoughts but would be interested in times when there was disagreement, “It would be very interesting to, you know, get the kind of feedback where I’m actually disagreeing with it .....because the notions, the ideas, the concepts are yeah, really you know, useful”. 
3.1.4 Comparison

In terms of the attributions, Mrs Smith appeared to exonerate her son Timmy in the majority of her statements (internal but uncontrollable). With regards to attributions made about Billie, the majority of statements made by Mr and Mrs Smith, indicated that they attributed blame that was internal and controllable. This was reflected in Clive’s interview where he felt that the family were “pathologising” Billie and felt that it was “poor Timmy”. Clive explained that whilst Mr Smith had “put it on the table” with regards to his long hours at work and his absence from the family home, he also exonerated himself by saying there was nothing he could do as this was part of his job. The was supported by the LACS analysis, which demonstrated that whilst Mr Smith made 11 statements in which he was the target of his own behaviour, eight of these were uncontrollable (exonerating).
3.2 Case Study 2 – Jones Family

3.2a Genogram of the Nuclear Family

Diagram 3: A genogram of the Jones family

3.2b Reason for Referral

The Jones family (see genogram above) were referred to family therapy, following concerns regarding the difficult behaviour of the youngest child Alice. Alice had been given an Autistic Spectrum Disorder diagnosis and was diagnosed with developmental and social communication delay, by the local paediatrician. Both children in the family were born with Gastro-oesophageal reflux. Neither children had received an ID diagnosis; however, it was the policy of the ID team not to begin to diagnose children with ID until they had reached school age. Children with such difficulties were often referred to the team because of their specialist knowledge and expertise, as this was unavailable in generic child services.
3.2c  The Process of the session

The research was conducted on the first session of family therapy. Family members present were Mr and Mrs Jones, Helen and Alice, and the lead therapist was Clive. During the first part of the therapy session, whilst the family were meeting with Clive, James (drama therapist) entered the therapy room to relay a question to the family and Clive, from the reflecting team. He also provided some additional toys for Helen and Alice to play with. The reflecting team entered the therapy room part way through the therapy session, to have a discussion in front of the family and Clive, present and involved in the reflecting team discussion were Jill, Liz and James.

3.2.1  LACS Analysis

Case Study two participants made a total of 99 attributions throughout the session. Mrs Jones made the majority of attributions (n=67) with Mr Jones making 12 attributions. Clive made seven attributions and Jill, Liz and James making four, six and three statements respectively. With regards to the two children (Helen and Alice), both children were engaged in conversation, however they did not make any attributional statements, choosing to express themselves through play and drawing (see Table 5).

Table 5: LACS: Number of attributions made by participants

<table>
<thead>
<tr>
<th>Name and role</th>
<th>Number of attributions</th>
<th>Percentage of attributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rob (Father)</td>
<td>12</td>
<td>12.1</td>
</tr>
<tr>
<td>Anna (Mother)</td>
<td>67</td>
<td>67.7</td>
</tr>
<tr>
<td>Helen (daughter)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Alice (daughter &amp; IP)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clive (Lead Therapist)</td>
<td>7</td>
<td>7.1</td>
</tr>
<tr>
<td>Jill (RTT)</td>
<td>4</td>
<td>4.0</td>
</tr>
<tr>
<td>Liz (RTT)</td>
<td>6</td>
<td>6.1</td>
</tr>
<tr>
<td>James (RTT)</td>
<td>3</td>
<td>3.0</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 6 illustrates the percentage of the speaker’s attributions which fell within each dimension. Further analysis was undertaken to explore each individual’s attributions, that is, who they identified as agent and the dimensions in which they made their attributions see Appendix-IX for further breakdown.

Table 6: Percentage of attributions made per LACS dimension

<table>
<thead>
<tr>
<th>Speaker and N of attributions</th>
<th>Percentage of Speakers Attributes of Agent per dimension</th>
<th>Unstable</th>
<th>Stable</th>
<th>Specific</th>
<th>Global</th>
<th>External</th>
<th>Internal</th>
<th>Universal</th>
<th>Personal</th>
<th>Uncontrollable</th>
<th>Controllable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father (n=12)</td>
<td></td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>100</td>
<td>16.7</td>
<td>83.3</td>
<td>66.7</td>
<td>33.3</td>
</tr>
<tr>
<td>Mother (n=67)</td>
<td></td>
<td>11.9</td>
<td>88.1</td>
<td>11.9</td>
<td>88.1</td>
<td>16.4</td>
<td>83.6</td>
<td>10.4</td>
<td>89.6</td>
<td>59.7</td>
<td>40.3</td>
</tr>
<tr>
<td>Clive (n=7)</td>
<td></td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>100</td>
<td>57.1</td>
<td>42.9</td>
</tr>
<tr>
<td>Jill (n=4)</td>
<td></td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>100</td>
<td>25</td>
<td>75</td>
<td>100</td>
<td>-</td>
</tr>
<tr>
<td>Liz (n=6)</td>
<td></td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>100</td>
<td>33.3</td>
<td>66.7</td>
<td>66.7</td>
<td>33.3</td>
<td>100</td>
<td>-</td>
</tr>
<tr>
<td>James (n=3)</td>
<td></td>
<td>100</td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>66.7</td>
<td>33.3</td>
<td>66.7</td>
<td>33.3</td>
<td>33.3</td>
<td>66.7</td>
</tr>
</tbody>
</table>

Mr Jones saw himself and his wife to be the agents in 66% (8/12) of his attributions. He saw himself and his wife to be the targets in all (n=12) his attributions.

For example Mr Jones attributed the majority of his own behaviour to be persistent into the future (stable) and have substantial effects (global). That they are part of his disposition (internal), they happened because he was involved (personal) and were not within of his control (uncontrollable) e.g. “[Being away from the Anna and the girls] because I’m upset to think this could be the possible future for us.”
In the analysis of Mrs Jones' attributions, she saw Mr Jones and Alice to be the agents in 53% (44/67) of her attributions. She also saw herself and Alice to be the targets in 57% (38/67) of the attributions made (Appendix-IX).

Mrs Jones attributed the majority of Alice's behaviour to be persistent into the future (stable) and have substantial effects (global). That they are part of her disposition (internal), they happened because she was involved (personal) and were out of her control (uncontrollable) e.g. "[Alice's behaviour — lashing out] it doesn't upset me, because she doesn't really mean em, it's just, she gets into such a tizz and things."

Further analysis was undertaken to illustrate how Clive, the therapist, attributed the behaviours of those he has identified as agents in his conversation within the family therapy session.

For example Clive attributed Helen's behaviour to be persistent into the future (stable) and have substantial effects (global). That the behaviour was part of her disposition (internal), it happened because she was involved (personal) and was out of her control (uncontrollable) e.g. "So you were having to feed her [Helen] three times as often as other mother."

Within this family therapy session, the attributions made tended to be stable, global, internal, and personal with approximately 40% of the attributions being seen to be within the agents control and 60% as uncontrollable.
3.2.2 Therapist Interview

Summary of IPA Themes
As can be seen below four superordinate themes emerged from the analysis, these together with their emergent themes are discussed in turn.

3.2.3 Superordinate Themes

3.2.3a. Referral to Family Therapy

Emergent Themes
i) Reason for Referral
ii) Disconfirmation referral diagnostic question

3.2.3b. Dynamics and Process of Therapy

i) Dynamics between parents
ii) Parents relationship with children

3.2.3c. Response of therapists to Family

i) Therapist’s Self-reflexivity
ii) Reflecting team normalising experience

3.2.3d. LACS Feedback

i) Similarities/Difference to LACS
ii) Utility/Limitations of LACS

3.2.3a. Referral to Family Therapy

i) Reason for referral
Clive was asked about the reasons for the family being referred to family therapy; he spoke about the referrer wanting a second opinion regarding a diagnosis of “Autism” as the team were seen to have “Expertise in ID”. There were also questions around, “A biological link” between Mr Jones’ “Emotional absence” and the diagnosis of autism in the girls.

ii) Disconfirming referral diagnostic question
Through the process of therapy hypotheses can be supported or disconfirmed,
“It did change in that one hypothesis was confirmed, that is, that the little girl did not seem autistic at all.” “He was the very opposite of 'bloke syndrome' and disconnected emotion.”

3.2.3b. Dynamics and process

i) Dynamics between Parents

In terms of the dynamics within the session Clive noted the way Mr and Mrs Jones related to one another, “Mum was very prone to ascribe guilt to herself, but at the same time she was very blaming of Dad.”

“I think he was quite frightened by her.”.... “But I would say that he attributed power, perhaps more power to her than perhaps she wanted.”

“And every time that Dad was speaking, Mum would get out of her chair or do something else.”

ii) Parents’ relationship with the children

Clive notes his perceptions of how the girls and their parents related to each other,

“The caring but ignorant concern Mum had about Helen’s wishing she could throw Alice away in the rubbish bin....although she clearly loves her, her understanding was, sort of, fairly limited.”

“Who the girls went to, it was Dad, both for help and for comfort”.

3.2.3c. Response of Therapist to Family

i) Therapist’s Self-reflexivity

Clive reflected on the dynamics of the relationship and the role he played within the process. He was clear about his own limitations, “I’m not an expert in ID” and how the setting impacted on his involvement within the process.
"[In] my normal work setting, yes, I would be much more involving all of them all the time".

Clive commented on how "Boring" the session appeared when viewing it again. He attributes this partly to do with the limitations in his expertise and that it was an initial session, having not made any initial hypotheses

"I think because it was the initial assessment session I was basically seeing myself as a conduit for their information..... it's a sort of grey area between having expectations and making initial hypotheses, so on the whole I tend to try to do neither and just see what comes".

ii) Reflecting team normalising experiences
Clive sees the role of the reflecting team within this session as normalising the parent’s experiences and noticing their achievements,

"You've done a good job by your children."

"Jill was able to help Mum feel connected with, because she also is the mother of small children and, you know, could relate to some of the issues that Mum had brought up".

3.2.3d. LACS Feedback
Once the findings of the LACS had been fed back Clive’s thoughts regarding the LACS were ascertained and these fell under three themes, similarities/difference, utility, limitations.

i) Similarities/Difference to LACS
Clive comments on how different the LACS findings are from his subjective experience,

"Well again, overall, my impression was, um, how different looking at them in this way is to my subjective experience and perception". He remarks at his surprise, "I'm quite surprised about some of it" and goes onto explain where he sees the differences "I just
thought, oh well, he's frightened and she's oppressive, I wasn't so aware of the dance between them which they were both choosing to participate in”.

ii) Utility/Limitations of LACS

In terms of the utility of the LACS for future sessions, Clive felt that it would make him more aware in future sessions,

“Next time I will also be more aware of how, yeah, the attributions I make and how I get drawn in, or not, yeah, so more sort of self-reflective”.

Clive notes that whilst the LACS gives greater insight into the verbal aspects of family therapy, there are components which are lost such as none verbal cues and interactions,

“You missed a lot in terms of seeing what was going on and who was more emotionally available and so on”.

3.2.4 Comparison between LACS and IPA analysis

Mrs Jones made the majority of attributions seeing Mr Jones and Alice as the agents. In these statements she appeared to be blaming of Mr Jones and exonerating of Alice. In terms of attributions about herself, she was self-blaming.

In comparing the findings of the LACS and how the therapist saw the family, there seem to be a number of factors to illustrate that the LACS mirrored the therapist’s experience. As noted above and by the therapist Mrs Jones was blaming of Mr Jones, Clive also notes that Mrs Jones ascribed guilt to herself, which were coded as blaming.

Clive felt that the session appeared to focus primarily on the parent’s relationship; the LACS analysis revealed that there were equal numbers of attributions made by Mr Jones about Alice as those regarding Mr Jones. In the interview Clive explained that he paid little attention to the girls as he felt he did not have sufficient ID experience.
3.3 Case Study 3 – Watts Family

3.3a Genogram of Nuclear Family

Diagram 4: A genogram of the Watts family

3.3b Reason for Referral

The Watts family (see genogram above) were referred to family therapy, following concerns regarding the challenging behaviour of Cara. Cara had an ID diagnosis and had also been given an Autistic Spectrum Disorder diagnosis. The team were also aware that Cara had been adopted as a young child and had recently been in contact with her biological mother. Cara had also been sexually abused as a child whilst in foster care.

3.3c The Process of the session

The research was conducted on the first session of family therapy, family members present were Mrs Watts and Cara, and the lead therapist was Jill. Mr Watts did not attend the session due to work commitments and Kevin did not attend as he was studying at University. During the first part of the therapy session, whilst the family were meeting with Jill, Clive entered the therapy room to relay a question to the family and Jill, from
the reflecting team. The reflecting team entered the therapy room part way through the therapy session, to have a discussion in front of the family and Jill, present and involved in the reflecting team discussion were Clive, James and Liz.

### 3.3.1 LACS Analysis

Case Study three participants made a total of 112 attributions throughout the session. Mrs Watts made the majority of attributions (n=55) with Cara making 43 attributions. Jill made five attributions and Clive and Liz made eight and one attribution respectively (see Table 7).

<table>
<thead>
<tr>
<th>Name and role</th>
<th>Number of attributions</th>
<th>Percentage of attributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edith Watts (mother)</td>
<td>55</td>
<td>49.1</td>
</tr>
<tr>
<td>Cara (daughter)</td>
<td>43</td>
<td>38.4</td>
</tr>
<tr>
<td>Jill (lead therapist)</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>Clive (reflecting team therapist - RTT)</td>
<td>8</td>
<td>.9</td>
</tr>
<tr>
<td>Liz (RTT)</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>James (RTT)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>112</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 8 (below) illustrates the percentage of the speaker’s attributions which fell within each dimension. Further analysis was undertaken to explore each individual’s attributions that is who they identified as agent and the dimensions in which they made their attributions see Appendix-X for further breakdown.
Table 8: Percentage of attributions made per LACS dimension

<table>
<thead>
<tr>
<th>Speaker and N of attributions</th>
<th>Percentage of Speakers Attributions of Agent per dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unstable</td>
</tr>
<tr>
<td>Mrs Watts (n=55)</td>
<td>23.6</td>
</tr>
<tr>
<td>Cara (n=43)</td>
<td>37.2</td>
</tr>
<tr>
<td>Jill (n=5)</td>
<td>20</td>
</tr>
<tr>
<td>Clive (n=8)</td>
<td>-</td>
</tr>
<tr>
<td>Liz (n=1)</td>
<td>62.5</td>
</tr>
</tbody>
</table>

Mrs Watts saw her daughter Cara as agent in 45% (25/55) of her attributions. She saw herself and Cara to be the targets in 64% (35/55) of her attributions.

For example Mrs Watts attributed the majority of Cara’s behaviour to be persistent into the future (stable) and have substantial effects (global). That they are part of her disposition (internal), they happened because she was involved (personal) and were within her control (controllable) e.g. “But sometimes when I say, go for time out, leave me alone, because you’re just being so aggressive and so horrible”. 

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In the analysis of Cara’s attributions, she saw herself and her brother Kevin to be the agents in 56% (24/43) of her attributions. She also saw herself and her mother to be the targets in 65% (28/43) of the attributions made (Appendix-X).

Cara attributed the majority of Kevin’s behaviour to be persistent into the future (stable) and have substantial effects (global). That they were part of his disposition (internal), they happened because he was involved (personal) and were within his control (controllable) e.g. "Well Kevin doesn’t care, he’s always being rude and nasty".

Further analysis was undertaken to illustrate how Jill attributed the behaviours of those she had identified as agents in her conversation within the family therapy session. For example Jill attributed Mrs Watts and Cara’s behaviour to be persistent into the future (stable) and have substantial effects (global). That the behaviour was part of their disposition (internal), it happened because they were involved (personal) and was within their control (controllable) e.g. "When you and mum get really angry with each other and even upset and say horrible things to each other".

Within this family therapy session, the attributions made tended to be stable, global, internal, and personal and controllable.
3.3.2 Therapist Interview

Summary of IPA Themes
Four superordinate themes emerged from the analysis; these together with their emergent themes are discussed in turn.

3.3.3 Superordinate Themes

3.3.3a. Expectations and Experiences

Emergent Themes
i) Referral Hypothesis centring on Cara
ii) Disconfirmation of Hypothesis

3.3.3b. Dynamics within Therapy

i) Family dynamics
ii) Family Scripts
iii) Empathy with Cara
iv) Feelings of Protection

3.3.3c. Process within Therapy

i) Changing family scripts
ii) Process of therapy
iii) Reflecting team

3.3.3d. LACS Feedback

i) Affirming perception
ii) Influence of LACS on future sessions
iii) Future utility

3.3.3a. Expectations and Experiences

i) Referral Hypothesis centring on Cara
Jill was asked about her initial hypotheses which led the family to be referred to therapy; she explained that this had been influenced by the referral and information the team had been given, which centred around Cara, "Cara's adopted ..... "She had been talking about her other Mum". 
Issue for her parents in managing her “Aggression” ... “She has a diagnosis of Autism”

ii) Disconfirmation of Hypothesis
In the semi-structured interview Jill was asked about her expectations of the family “I wasn't aware that I had any until I met the family, where I became very aware of my expectations”

Jill’s expectations centred around the families engagement, “I, wrongly I think I’d assumed that this family would be easy to engage and nice to work with and motivated, the sorts of families that, you know, are a dream to work with”

Jill had specific expectations of Mrs Watts, “I got the impression of, um, you know, your fairly dynamic Mum I suppose somebody who was fairly upbeat and able to be motivating” and Cara “I was expecting somebody quiet, withdrawn .... avoiding eye contact ... difficult to engage...”

Jill reported her experience of therapy with Mrs Watts as difficult, “cold sort of quite difficult to engage demeanour... she looked very angry, quite dismissive of family therapy” and that she found Cara to be “calm, wasn’t aggressive, was very polite, very charming, very smiley, you know, and not terribly autistic in her manner”

3.3.3b. Dynamics within Therapy
i) Family Dynamics
Another theme that emerged was Jill’s experience of the family dynamics, this included how the family related to one another “the family were full of arguments and, um, distress, people feeling very upset”

Mrs Watts describing herself as a victim, “she felt very bullied by Cara” and her son Kevin as being “verbally abusive, using them, spending all their money, 'he only wants us when he wants money’”
ii) Family Scripts
Jill described the family scripts as negative and how difficult these were to penetrate, "it's quite difficult to penetrate the negativity, quite difficult to, other than to meet them and affirm how they were feeling".

The difficulties Cara experienced in attempting to free herself from the negativity, "I seem to remember Cara saying, 'but I have got better Mum' ... she was able to sort of, um, see the whole picture in a way that I felt Mum couldn't".

How mum's experiences were trapping the family, "Mum found very difficult and was really stuck in this sort of, 'it's all awful and she won't do anything, and she lies and she calls me dreadful names, and she really upsets me and she's making me ill'... I felt very much that they were the messages that Mum was giving out".

Jill notes how she responded to the family's style "so I felt that I was very much treading on egg shells around the family, and possibly I worried that I was joining them as I said earlier in their kind of hopelessness".

iii) Empathy with Cara
Another theme that emerged were Jill’s feelings of empathy towards Cara in particular her experiences of adoption and abuse.

"Given away as a baby of eight months and then given to another family where yet again there was another traumatic experience, so thinking a lot about trauma and how that might resurface and how she might not be feeling terribly safe or protected".

"The absence of her real mother ... make links between her real mother and the one that she's living with".
iv) Feelings of Protection
Jill expresses feeling of protection towards Mrs Watts and notices Cara’s protection towards her mother, “I felt I think quite intimidated by Mum, by the situation, because I felt she was so fragile ...that if I’d said something too confrontational, that it could have been too difficult for her, too much for her”.

“But it was almost sort of taking the mothering role a bit, she felt protective over Mum”.

“I felt she was editing some of what she was saying to me ..... she was being quite careful about what she was saying so as not to upset Mum”.

3.3.3c Process within Therapy
i) Changing family scripts
Another theme that emerged was Jill’s descriptions of her attempts to change the family scripts by normalising, “Wanting to kind of normalise it, and actually this is often what teenagers are like”. By providing alternative scripts “Provide a slightly alternative, you know, the alternative perspective, that was maybe more inclusive, more... positive”.

ii) Process of therapy
Jill reflected on her role and the process within the session “I was probably the quietest I’ve ever been in a session I think for a very long time ... but it seemed for this family that that was maybe the right thing to do, and it allowed Cara to really speak about how it felt”. This process appeared to be facilitative as, “Mum was able to see more from Cara’s perspective”.

iii) Reflecting Team
Jill spoke about how the reflecting team worked to echo issues she had raised within the session, but also issues she had been silenced by.

“The team were able to say how connected they were, albeit through negativity at times”.
"That's what I was trying to do, sort of re-affirm or affirm what they were saying, but, provide a slightly alternative ... perspective".

"They were able to say things which I'd felt silenced by".

3.3.3d. LACS Feedback

i) Affirming Perceptions

Within the semi-structured interview Jill was asked her perceptions of the LACS results,

"It's interesting that it does fit with what I felt I needed to do which was about affirming their position and how difficult things were with them".

ii) Influence of LACS on future sessions

Jill spoke about how the findings of the LACS might help in future session,

"I think partly because it meets my understanding of what happened so much that ..... I don't think it will in that sense"

"I'm quite keen to give them some control back, allow them to feel that, um, you know, there are patterns to their behaviour, and that the way that they make sense of things can have a big impact on how they, their behaviour and how they feel about things".

iii) Future utility

Jill spoke about the future utility of the LACS as a family therapy tool as a validating tool,

"I think it's, it's validated, and it's nice for me to have that, because with this family, I didn't feel I'd done very well".
“In a way validation I suppose of my understanding of what happened and what’s happening for Mum and what’s happening for Cara, for that to come through in your work has been interesting for me”.

3.3.4 Comparison

In this case study, the analysis of the LACS revealed that Mrs Watts saw her daughter Cara as the agent in a large majority of her attributions, these appeared to be blaming in nature. In attributions regarding herself, Mrs Watts’ attributions tended to be uncontrollable and interpreted as exonerating. The majority (65%) of Cara’s self attributions echoed in part how her mother saw her; interpreted as self-blaming.

The semi-structured interview with the lead therapist post therapy indicated her experiences of the family to replicate those of the LACS findings; Jill described this as a “validating” experience. Jill noted that there seemed to be a negative blaming script about Cara and these appeared difficult to shift. Jill reported that Cara’s attempted to break free from this script; it could be argued that this can be seen in a third of her attributions in which Cara makes uncontrollable/exonerating statements.
3.4  Case Study 4 – Harris Family

3.4a  Genogram of Nuclear Family

Diagram 5: A genogram of the Harris family

3.4b  Reason for Referral

The Harris family (see genogram above) were referred to family therapy, following concerns regarding the challenging behaviour of Neil (IP). Neil had recently attracted an ID diagnosis, he was also diagnosed with sensory defensiveness, which is a condition that causes individuals to react negatively or with alarm to sensory input which is generally considered harmless or non-irritating. The team was also aware that Georgia the eldest daughter had dyslexia, Conner had an Autistic Spectrum Disorder diagnosis and Tara the youngest child had an eye squint.

3.4c  The Process of the session

The research was conducted on the first session of family therapy, family members
present were Mrs Harris and her two year old daughter Tara. Mr Harris did not attend the session due to ill-health and the three other children did not attend as they were in school. The team had been expecting the whole family to attend and so both Jill and Clive were present during the entire session. During the first part of the session, the reflecting team did not interrupt the consultation. The reflecting team entered the therapy room part way through the therapy session, to have a discussion in front of the family, Jill and Clive. Present and involved in the reflecting team discussion were James and Viv.

3.4.1 LACS Analysis

Participants in case study four made a total of 84 attributions throughout the session. Mrs Harris made the majority of attributions (n=68). Jill made two attributions and Clive nine, James two, Liz one and Viv two. Tara did not make any attributitional statements, whilst she was engaged in some conversation, due to her age she was not able to fully participate in the session (see Table 9).

Table 9: LACS: Number of attributions made by participants

<table>
<thead>
<tr>
<th>Name and role</th>
<th>Number of attributions</th>
<th>Percentage of attributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Harris (Mother)</td>
<td>68</td>
<td>81</td>
</tr>
<tr>
<td>Tara (daughter)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jill (lead therapist)</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Clive (lead therapist)</td>
<td>9</td>
<td>10.7</td>
</tr>
<tr>
<td>James (reflecting team therapist - RTT)</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Liz (RTT)</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Viv (RTT)</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Total</td>
<td>84</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 10 illustrates the percentage of the speaker’s attributions which fell within each dimension. Further analysis was undertaken to explore each individual’s attributions, that is, who they identified as agent and the dimensions in which they made their attributions. See Appendix-XI for further breakdown.

Table 10: Percentage of attributions made per LACS dimension

<table>
<thead>
<tr>
<th>Speaker and N of attributions</th>
<th>Percentage of Speakers Attributions of Agent per dimension</th>
<th>Unstable</th>
<th>Stable</th>
<th>Specific</th>
<th>Global</th>
<th>External</th>
<th>Internal</th>
<th>Universal</th>
<th>Personal</th>
<th>Uncontrollable</th>
<th>Controllable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Harris (n=68)</td>
<td></td>
<td>7.4</td>
<td>92.6</td>
<td>5.9</td>
<td>94.1</td>
<td>16.2</td>
<td>83.8</td>
<td>17.6</td>
<td>82.4</td>
<td>55.9 (2.9 n=2)</td>
<td>41.2, uncodeable</td>
</tr>
<tr>
<td>Jill (n=2)</td>
<td></td>
<td>22.2</td>
<td>77.8</td>
<td>22.2</td>
<td>77.8</td>
<td>22.2</td>
<td>77.8</td>
<td>33.3</td>
<td>66.7</td>
<td>77.8</td>
<td>22.2</td>
</tr>
<tr>
<td>Clive (n=9)</td>
<td></td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>100</td>
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<td>James (n=2)</td>
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<tr>
<td>Liz (n=1)</td>
<td></td>
<td>-</td>
<td>100</td>
<td>100</td>
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<tr>
<td>Viv (n=2)</td>
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</table>

Mrs Harris saw her sons’ Conner and Neil as agents in 32% (22/68) and 16% (11/68) respectively, of her attributions. She saw herself, Conner and Neil to be the targets in 63% (43/68) of her attributions.

For example Mrs Harris attributed the majority of Conner’s behaviour to be persistent into the future (stable) and have substantial effects (global). That they are part of his disposition (internal), they happened because he was involved (personal) and were out of his control (uncontrollable) e.g. “If someone’s in the way he doesn’t perceive, his spatial awareness isn’t very good”.

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In her attributions regarding her son Neil, Mrs Harris attributed Neil’s behaviour to be persistent into the future (stable) and have substantial effects (global), they are part of his disposition (internal), they happen because he was involved (personal). In half of the statements she made, Mrs Harris attributed Neil’s behaviour to be within his control and the other half out of his control e.g. “Neil’s my problem, the one I worry about and he’s the one I think, he’s, he’s so aggressive”.

Further analysis was undertaken to illustrate how Jill and Clive attributed the behaviours of those they had identified as agents in their conversations within the family therapy session. For example Jill attributed Mrs Harris’ behaviour to be persistent into the future (stable) and have substantial effects (global). That the behaviour was part of her disposition (internal), it happened because she was involved (personal) and was outside of her control (uncontrollable) e.g. “Just how much do you do [Mrs Harris]?..... Coz there’s a, there’s a thing about how much you have to organize in a day”.

Clive attributed Mrs Harris’ behaviour to be persistent into the future (stable) and have substantial effects (global). That the behaviour was part of her disposition (internal), it happened because she was involved (personal) and was within her control (controllable) e.g. “So you’re being positive about it, it doesn’t seem like, you make a face but your not bothered about it?”

Within this family therapy session, the attributions made tended to be stable, global, internal, and personal and uncontrollable.
3.4.2 Therapist’s Interview

Summary of IPA Themes
Two semi-structured interviews were conducted separately, with the two lead therapists’ for the fourth case study, one with Clive and one with Jill. The interviews were analysed separately and then pooled. Three superordinate themes emerged from the analysis; these together with their constituent themes are discussed in turn.

3.4.3 Superordinate Themes
3.4.3a. Difficulties within the session
Emergent Themes
i) Understanding of difficulties
ii) Difficulty connecting
iii) Distractions
iv) Reason for not engaging
v) Usefulness of session

3.4.3b. Dynamics within Therapy
i) Impact of Diagnosis
ii) Empathy towards Mrs Harris
iii) Parental Relationship
iv) Self-reflexivity

3.4.3c. LACS Feedback
i) Affirming perception
ii) Utility of the LACS

3.4.3a. Difficulties within the session
i) Understanding of difficulties
Clive and Jill spoke about the difficulties in ascertaining from Mrs Harris what she believed were the difficulties that led to being referred for therapy:

Jill: She was really quite vague about problems quite vague about how they impacted in some ways on her and her husband and the other children
Clive: The experience was not a positive one.... it was clear she wasn't paying any real attention....I think she was showing no sign of responding.

ii) Difficulty connecting
Both therapists spoke about the difficulties connecting with Mrs Harris and experiences:

Clive: I think she was showing no sign of responding to any of the things that people were saying even including um Jill actively inviting her so to do

Jill: I found it difficult to get to the bottom if you like, of what were her key issues, and what we could help her with

iii) Distractions
Both therapists spoke about how Mrs Harris had used her two-year-old daughter as a distraction from conversation:

Jill: She was very distracted, and again to me I, I thought her daughter was a useful distraction for her, that she, it was a barrier to engaging with us

Clive: I know that mums of small children have to multi-task and they can look after their child and concentrate on an adult conversation

iv) Reasons for not engaging
In attempting to understand why Mrs Harris had been difficult to engage, both therapists reflected on the possible reasons for engagement difficulties:

Clive: The fact that her husband and her children and not even Georgia had come um the fact that she seemed not to be concentrated or listening
Jill: And maybe because it just there was just too much to actually you sort of where do you start

v) Usefulness of Session
The therapists expressed opposing views of how useful they thought the session had been:

Clive: It hadn't felt altogether appropriate use of the time ...I think ya know she was just sailing through the session and ya know there was other things she'd got on her to do list

Jill: Maybe hearing that from a detached perspective allowed her to get some distance from it, that is one of the things I hope she found useful

3.4.3b. Dynamics within Therapy
i) Impact of Diagnosis
Diagnostic labels and their impact on the family and how “difficult” it was for Mrs Harris to get in touch with the “distress”:

Clive: Conner's um diagnosis with autism and the effect on the family

Jill: But all four children have some degree of either health or kind of learning difficulties stroke behavioural problems..... it's actually quite difficult for her to get in touch with her, her sense of the enormity and how distressing it is to have those children

ii) Empathy towards Mrs Harris
Jill spoke about the how hard it seemed “Just such a lot of hard work” for Mrs Harris to have children with difficulties and also wondered “Where she gets her own needs met”.

iii) Parental relationship
Both therapists hypothesised about the relationship Mr and Mrs Harris had:
Clive: Dad working shifts as a postman and the house having to be silent we guessed when he came in, in order for him to get some sleep

Jill: But there was a sense he wasn't all that supportive or that he himself was wrapped up in things

iv) Self-Reflexivity
Both therapists were able to reflect on their own feelings in response to the session with Mrs Harris:

Jill: Sometimes you're not sure your whether you're just asking the wrong questions or, is it something about your style that doesn't work with that person

Clive: Internally I found myself feeling frustrated and angry ....externally ... I became increasingly um polite as I recognised that the referral was not going to be one that ya know that we're gonna be able to um do any verbal work with

3.4.3c. LACS Feedback
i) Affirming Perception
On feeding back the results of the LACS, both therapists commented on how the results fitted with their perceptions of the process:

Jill: What your reading its sounds to me it fits well with this idea, about things being quite generalized, quite nebulous, quite difficult to pin down, you know that, that's how she feels

Clive: Which would fit with his um autistic label I guess

ii) Utility of LACS
Both therapists commented on the utility of the LACS as both a confirmation of their perceptions but also a reminder that they can be subjective:
Clive: I think that it has been helpful, it seems to me that perhaps mum did make more appropriate use of the session .... reminding me that my perceptions are very subjective

Jill: It does fit. ...having that corroborated

iii) Future Use
Both therapists spoke about how they might use the information from the LACS in future sessions with this family:

Jill: Feeding back she is possibly overwhelmed by the children and their needs, and it's difficult for her to get some distance on, how she can get her needs, and how she can think about what the children's needs are and prioritize and then take a more proactive approach to getting help

Clive: Want to get ya know more specification of from her and what use she wanted to make from the session.

3.4.4 Comparison between LACS and IPA analysis
Case study analysis using the LACS revealed that 48% of the attributions Mrs Harris made concerned her sons Conner and Neil as the agent, with 66% of these attributions being made regarding Conner. The majority of attributions regarding Conner were uncontrollable and therefore exonerating. Whereas the attributions made regarding Neil were split between controllable and uncontrollable.

In the semi-structured interview, the therapists both appeared to experience Mrs Harris as "vague" "woolly" and "distractable". As the LACS analysis indicated Mrs Harris was able to make attributions, however the majority of these were exonerating in nature and could reflect the difficulties the therapists experienced in gaining an understanding of the areas Mrs Harris felt she needed support with. Jill reported feeling that Mrs Harris was very “accepting of her lot” but whilst this can be a helpful perspective to take, Jill felt that it “lacked emotional impact” of having four children with difficulties. It is not possible
to assess emotional impact using the LACS, however the uncontrollable attributional pattern noted in this case study will be discussed later in the discussion.

Clive expressed feeling the LACS had made him more aware of his own perceptions and draws a distinction between the emotional aspects of being in a room with families and paying close attention to language. The researcher has the benefit of hindsight and a transcript to analyse, whilst therapists are subjected to the many dynamics of the therapeutic process in the moment.
3.5 Comparison

3.5.1 Overview of LACS across Families

It is not possible to generalise the findings of this study, firstly because of the discrepancies in the number of family members who attended the sessions, but also because these findings are preliminary and are open to evolving development in the context of further research. Table 11 illustrates that the mean number of attributions was 102.5 (SD=14.15), the Smith family made the majority of attributions (N=115) and the Harris family made the least attributions (N=84).

Table 11: Overview of attributions made regarding the Agent in each statement per family

<table>
<thead>
<tr>
<th>Families</th>
<th>Total No. of attributions</th>
<th>Percentage of Speakers</th>
<th>Attributions of Agent per dimension</th>
<th>Stable</th>
<th>Unstable</th>
<th>Specific</th>
<th>Global</th>
<th>External</th>
<th>Internal</th>
<th>Universal</th>
<th>Personal</th>
<th>Uncontrollable</th>
<th>Controllable</th>
</tr>
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<tbody>
<tr>
<td>Smith</td>
<td>115</td>
<td>7.8 (n=9) 92.2 (106)</td>
<td>5.2 (6) 94.8 (109)</td>
<td>18.3 (21) 81.7 (94)</td>
<td>12.2 (14) 87.8 (16)</td>
<td>56.5 (65) 43.5 (50)</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Jones</td>
<td>99</td>
<td>11.1 (11) 89.9 (88)</td>
<td>11.1 (11) 88.9 (88)</td>
<td>15.2 (15) 84.8 (84)</td>
<td>16.2 (16) 83.8 (83)</td>
<td>63.6 (63) 36.4 (36)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watts</td>
<td>112</td>
<td>31.3 (35) 68.8 (77)</td>
<td>30.4 (34) 69.6 (78)</td>
<td>18.8 (21) 81.3 (91)</td>
<td>18.8 (10) 91.1 (102)</td>
<td>27.7 (31) 72.3 (81)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Harris</td>
<td>84</td>
<td>10.7 (9) 89.3 (75)</td>
<td>9.5 (8) 90.5 (76)</td>
<td>16.7 (14) 83.3 (70)</td>
<td>17.9 (15) 82.1 (69)</td>
<td>61.9 (52) 35.7 (30)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mean (SD)</td>
<td>102.5 (14.15)</td>
<td>15.2 10.81 85.5 10.91 14.05 11.18 11.18 1.63 1.60</td>
<td>17.25 82.77 1.63 1.60</td>
<td>16.27 86.2 2.92 4.05</td>
<td>52.42 17.25 46.97</td>
<td></td>
<td></td>
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</table>

Analysis across the four case studies as a whole illustrates that families one, two and four have similar attributional styles that is stable, global, internal, personal with the majority of attributions falling within the uncontrollable domain. Family three however have a slightly different style, whilst the majority of attributions fall within the stable domain, there are almost three times more
attributional statements than the other three families, that fell within the unstable domain. The same is found within the specific/global domain. Within the controllable/uncontrollable domain there almost appears to be a reverse to what is found within the other families, with the majority of attributions deemed to be controllable. It is worth noting that the Watts family case study consisted of a mother with a teenage daughter, whereas the other families involved parents of younger children.

In case studies one and two where both parents attended, they both appeared to have similar attributional styles. In their therapeutic conversations with the families the therapists used predominately exonerating statements (uncontrollable) towards members of the family.

3.5.2 Overview of IPA themes across Therapist Interviews

All the right margin analysis was pooled across the five interviews; four superordinate themes emerged from the analysis, together with their emergent themes. These are discussed in turn, however due to limitations in the word count, only one example for each emergent theme is given, additional quotes can be found in Appendix-XII.

Summary of IPA Themes

3.5.3. Superordinate Themes

Emergent Themes

3.5.3a. Hypothesis/Expectations

i) Initial hypothesis
ii) Disconfirming initial hypothesis
iii) Therapist's expectations of the family

3.5.3b. Experiences of the Family

i) Therapist's experiences of family members
ii) Dynamics
iii) Family scripts
iv) Changing family scripts
3.5.3a. Hypothesis/Expectations
i) Initial hypothesis
The therapist's were asked about their initial hypotheses about the families and the difficulties they felt had led the family to be referred for family therapy. One of the themes to emerge was the nature of the information given by referrers, these seemed to use diagnostic labelling to describe difficulties such as:

**Clive:** *Wooster-Drought Syndrome*

Clive described the difficulties of one family as having a biological link:

**Clive:** *biological link between his affective and relational disconnection as perceived by Dr Phil and that of the girls? ... Dad is emotionally absent...*

This contrasted Jill description centred less on biological/diagnostic labelling and more on the behavioural/relational aspects of interpersonal relationships

**Jill:** *Cara's aggression, particularly towards Mum, although sometimes Dad ...worries about managing some of her behaviours, particularly around her losing her temper and not co-operating with their requests to do activities around the house.*
ii) Disconfirming initial hypothesis

In describing the evidence which formed their initial hypothesis, the therapists described how these hypotheses were confirmed/disconfirmed during the process of therapy:

**Clive:** *It did change in that one hypothesis was disconfirmed, that is, that the little girl did not seem autistic at all.*

iii) Therapist's expectations of the family

The therapists were asked about their own expectations of the family. Interestingly Clive described trying not to have either initial hypothesis or expectations:

**Clive:** *I don't think I did, it's a sort of grey area between having expectations and making initial hypotheses, so on the whole I tend to try to do neither and just see what comes, but I'm descending a little bit because I do enjoy the team having lots of ideas, and then I cherry-pick those that I find interesting.*

Whereas in contrast Jill described the moment when she realised she had had expectations:

**Jill:** *I wasn't aware that I had any until I met the family, where I became very aware of my expectations, if that makes sense? .... I got the impression of, um, you know, your fairly dynamic Mum I suppose*

3.5.3b. Experiences of the Family

i) Therapist's experiences of family members

Therapists were asked about their experiences of how the families presented in therapy. Clive described experiencing strong emotions in response to how family members presented:
Clive: See, I didn't believe him. I felt well ok, but then if you didn't have your second house in seaside, then maybe you could have a slightly lower salary, I mean be earning less money, but being away less often, and give more time to your family.

In contrast Jill experienced centred on descriptions of how family members presented:

Jill: Mum seemed very, very low, if not depressed, um, she looked unwell, she looked incredibly tired.

ii) Dynamics
The therapist’s gave rich descriptions of how they perceived family members related to one another in particular during the therapy session:

Jill: I, again my strong feeling was that she, um, was almost, and it’s a very strong thing to say, but it was almost sort of taking the mothering role a bit, she felt protective over Mum.

iii) Family scripts
A theme to emerge when exploring the therapist’s experience of the families was family scripts and how these dominated discourses and maintained patterns of interpersonal relating.

Clive: She was very loyal to her husband so she wasn’t going say it’s ya know coz he’s not here or he’s always asleep when he is here.

iv) Changing family scripts
Both therapists spoke about their attempts at changing family scripts and normalise experiences:

Clive: Only liking to wear skirts, and I was thinking, many three year old girls are exactly like that, they don’t want to wear trousers.
v) **Barriers to Engagement**

Another theme to emerge from the therapist's experience of the family, were issues around engagement and the issues which the therapists perceived hampered the families' abilities to engage within the therapeutic process:

*Clive: I felt he was, too sort of nice and defensive*

vi) **Empathy**

Both therapists spoke about their feelings of empathy towards family members:

*Clive: Timmy had been dealt with, because he'd had his brain done and poor thing he wasn't sleeping, and so there was something about poor Timmy that made Timmy easier to deal with.*

3.5.3c. **Internal/External Processes**

i) **Self-reflexivity**

Both therapists in their interviews reflected on their own beliefs and "Prejudices" and how these affected their interactions with family members and how they changed or did not change through the course of their therapeutic encounter with the families:

*Jill: I was probably the quietest I've ever been in a session I think for a very long time, I felt I didn't say very much*

ii) **Reflecting Team**

Both therapists spoke about the reflecting team, interestingly Clive spoke about their expertise in ID and feeling abandoned by them as he was not an "expert in ID"

*Clive: I suppose I felt a bit abandoned with them*

Jill spoke about the reflecting team echoing conversations from the therapy session, but also the team's ability to say things she had felt silenced by:
Jill: They were able to say things which I’d felt silenced by

3.5.3d. LACS

i) Fitting in with perceptions

The therapists were asked how the LACS feedback fitted with their perceptions of the family, there seemed to be a general consensus that the information fed-back, validated and confirmed their experiences:

Clive: The attributional coding has affected my perception of the family and I guess my experience of the family.

However there were times when it did not fit and the findings were a surprise:

Clive: Perhaps I’m not thinking, just reacting, yeah, I’m quite surprised about some of it... I was thinking earlier that you miss a lot in terms of seeing what was going on and who was more emotionally available and so on, but actually that didn’t matter

Clive described the information from the LACS giving him greater insight into the utility of the session for the family:

Clive: It seems to me that perhaps mum did make more appropriate use of it then I experienced at the time or indeed experienced last night as I viewed it and tried to stay awake.

ii) Utility of information for future sessions

Clive spoke about how the information from the LACS would aid his thinking in future sessions with the families and give him a sense of agency, allowing him to be more proactive in future sessions:

Clive: It would affect me urm in terms of my thinking and urh might have helped me stop just reacting
In slight contrast, Jill felt that because the LACS met her understanding of the family, that it simply validated her perspective, giving her permission almost to feedback her ideas on how the family saw their difficulties and work with this to effect change:

**Jill:** I don't think it will, I think partly because it meets my understanding of what happened so much that, um, that you know, I don't think it will in that sense.

**iii) Future utility for Family therapy**

The therapists were asked whether they thought the LACS had any future utility within the family therapy service.

**Jill:** I think it would be useful.

Clive goes onto explain how he sees the LACS being used:

**Clive:** I'd like a sort of permanent erm, LACS person on the team... and then yes, maybe every twenty minutes of so, summing up, you know, what the scores are, who's seeing each other

There is also an acknowledgement of the limitations of the LACS:

**Clive:** You missed a lot in terms of seeing what was going on and who was more emotionally available

The LACS and IPA analysis across case studies will be explored in the discussion.
4. DISCUSSION AND SUMMARY OF MAIN FINDINGS

Using the LACS, the first aim of this exploratory study was to understand how families attributed the difficulties, which led them to attend family therapy, during their first session of family therapy. In the second part of the study, lead therapists were interviewed to explore their perspectives on the first family therapy session, with respect to how family members made attributional statements and how this subsequently fitted with the findings of the LACS. Part of the purpose of this research was to explore the clinical utility and feasibility of the LACS for regular use. This research has potential clinical implications for services in targeting interventions which reflect the needs of families within ID services.

Attributional research within generic family therapy services have shown there to be the dominant ‘blame-frame’ directed towards the identified patient (often the child) (Stratton, 2003a). The attribution styles of families in this study must be interpreted in the light of the small numbers involved, together with the fact that only two therapists participated in the study. This may also introduce sources of bias, for example attributional style could be influenced by the particular way these therapists questioned the families. Also the use of therapy sessions from only one institution means that specific findings cannot be generalised. Whilst the findings provide a fairly comprehensive picture of the causal explanations offered during the first session of therapy, we cannot be sure how representative these discourses are of conversations in the rest of these families’ lives.

This research has adopted the style of Stratton (2003a) in an open-ended exploration of the full range of styles of attributing, treating consistent patterns that emerge as strategies that these individuals have adopted. The findings of this study did not follow the clinical impression that families come to therapy with a tendency to blame the referred child. Due to the nature of the study it is important to pay attention to the individual case examples and how they fit with the current literature.
Mrs Smith made the majority of attributional statements in case study one. Attributional statements made about Timmy (by Mr & Mrs Smith) were coded as uncontrollable and interpreted as exonerating in nature. There appeared to be a balance between controllable and uncontrollable statements for the rest of the family with the exception of attributions made about Billie the youngest child in the family, where the majority of statements made by both parents were controllable – blaming in nature. Billie had recently attracted a diagnosis of Wooster-drought syndrome, a form of encephalopathy. These findings do not fit with a similar study looking at mothers of children with developmental disability in which Chavira et al., (2000) found that mothers did not view their children as being responsible for their problem behaviours.

Mr Smith's made half the number of attributional statement compared to his wife. His self-attributional statements were predominantly coded as uncontrollable and interpreted as self-exonerating. Mr Smith made two attributional statements about his wife one was internal and controllable and the other was external and uncontrollable, due to the limited number of attributions it is not possible to draw conclusions.

Mrs Smith’s self-attributional statements were coded as stable, global, predominantly external, personal and predominantly controllable, these findings reflect findings from previous research by Campis et al., (1986) using the Parenting Locus of Control Scale (PLOC) as a measure of parents’ control beliefs. The study found that parents of children with behavioural difficulties were more likely to display an external locus of control. Other studies using more general locus of control measures with parents of children with ID found that low personal control is associated with higher parenting stress and psychological distress (Sloper et al., 1991; Wiggs & Stores, 2001).

There also seemed to be a disparity between the attributional statements of Mr & Mrs Smith and their daughter Joanne. In her statements Joanne attributed control to her parents and uncontrollability to her brother Billie. It is important to note however that Joanne made only one of each statement regard specific incidences, so caution must be made when interpreting these results. They are noted here because they pose questions
about the number and type of attributional statements made by children across the study, which does not appear to fit with the literature (Stratton, 2003a), this will be discussed at a later point.

In the second case study Mrs Jones's attributional statements regarding her husband were blaming in nature and her self-attribution were stable, global, internal, personal and controllable, indicating high perceived parental control (Sloper, 1991). Mr Jones' self-attributional statements were stable, global, internal, personal and uncontrollable, which could be seen as either exonerating in nature or depressive self-attributional statements (Munton et al., 1999). Attributions regarding his wife were stable, global, internal, personal and controllable. In attributional statements regarding their daughters, Mrs Jones appeared to exonerate their behaviour (Chavira et al., 2000). Mr Jones did not make any attributional statements regarding their daughters. It is worth noting that this particular therapy session was dominated by talk about the marital relationship and this could explain why Mr Jones did not make any attributional statements about his daughters. Whilst analysis of 'talk-time' was not conducted, Mr Jones made approximately half the number of attributional statements made by Mrs Jones.

In case study three Mrs Watts predominantly made statement about her daughter Cara, these were stable, global, internal, personal and controllable, which can be interpreted as blaming in nature. This supports findings by Stratton (2003b) who found that adoptive parents allocated more responsibility to the child. Whilst these results are indicative of previous research, other factors such as Cara's age and behavioural difficulties (anger and aggression) could also play a part in Mrs Watts' statements.

Mrs Watts' self-attributions were predominantly stable, personal and uncontrollable which fits with the literature regarding depressive self-attributional pattern (Gotlip & Abramson, 1999). Corcoran & Ivery (2004) suggest the mothers of children with behavioural problems show increased stress and depression, with a tendency to blame the child; they become angry and use harsh discipline towards their children. Cara's self attributional statements were predominantly stable, global, internal, personal, and
uncontrollable, which can be interpreted as self-blaming, however within her self attributional style there were a number of unstable, specific, external and uncontrollable statements. This could be attributed to Cara attempting to break-free from her mother’s blaming attributions. Cara’s self-blaming attributions are consistent with Stratton’s (2003a) research which highlighted that upon hearing their parent’s attributions about them, children may not only repeat them, but also use them as a strategy by which to avoid trouble. There may also be issues around life-cycle transitions, as Cara attempts to gain greater independence (Carter & McGoldrick, 1982).

In case study four Mrs Harris’ self-attributional statements tended to be stable, global, internal, personal and uncontrollable, which could be indicative of a depressive self-attributional pattern (Gotlip & Abramson, 1999). Attributions regarding her husband tended to be stable, global, internal, personal and uncontrollable, again this could be interpreted as exonerating. Attributions regarding her son Connor were stable, global, internal, personal and predominantly uncontrollable, again exonerating. Attributions about her son Neil tended to be stable, global, internal, personal and a mixture of controllable and uncontrollable attributions.

A point of interest across the studies is that parents presented their children as agents more often than themselves, but saw themselves as targets more often than their children; this is similar to findings in Stratton (2003a). So even though parents were not overly attributing blame to their children, they still saw themselves as targets of their behaviour.

There also appears to be some similarities and differences between the family members across the study. Mothers in this study appeared to make the majority of attributional statements, whereas fathers made approximately half the number of statements that mothers did. Two of the father’s did not attend the therapy session one due to work commitments and the other to ill-health. For the two fathers who did attend, Mr Smith made very few attributional statements about his children in comparison to his wife and Mr Jones made none, this could be an artefact of the limited talk time that fathers had. Due to the small numbers involved in this study, it is not possible to draw conclusions at
this stage. In a study by Carr (1991) highlights the importance of engaging fathers in the therapeutic process, as therapy outcomes are more likely to be successful. Walters et al., (2001) found that if fathers attend and are committed to therapy, there is no difference in the overall short term outcome, but the family is less likely to drop out early. However there are better long term gains, interpersonal conflict within families decreases, mother-child interactions become less negative and the father is less likely to “sabotage” therapy.

In addition to the above points, children across the study made a smaller proportion of attributional statements, again it is unclear why this was the case, perhaps this could be an artefact of talk time, or that questions were directed at the adults. There were very young children (ages 2-4) involved in the study, so age could also be a factor in limited statements made. Whatever the cause, more work is needed to explore these issues further. It does however have some significance clinically, by helping therapists to think about how attribute statements are made and by whom, this could allow therapists to invite others into the conversation on later occasions.

Therapists are subject to competing discourses within therapy sessions as different members of the household attempt to recruit the therapist to view their difficulties as more serious than another member of the household. The way a therapist responds to these competing statements can impact on families’ engagement with the therapeutic process. The therapists in this study did not make overly blaming or exonerating statements, this fits with research which found that systemic therapists do not often make cause-effect statements (Stratton, 2003a).

Stratton (2003a) highlights that therapists even with a reflecting team, can fail to hear many attributional statements, supporting the utility of the LACS as a method of drawing attention to such crucial statements. The LACS provides a framework in which members of the reflecting team can pay attention to specific discourses within the therapeutic process.
4.1 Comparison of LACS and IPA Analysis across the Case Studies

The second part of the study explored the therapist's perspectives of the therapeutic process, before the findings of the LACS were fed back to them in the same interview. Comparisons are drawn between the LACS analysis and the therapist's perspective, together with thoughts on the therapeutic utility of the tool. It is important to highlight that the emergent themes do not necessarily translate to how the therapists were in session with the families, as a discourse analysis of the therapy was not undertaken. Also, the emergent IPA themes do not map directly onto the LACS analysis and caution must be taken when interpreting these findings as they can not be generalised to the general population. There is a paucity of research exploring therapists' perceptions of families in family therapy; this research aims to highlight potential areas for future study.

The two therapists involved in this study gave a rich description of their experiences of therapy with the families, which were described in detail within the results section. Two therapists were involved in this study, this means that the results of this study can not be generalised to population, but hypotheses can be drawn from the results of this study.

There were a number of emergent themes that transpired from the IPA analysis, which supported the LACS findings, these will be explored further. The use of diagnostic labels to define the children and their difficulties was an issue highlighted by the therapists. This fits with the literature discussed earlier and how families see their children's difficulties as being internal and personal to them, but outside of their control, exonerating attributions (Chavira et al., 2000).

Jill noted specific issues of aggression, anger and hostility with Mrs Watts in case study three; which fits with Mrs Watts' self-depressive and blaming attributional styles (Gotlip & Abramson, 1999), but also fit Corcoran & Ivery (2004) study of maternal stress and depression.

Both therapists spoke about family scripts and how these were pervasive throughout the sessions, which the therapists believed trapped members of these families i.e. Cara's
aggression and family loyalty. Aggression within case study three was noted earlier, but of interested is the subject of loyalty noted in case study four and the therapist’s belief that Mrs Harris was too accepting of her situation (using predominately exonerating statements). The idea of acceptance however fits with research by Chavira et al., (2000), who found that mothers who attributed less responsibility to their children were less likely to experience negative emotional reactions. Hassall & Rose (2005) argue that the presence of behavioural problems in a child with an ID represents significant stressors to the parents beyond any stress arising from the child’s disability. It could therefore be argued that Mrs Harris’ responses in therapy were more appropriate than the therapists perceived, that having four children with some form of disability was not the issue for her, it was the aggressive behaviour of her son Neil that she felt she needed help with. It is interesting that both therapist’s had similar experiences and the researcher is curious as to what led the therapist’s to make the assumptions they did. One factor could be information gleaned from other health care professionals working with the family, however Vetere & Dallos (2003) highlight the importance of understanding the parents and family members’ own appraisals and concerns and that sometimes families need practical help, such as respite, before they can think about behavioural or emotional concerns.

Both therapists’ were able to reflect on their personal experiences of being in therapy with these families. These experiences evoked strong responses from the therapists during the interviews e.g. Clive expressing that he did not believe Mr Smith’s arguments for working long hours and the feeling that the session with Mrs Harris was a “waste of time”. Anderson & Goolishian (1988) suggest that the thoughts, ideas, prejudices, and images of a therapist during therapy are an opportunity to initiate dialogue with families. This does not mean that the therapist says what comes into their mind during therapy, but that the therapist reflects on these inner conversations before deciding what is relevant. Fine & Turner (1991) highlight the need for therapist’s ideas to be tentative, thinking to be flexible whilst being able to entertain multiple perspectives.
It was interesting to note the negative language used to describe mothers in the second part of the study; in the light of feminist critique of family therapy, the researcher is interested in how these discourses might reflect a wider tendency by clinicians to speak negatively of mothers (Vetere & Dallos, 2003).

Another theme to emerge was the therapists' desire to normalise parent's experiences and the behaviours of their children. The LACS proved helpful in both identifying and validating the therapists' experiences so that they could think about ways in which to work with these families without increasing feelings of hostility towards their children. The therapists also identified the utility of the LACS in allowing them to think about agency, as they and their team were not always aware of attributional statements (Stratton, 2003a).

Overall feedback from the therapists indicated that the LACS analysis was valuable in either affirming their perspective and helping them think about agency, but also giving greater insight into the therapeutic process. Whilst Jill felt that the information would not change the way she would work with the family, as it fitted with her perspective, she reported that it would help her reflect on the conversation she would have with the families she worked with. Clive felt that the LACS helped him become more aware of his own perspectives, drawing a distinction between the emotional aspects and the language used within therapy.

4.2 Clinical Implications and Utility of the LACS

This was an exploratory study with a small sample size, therefore the results of this study can not be generalised to wider family therapy practice. Very little research has been conducted within the ID and family therapy field, it is hoped that this research will create curiosity and interest within the field, leading to further research.

The research has demonstrated that therapists are not always aware of the attributional styles of families and can get caught up in other dynamics. The LACS allows therapists to think about agency and about appropriately targeting interventions to meet these
families' specific needs. Through exploration of the LACS in interviews with the lead therapists involved in this study, the use of attributional theory in systemic family therapy, with a specific focus on reattribution as a route to second order change (Stratton, 2003a) was viewed as a potential adjunct to the therapeutic process. However, transcribing and analysing transcripts using the LACS is a time consuming and costly process. It may be more feasible for one or two members of the reflecting team to be set the task of coding attributional statements during live therapy. A suggestion would be to use momentary time sampling, where the coders listen for one minute and then code attributional statements they have heard during that time. This process may not be a true reflection of all the attributions made, but could provide a picture of how families attribute their difficulties. These findings could then be discussed within the team and reflected back during the reflecting team discussion, or could be used in the post-therapy discussion in thinking about further work.

One of the issues raised by the therapists was that they did not feel supported by the reflecting team. This process could aid the training practice and supervision of members of the reflecting team, with potential guidelines being implemented for the reflective team functioning.

Whilst further research is needed to better understand the attributional styles of families attending an ID family therapy service, the research does pose other interesting questions. In particular, how do teams address the issue of the relative silence of certain members of the families attending family therapy? How can others within the family be encouraged to make more attributional statements? How can fathers be encouraged to participate and engage? Further study may be needed to understand the specific needs of this population, are they being sufficiently supported and do they have access to adequate social resources? It is difficult however to draw firm conclusions from this study or to make clear recommendations with regards to the practice of family therapy within ID, without further research.
4.3 Ethical Considerations and Dilemmas

One of the dilemma's the researcher was faced with, was how to stay faithful to the research findings and the critical research perspective, whilst also being aware of the small sample size and the possibility of identifying people. The researcher was conscious about how she presented the findings and the picture it painted of participants and how it could throw a certain light on the participants.

Of concern to the researcher has been the negative talk she has witnessed about these families. One argument in support of this type of talk could be that therapists are engaging in a process of self-reflexivity, exploring their own biases and prejudices (Anderson & Goolishian, 1988). However it could also be argued that it is not possible to engage in work with these families without these prejudices and biases showing themselves either overtly in conversation and questioning or through more dynamic processes.

4.4 Critique and Challenges of the Study

Some limitations on the procedure were noted, in particular, the process was relatively time-consuming, since each case study involved approximately 1½ hours worth of family therapy, which had to be listened to and transcribed verbatim\(^8\), with all attributional statements extracted and coded, this proved to be particular challenging given the limited time frame within which the study had to be conducted. At times transcribing proved to be particularly difficult as the sound quality was often compromised by the noise of children playing with toys, and where individuals spoke over others. When conversations were deemed inaudible, these parts of the therapeutic conversation were excluded from the analysis.

 Whilst listening and coding attributions within sessions proved to be a fruitful exercise, non-verbal aspects of communication were lost in the analysis. This included who sat next to whom and who interacted with whom. Other aspects of verbal communication

\(^8\) One Family Therapy transcripts took on average 20 hours to transcribe, whilst therapist interviews took approximately six hours to transcribe.
were also lost within the analysis which did not meet the definition of an attributional statement. However, given the research question and time consuming nature of the analysis, it was not possible to pay attention to these other aspects.

Whilst the therapist interviews were easier to listen to, they still require transcription which was also a time-consuming process. These interviews were then analysed using IPA, another time-consuming analytic process.

Recruiting participants also proved to be difficult. Whilst the researcher had the full cooperation of a specific family therapy service, this service only provided sessions for families with children with ID during a Monday lunch hour. There was insufficient throughput through the service, which delayed recruitment and impacted on the time in which the researcher had to conduct the study.

This type of research does not lend itself to a time restricted research project; in future such research needs to be based within one or more services, where the researcher is an integrated member of the team with the facilities to conduct an elongated study, rather than having a visiting researcher with a specific time-frame.

4.5 Directions of Future Research
The initial LACS analysis coded attributions on causal dimensions for the speaker, agent and target. Due to limitations of the study i.e. time and word count, the researcher was only able to look at the dimensions for the speaker and target, future research could expand this study and look specifically at these dimensions.

Two of the families (Jones and Watts) involved in this study returned to therapy, whilst the other two families declined further offers of sessions. Given more time it would be interesting to explore issues that promote engagement, what was it about the process which enable families to return for therapy. It would also be interesting to gain the perspectives of families with children with ID who have attended family therapy, what did they find helpful/unhelpful?
5. REFERENCES


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Appendix I

Ethical and R&D Approval Letters
Full title of study: An exploratory study of the causal attributions of both therapists and families attending family therapy where a child within the family has a learning disability. What are the therapist's views and perspectives of the therapeutic experience and how might this information contribute to the therapeutic process?

REC reference number: 06/Q0801/95

Thank you for your letter of 05 September 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:
You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

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

Please quote this number on all correspondence

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

Yours sincerely
Dear Suzanne

Re: - An exploration study of the casual attributions of therapists and families attending family therapy where a child within the family has a learning disability. What are the therapist's views and perspectives of the therapeutic experience and how might the information contribute to the therapeutic process?

Thank you for sending the Research & Development office a copy of your study protocol and associated documents that include an application form, NHS Research Ethics approval, information sheet and consent forms using qualitative methods.

The study aims to gain a better understanding of the attribitonal style of families with a child with a learning disability. The study is conducted as part of higher education leading to a post-graduate degree in clinical psychology. I also noted that the study is supervised by your academic and clinical supervision.

The Trust is supportive of this study as proposed subject to ethical approval from a NHS Research and Development Ethics Committee.

Yours sincerely
Dear Suzanne,

Reference: 75-PSY-06
An exploratory study of the causal attributions of therapists and families attending family therapy where a child within the family has a learning disability. What are the therapist's views and perspectives of the therapeutic experience and how might the information contribute to the therapeutic process?

Thank you for your submission of the above proposal.

The School of Human Sciences Ethics Committee has given a favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the School Ethics Committee.

Yours sincerely,
Appendix II

Therapist Interview Schedule
TOPIC GUIDE AND SAMPLE PROMPTS FOR SEMI STRUCTURED INTERVIEW ON WITH LEAD THERAPIST

TITLE OF RESEARCH: An exploratory study of the causal attributions of therapists and families attending family therapy where a child within the family has a learning disability. What are the therapist's views and perspectives of the therapeutic experience and how might the information contribute to the therapeutic process?

1. **Details of therapy**
   What were the concerns that lead the family to be referred in the first place?
   Who did you expect would attend?
   Who attended the therapy session?

2. **Initial Hypotheses**
   What was your initial hypothesis of the family before meeting with them?
   Did you have any expectations of the family?

3. **Experience of the family**
   What was your experience of how the family presented during the therapy session?
   What were your perceptions of the family's attributions?
   Were they directed at anyone in particular?

4. **Therapists' response**
   How do you think you responded to the family's attributional style?
   How do you think family members responded?
   What do you think was helpful/unhelpful for them?

5. **Feedback of the LACS**
   Are the causal attributions different to how you perceived them during therapy?
   What strikes you as being most different/similar?

6. **Utility of LACS findings in therapy**
   Do you think this information may be useful in future sessions with this family?
   How do you think this information may impact on the process?
   Do you think this information will influence the way you are with this family?
Appendix III

Family Information Pack and Consent Form
Dear,

Re: Families reasons for coming to family therapy and the therapists' experience of this.

I am a trainee clinical psychologist studying at Surrey University and am carrying out a research study at the family therapy clinic, xxx team for people with learning disabilities (xxx NHS Trust) as part of my training course. I am writing to invite you to take part in the above confidential and anonymised research study.

Enclosed is an information sheet highlighting what the study is about and what it will involve and how it will benefit you and future users of this service. Please read this carefully and discuss with your family before you decide whether you would like to take part in this study or not.

If you and your family decide to take part in the study, enclosed are two brief forms to be completed that should take no longer than 5 minutes to fill in:
- a consent form, showing you agree to take part in the research
- a brief form asking you some information about yourselves.

Please bring these questionnaires with you to your first family therapy session. If you forget them, there will be additional copies for you at the service if you require.

At your first family therapy session, you will be asked if you have read the information sheet and if you are willing to take part in the study. If you agree, the consent and information sheets will be collected from you, and your first session of family therapy will be recorded. If you would like to discuss any aspects of this research further before making a decision, please contact Suzanne Haddad, chief investigator/researcher.

Thank you for taking your time with this research.

With kind regards,

Suzanne Haddad
Chief Investigator/Researcher
Trainee Clinical Psychologist
INFORMATION SHEET

Families' experiences and reasons for coming to family therapy and the therapists' experience of this.

You and your family are being invited to take part in a research study. Before you decide whether or not 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 and ask us if anything is not clear or you would like more information about the study. You and your family are encouraged to discuss this information sheet and your potential involvement in the study. It is important that the decision to take part in this study is one that the whole family make.

Purpose of the study

This is being conducted by Suzanne Haddad, Trainee Clinical Psychologist. This study is an academic requirement of the PsychD Clinical Psychology Training Programme at the University of Surrey, in Guildford. The study will be supervised by Dr xxx, Clinical Psychologist, xxx People with Learning Disabilities Service, and Dr xxx, Research Tutor, University of Surrey, Guildford.

What's this research about?

The aim of the research is to find out more about your experiences of therapy as a family. We are interested in understanding how you explain events, that is the descriptions you make during family therapy about your thoughts about events and what has caused them. We are interested in how the therapist responds to your descriptions and how this influences your therapy. The information that you are able to provide is invaluable in helping us better understand how therapists and clients describe events and will help to inform future services offered by the clinic.

Do we have to take part in this study?

No. Your involvement in this study is voluntary. It is up to you and your family whether you would like to take part. Your decision whether or not to take part will not affect your current or future care offered by services in any way. If you agree to take part you are free to change your mind at any stage during the research, and you do not have to give a reason for this.
If you do wish to take part you will be given this information sheet to keep, you will be asked to read and sign a consent form and you will be asked to complete a background information sheet to record details such as your age and ethnicity for each member of your family attending family therapy. You are free to withdraw from this study at any time.

What will my family and I have to do if we take part?

If you volunteer for the study, the first session of family therapy session you and the family members who attend will be recorded. The study will not alter the therapy you receive in any way, the session will simply be DVD recorded. Recording family therapy is routine practice in many services and is something the family therapy service you are attending is considering using. There are facilities within the service you are attending to record the session, through installed equipment. The DVD will be transcribed into typed/written transcripts. Your names and any identifying information will be taken out of the transcript so they will be completely anonymous.

What are the advantages and disadvantages of taking part in this study?

This study will be of benefit to future users of this service, but there are no direct advantages or disadvantages to you and your family taking part in the study. The study will however provide important information for the development of the service.

What will happen to the information that we provide?

The information provided will be treated entirely confidentially within the research team. The lead therapist will be contacted to take part in an interview about their experiences of the family therapy. The DVD recording of the therapy session will be transcribed and will be made anonymous; this means that all your names and identifying details will be removed from the data. Once the DVD has been transcribed it will be given back to your family therapist, who will offer it to you to keep. If you do not wish to keep the DVD it will be destroyed. The data files produced during the study will be password protected; all data will be kept secure and will only be used for research purposes. The anonymous data will be stored at xxx learning disabilities service and Surrey University for 10 years before being destroyed. When the research is written up, quotes from your transcripts may be used in the written report, but these will be anonymously reported, so that people involved cannot be identified.
What will happen to the result of the research study?

The results of the research study will be written up and reported in the following ways:

- The study will be written up by the chief investigator as a thesis for the PsychD Doctorate in Clinical Psychology at the University of Surrey.
- Key research findings will be anonymised and presented to team members of the xxx family therapy services for people with learning disabilities.
- The research findings will be anonymised and written up for submission to an appropriate peer review journal.

What to do next?

Think about whether you and your family would like to take part in this study. Once you have decided, please bring the enclosed forms along with you to your first family therapy session. If you forget them, please do not worry, we will have additional ones for you. At your first family therapy session, you will be asked if you have read the information sheet and if you are willing to take part in the study. If you agree, the consent and demographic information sheets will be taken from you. If you would like to discuss any aspects of this research further before making a decision, please contact Suzanne Haddad, chief investigator/researcher.

Many thanks for taking the time to read and consider this information.

Suzanne Haddad
Chief Investigator/Researcher, Trainee Clinical Psychologist
Tel: xxx, E-mail: xxx

Under the supervision of
Dr xxx
Clinical Psychologist
Tel: xxx
E-mail: 

Dr xxx
Clinical Psychologist
Tel: xxx
E-mail: 
Title of Project: Families reasons for coming to family therapy and the therapists’ experience of this.

Name of researcher: Suzanne Haddad, Trainee Clinical Psychologist

Please complete the following questions on behalf of your family. 1 copy is for you to keep for your records and 1 copy is to be returned with the background information sheet.

RESEARCH CONSENT FORM

1. I confirm that my family and I have read and understood the information sheet previously sent to us (dated September 2006, version 2) for the above study.

2. We have had the opportunity to think about whether we would like to take part in this study. We have had an opportunity to ask questions.

2. We understand that our participation in this study is voluntary and that we are free to withdraw at any time, without giving reason and without our professional care or legal rights being affected.

3. We understand that all information gathered will remain confidential but will be included in an anonymised form in a written report.

4. We are aware that taking part in this study involves our first family therapy session being DVD recorded.

5. We understand that: - The DVD’s of our session will be used by the researcher to transcribe the session onto a written computer file. - This file will be password protected and any of our identifying details will be removed from the data file. - Once the DVD has been transcribed, it will be given back to our family therapist, who will offer it to us to keep. If we do not choose to keep it, it will be destroyed. [PTO]
6. We understand that the researcher may wish to use quotes from our therapy session in written reports about the research. These quotes will be anonymous. We agree to the researcher using our anonymous quotes in this way.

7. We agree to take part in the above project – consent obtained prior to therapy session.

8. We agree to take part in the above project – consent obtained post therapy session.

Name of participant family Date Signature

Name of person taking consent Date Signature

Thank you for completing this form.
**INFORMATION QUESTIONNAIRE**

The information provided on this sheet will be held in the strictest confidence.

**Date attending therapy:** _______________________

**Your D.O.B:** _______________________

**Job title**

____________________

Please tick the appropriate box for the sections below.

**Were you the referred client to family therapy?**

*Yes ☐*  *No ☐*

If no, what relation are you to the referred client?

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**Gender:**

*Male ☐*

*Female ☐*

**What is your age?**

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Any other 

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**Mixed**

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| White and Black African  | ☐ |
| White and Asian          | ☐ |

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<td>Social Work</td>
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<td>Portage worker</td>
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<td>Paediatrician</td>
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<td>Speech and Language</td>
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Thank you for completing this form.
Appendix IV

Therapist Information Pack and Consent Form
Dear,

Re: Families reasons for coming to family therapy and the therapists' experience of this.

I am a trainee clinical psychologist studying at Surrey University and am carrying out a research study at the family therapy clinic, team for people with learning disabilities (NHS Trust) as part of my training course. I am writing to invite you to take part in the above research study.

Enclosed is an information sheet highlighting what the study is about and what it will involve. Please read this carefully before you decide whether you would like to take part in this study or not.

If you decide to take part in the study, enclosed are two brief forms to be completed that should take no longer than 5 minutes to fill in:
- a consent form, showing you agree to take part in the research
- a brief form asking you some information about yourself.

Please return these questionnaires in the envelope provided as soon as possible.

Following the receipt of your forms, arrangements will be made to record the first family therapy session you have with a consenting family, after which you will be contacted to arrange a suitable time to conduct the research interview.

If you have any questions, please do not hesitate to contact me.

Thank you for taking your time with this research.

With kind regards,

Suzanne Haddad
Chief Investigator/Researcher, Trainee Clinical Psychologist
INFORMATION SHEET

Families’ experiences and reasons for coming to family therapy and the therapists’ experience of this.

You are being invited to take part in a research study. Before you decide whether or not 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 and ask us if anything is not clear or you would like more information.

Purpose of the study

This is being conducted by Suzanne Haddad, Trainee Clinical Psychologist. This study is an academic requirement of the PsychD Clinical Psychology Training Programme at the University of Surrey, in Guildford. The study will be supervised by Dr , Clinical Psychologist, team for People with Learning Disabilities, and Dr , Research Tutor, University of Surrey, Guildford.

What’s this research about?

The aim of the research is to find out more about your experiences of therapy as a family therapist. We are interested in your perceptions of the causal attributions made by families’ in the first therapy session. We are interested in how you respond to these and the impact on the therapeutic relationship and process. The information that you are able to provide is invaluable in helping us better understand therapists and clients attributional styles and to inform future services offered by the clinic.

Do I have to take part in this study?

No. Your involvement in this study is voluntary. It is up to you whether you would like to take part. If you do wish to take part you will be given this information sheet to keep, you will be asked to read and sign a consent form and you will be asked to complete a background information sheet to record details such as your age and ethnicity. You are free to withdraw from this study at any time, and you do not have to give a reason for this.
What will I have to do if I take part?

Taking part in this study will involve the first family therapy session you have with a consenting family to be DVD recorded. The tape will be transcribed into typed/written transcripts. Your name and any identifying information will be taken out of the transcript so they will be completely anonymous. You will then be asked to take part in an interview lasting approximately one hour to explore your experiences of the therapy session. Data from the therapy transcript will be fed back during the interview and you will be asked about your thoughts on the transcript. This will be conducted by Suzanne Haddad, chief investigator/researcher. The interview will be tape-recorded so it can later be accurately transcribed.

What are the advantages and disadvantages of taking part in this study?

The interview will ask some background questions about the issues the family was referred for, your expectations prior to seeing the family and what your experiences were of the families' causal attributions during the therapy session and your responses to these. The interview will also explore data from the therapy transcript, your thoughts of this and how it might be useful for future work with the family. These questions are not thought likely to cause distress, but may cover issues of a sensitive nature. You are only asked to offer information that you feel comfortable with and are free to withdraw if you wish. On the other hand, taking part will offer you an opportunity to reflect on your experiences of therapy, which may be helpful.

What will happen to the information that we provide?

The information provided will be treated anonymously and confidentially within the research team. The DVD, audio-tape of the therapy session and your interview will be transcribed and made anonymous so your name and identifying details will be removed from the data. Once the DVD has been transcribed they will be returned to you to offer them to the family to keep. If the family do not wish to keep the DVD, it will be destroyed. In addition, tapes from your interview, once transcribed, will be destroyed. The data files produced during the study will be password protected; all data will be kept secure and will only be used for research purposes. The anonymous data will be stored at learning disabilities service and Surrey University for 10 years before being destroyed. When the research is written up, quotes from your transcripts may be used in the
written report, but these will be anonymously reported, so that people involved cannot be identified.

What will happen to the result of the research study?

The results of the research study will be written up and reported in the following ways:

- The study will be written up by the chief investigator as a thesis for the PsychD Doctorate in Clinical Psychology at the University of Surrey.
- Key research findings will be presented to team members of the family therapy services for people with learning disabilities.
- The research findings will be written up for submission to an appropriate peer review journal.

What to do next?

Think about whether you would like to take part in this study. Once you have decided, please complete the enclosed forms and return them to Suzanne Haddad. If you would like to discuss any aspects of this research further before making a decision, please contact Suzanne Haddad, chief investigator/researcher.

Many thanks for taking the time to read and consider this information.

Suzanne Haddad
Chief Investigator/Researcher, Trainee Clinical Psychologist
Tel: , E-mail:

Under the supervision of
Dr 
Clinical Psychologist
Tel: 
E-mail:

Dr 
Clinical Psychologist
Tel: 
E-mail:
Title of Project: Families reasons for coming to family therapy and the therapists' experience of this.

Name of researcher: Suzanne Haddad, Trainee Clinical Psychologist

Please complete the following questions. 1 copy is for you to keep for your records and 1 copy is to be returned with the background information sheet.

RESEARCH CONSENT FORM

Please initial each box

1. I confirm that I have read and understood the information sheet previously sent to me (dated September 2006, version 2) for the above study.

2. I have had the opportunity to think about whether we would like to take part in this study. I have had an opportunity to ask questions.

2. I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving reason.

3. I understand that all information gathered will remain confidential but will be included in an anonymised form in a written report.

4. I understand that taking part in this study involves the first family therapy session being DVD recorded and also involves taking part in an interview that may last up to 60 minutes.

5. I understand that: - The DVD of the family therapy session will be used by the researcher to transcribe the session onto a written computer file.
   - The subsequent interview will be audio-taped by the researcher.
   - The audio tape will be used by the researcher to transcribe the interview onto a written computer file.

[PTO]
- These files will be password protected and any of your identifying details will be removed from the data file.
- The DVD will be returned to me to pass onto the family. If the family do not want the DVD, it will be destroyed. Once transcribed the tape from my interview will be destroyed.

6. I understand that the researcher may wish to use quotes from the therapy session and/or the interview in written reports about the research. These quotes will be anonymous. I agree to the researcher using our anonymous quotes in this way.

7. I agree to take part in the above project - consent obtained prior to interview.

8. I agree to take part in the above project – consent obtained post interview

............................................  ............................................  ............................................
Name of participant therapist Date Signature

............................................  ............................................  ............................................
Name of person taking consent Date Signature

Thank you for completing this form.
INFORMATION QUESTIONNAIRE

The information provided on this sheet will be held in the strictest confidence.

Your name ____________________________
Your D.O.B ____________________________
Your profession _______________________

Please tick the appropriate box(es) for the sections below.

Background training
Family therapy □ Nursing □
Social Work □ Psychology □
Any other □
(please state) _______________

Gender:
Male □
Female □

What is your age?
20-30 □ 50-59 □
30-39 □ 60-69 □
40-49 □ 70+ □

Ethnicity
White □
British □
Irish □
Any other □
(please state) _______________

Mixed
White and Black Caribbean □
White and Black African □
White and Asian □
Any other □
(please state) _______________

[PTO]
Asian or Asian British

- Indian □
- Pakistani □
- Bangladeshi □

Any other □
(please state) _______________

Black or Black British

- Caribbean □
- African □
- Any other □

(please state) _______________

Chinese

- Chinese □

Chinese □

Other ethnic group

- Any other □
(please state) _______________

Highest attained educational level

- No formal examinations □
- BTEC/GNVQ □
- HNVQ □
- Masters degree □
- Any other □

(please state) _______________

- GCSE □
- A Levels/Highers □
- Bachelors degree □
- Doctorate □

Thank you for completing this form.
Appendix V

Sample Family Therapy Transcript
Therapist: How do you do everybody
Mum: hello
therapist: hi my name is Clive and I will start if I may before you introduced yourself to me to just tell you what to expect this morning or rather this afternoon which it is now eerm
Dad: Billy can you sit down please
therapist: hi your Billy are you right there there are some toys over there if you'd like to play with them we work in teams doing family therapy because many heads are better than one in thinking about all the different members of the family and different family relationships and I got a team of people helping me and they're behind that screen it's no secret and if you can't really bear them to be there then they don't really have to be there it's just being behind their they can talk about what they're seeing hearing and come up with ideas that we hope you might find helpful by the time you leave us which will be approximately an hour an hour and half you'd expect to be here and occasionally a colleague might knock on the door coming in with a message from the team or asking me to follow something up and as I say you can meet them at any time the commitment the end one-hour flight is their purpose is to is to really give you some food for thought and ideas so maybe that near the end of the session I would join you they will come in here and will listen to a conversation between them or between some of them anyway about what would be talking about so that's what you can expect so my name is Clive Clarkson and I am a family therapist and an already heard that you all Timmy and will you introduce which the rest of your family Timmy
Timmy: that's mummy
therapist: that's mummy and what's mummy's name
Timmy: that's Joanne
therapist: mummy and Joanne and what's mummy's name
Mum: what's my name
Timmy: Louise
therapist: Louise do you think I can ask her if it's okay to call her Louise and she would let me
Timmy: okay
therapist: yeah I will, Louise is it okay if I call you Louise
Mum: yes of course
therapist: and who is the young lady next to your mum
Timmy: Joanne
Therapists: that's Joanne hi Joanne is it all right to call you Joanne
Joanne: yes
therapist: and then there is your little brother hello Billy
Billy: hi
therapist: hi
Dad: should I just let Billy do what he does all or should I get him to sit down here
therapist: just relax
Dad: just relax
therapists: yes just make yourselves at home it's difficult enough being in this goldfish bowl without having to be constrained in what you're doing so your little brother’s introduced himself and then there's your dad and what's his name
Timmy: erm, Peter
therapist: Peter actually he's already said to me when I went to get to you that it's Peter So I guess it's all right to call you Peter
Dad: yes
therapist: I'm Clive. Okay how when you had your discussion together Peter and Louise what thoughts did you have together about how the family therapy session be of use to you if you did I don't know if you did
Mum: erm is probably about communication between us as a family
therapist: right
Mum: that's the most important thing
therapist: communication that is the most important thing that's the thing you most want help with
Mum: yes communication and to see if there is anything that we as a family with having two children with special needs that's available to us that we currently not getting as in help
therapists: okay so so
Mum: with the children

therapist: So thinking about communication and help for the children in terms of things that that you're not already getting

Mum: yes

therapist: okay I've repeated it in that laborious way because I want the team to be thinking about that now

Mum: okay

therapist: okay let's start with the communication issue first maybe ask you Joanne what do you think Mum was talking about

Joanne: erm I don't know

therapist: okay

Joanne: well erm I think erm well me mum and dad get along quite well but erm the boys they don't seem to like communicate with us a lot they just sort of just kind of communicating with each other quite well more than they communicate with us

therapist: ha ha

Joanne: yes that's just it

therapist: okay so that's what you would say is the main communication problem your brothers communicate with each other but not so much with the rest of the family

Joanne: yeah

therapists: I'm going to ask your dad if he agrees with you what would you say that is the main communication problem or pattern or problematic pattern in your family

Dad: I wouldn't disagree because I think that's Joanne's thoughts and I wouldn't disagree with what Joanne's thoughts are but for me probably a big issue I guess as a family are my my working hours I'm not around very much so I can imagine that's erm being an issue we can talk about in more detail

therapist: yes how does that fit in with your wife saying we can put communication at the top of the list is the fact that you are working long hours making it difficult for you to communicate

Dad: I guess yes because usually I work evenings as well as during the day so that it is a classical situation where by you're not around very much when you are around you tend
to be very tired or sometimes we have an argument or we argue about me not being around some of this is a knock-on effects erm on the rest of the family

therapist: who do you think find it most difficult with your long hours

Dad: I would say Louise but that may not be the case

therapist: Louise

Dad: or maybe the children find it difficult but there again it's something they used to so I'm not sure it's an issue or if it’s just what they’re used to

therapist: absolutely and who do you think misses you the most

Dad: I try to think equally

therapist: equally

Dad: I don't know

therapist: I'm sure

Dad: I'm sure they have their different reasons

therapist: everyone does for their different reasons

Dad: erm yes

Billy: I need the toilet

Mum: you've just been to the toilet

Dad: I have just taken you you're just saying that to get out of the room

Billy: I do need to go

therapist: well it's a very interesting with talking about communication and yes I just let the team know that Billy you just had the toilet just before we came in so you may need it again but you said it to Dad it may be Billy finds ways of communicating to you

Dad: yes yes interesting point

Billy: I said toilet

therapist: you did say the toilet

Billy: and I said the toilet again

therapist: and who would you like to take you to the toilet who would you like your mummy or daddy your sister

Billy: mummy

therapist: your mummy

Mum: do you want me to take you
Billy: yes
Mum: are you sure you need to go for wee wees
Billy: aahhhaaa
Mum: okay all right then
Dad: is that okay
therapist: that's fine perhaps if you turn left at the door and a colleague show you where
Mum: yes I know where it is because we came to music therapy
therapist: Oh okay fine
Mum: okay Billy, this way I shall take you to the toilet
therapist: I'll the fact that you named Louise first when she comes back in but just just saying with the the matter that you raised to Joanne that you must feel so your mommy and daddy are both adults so that kind of got each other and your brothers tend to just talk with each other to they got each other so your a bit kind of you're the one with the you may want to communicate but perhaps feel the most left out do you think
Joanne: well I don't really but erm because Dad is like working all the time and we only really see him I see him in the morning and at the weekends and so me and Mum sort of get along sort of very well and I am I sort of okay and when I'm by myself we've got four cats and our way just like to play with them really and look after them and stuff like that
therapist: how interesting when you've got four cats I know this because I've got quite a few cats too erm cats tend to some of them will spend more time with one another than others won't they and perhaps spend more time with each other then with you I don't know but they're your friends the cats are your friends
Joanne: yeah
therapist: and when cats communicate I don't know through purring or hissing or scratching or not doing what you want them to do when you want them to do it erm they've got all different types of ways of communicating but they don't use words do they
Joanne: no
therapist: and I'm just wondering Timmy are you in your brother like that's do you communicate with words
Timmy: yeah
therapist: you do, you two talk to each other
Timmy: yes we do
therapist: right and you don't just just play without words
Timmy: not really
erapists: who talks the most between you and Billy
Timmy: Billy does
therapist: does he you're the quieter one
Timmy: yeah
therapist: right and yet are you happy about that or would you like to be the louder as well
Timmy: louder
therapist: you like to be louder would you really
Timmy: yeah
therapist: you're quite as quiet are you a shy person
Timmy: yeah
therapist: are you but you're not shy with your sister
Timmy: not really
therapist: or your dad
Timmy: no
therapist: in fact I thought I caught out of the corner of my eye I thought they both looked slightly taken aback when you said you were shy but I don't know do you think they think that you're shy
Timmy: yeah
therapist: shall we check it out do you think that Timmy is shy
Dad: yes Timmy you are I think
Billy: I'm back
Dad: are you back
therapist: hello again
Dad: you did go to the toilet
Mum: yes he did
Dad: do you want to sit down for a little bit Billy
Billy: no
Dad: why don't you sit down for a few seconds

therapist: while you were out we were just talking about the fact that the boys have each other and the two of you are adults and so I wondered whether Joanne felt a bit out on a limb which she said no she is very close to you generally and she sees her dad at weekends so she doesn't feel lonely at all and she's also got the cats

Mum: yes that's very true yes all four of them

Dad: she seems to be keeping up pretty well she is now 12 going on 18 and I've noticed Joanne and Louise getting on better now 'cos Joanne is a bit older now they argue like teenagers sometimes

therapist: right is the closest that blows hot and cold

Dad: absolutely

Mum: yes I agree

therapist: but before Louise left you were saying in terms of the problem you have identified as communication that perhaps Louise found it the most difficult do you agree with that Louise do you think Peter is right

Mum: yes I do I do because obviously there's times when I've had a particularly bad day with the children and I'd like to discuss it with Peter but he's not there or we have a talk on a mobile or Peter's mobile and we gets cut-off and I get very frustrated and then the issue which was very important at the time seems to decrease as the week goes on when we have time to actually sit down and discuss it is forgotten about and so I find that frustrating erm but obviously I understand it's the nature of Peter's job erm

therapist: what is the nature of Peter's job

Dad: I'm in records and so I'm the * and * director at ***** and so I spend a lot of my time going to studios going to see bands play so literally that's

therapists: all over the country then

Dad: yes

therapist: all over Europe than

Dad: yes that's why physically that's not something whereby I'm not just out socialising with clients I'm going to see a venue or going to studio which alongside because I'm a director of the company I also have to be there early and do a normal day's work as well so it's I know it's an issue we often talk about how we can try to change it
Therapist: and what solutions have you come up with?
Mum: Well we haven’t really
Dad: Well we haven’t really
Mum: Well Peter you do try and come home at least one night a week home early to put the children to bed, which I think that is important and certainly since Christmas you’ve been achieving that so that’s good and obviously we we Peter now tries to keep Fridays free don’t you because we have a place down in Seaside and we go down to Seaside on the weekends so by the time I've driven down to Seaside with the children and Peter has gotten the train we seem to meet along the seafront and then were all together again as the family which makes it easier
Therapist: that sounds very nice
Dad: we are very lucky because we know it's an issue a bought this place a year ago by buying a place in Seaside it's enabled us to be more of a family when we go there I switch off straight away and we actually spend a lot of time chatting or
Mum: yeah
Dad: that's been a big help
Therapist: very good solution
Dad: were very lucky we can do that
Therapists: I'm sure
Dad: it's been a big help would I be correct in saying that
Mum: yes I totally agree it's been a lifesaver really hasn't it's because communication wise it's been for us
Dad: and Timmy really likes it as well
Therapist: do you, do you like being by the sea
Timmy: yeah
Dad: can I comment it’s just a comment
Therapist: say anything you like
Dad: it's just
Therapist: it's your time
Dad: it's probably worth mentioning because often Timmy will get lost because erm because in a family situation in Joanne is you can see is a very competent young girl erm Billy as you can see Billy needs a lot of attention and so Timmy may get a bit lost in the

Mum: yes

therapist: okay so then if I'm thinking it might have been you Joanne but actually no your dad saying it's Timmy

Dad: it's the same issue Joanne So speaks sweetheart it is anything I'm not saying

Joanne: no I'm fine

Mum: I think Joanne and her interests definitely get nurtured she's a very good swimmer and swims with the school she also sings with the choir so three nights is it three nights a week she has after class activities which sometimes take her to six o'clock half past 6 one incidents last week was half past nine erm and so I think Joanne is fine and obviously she has a social group of friends. But I think it's Timmy, I agree with you he does get left out

therapist: isn't that interesting because what you are out we were just discussing Timmy was telling me that he's a bit shy and he can be a bit shy

Mum: yes

therapists: and Dad was agreeing with that

Mum: yes

therapist: I don't know I was shy when I was a little boy Timmy and I don't know whether if you are a little shy it suits you not to have too much attention but not in a family you'd like more family attention, who would you like more attention from

Timmy: Daddy

therapist: Daddy rights and as aware of this so that's good do you think that he knew that before

Timmy: yes

therapist: that you wanted more attention from him yeah yeah but when you live in a large family and dad's away a lot and I guess you all will want to spend more time with him

Mum: yes

therapies: and if your little brother is louder than you and better at getting it

Timmy: yeah
therapist: and your sister is more confident and speaks very well and so she's good at getting it to
Timmy: yeah
therapist: yeah let's stay with this communication thing then I would have thought on the surface so far you're telling me you've come up with some very creative solutions to dealing with it but yet it's still a problem
Dad: I think it still is we're it's a bit like we've been it's a bit like when you're an alcoholic it's like we know we're alcoholics so we know there are issues and we try to work through the issues I think if we were having this conversation a year ago I think we would be having a much more distressing conversation am I right in saying that
Mum: yeah
Dad: but we've been trying to work through the issues for a while now I think we're making some progress
therapist: yes yes, so of all these communication issues we've been talking about what is the one thing you'd like help with today perhaps?
Dad: I guess it's just your thoughts about managing the boys because we're deliberately today ignoring Billy today because normally I'd be up and down flapping about making him sit down and that will take over all our attention and Louise's attention so we deliberately letting Billy do what he does so I'm not sure if we ever if you have any thoughts about how we manage Billy managed Timmy because Timmy to sits and this is classic if you like Timmy will sit there very happily very calm
Mum: but obviously I'm sure Timmy is saying I want to do this that or the other in his head but he is frightened of asking in case we say no I think
therapist: Timmy do you want to have a look at the toys your brother is playing with you might find something interesting to play with
Timmy: okay
therapist: sorry Louise can you say that again because I lost it thinking about giving something for Timmy to look at
Louise: yes I think that Timmy probably wants to do a lot more but he is frightened of actually saying this is what I want to do because he's frightened that I'll say no or no we will say no we've got to sort Billy out first or I have to takes Joanne to swimming first
and I think and I think in the pecking order his right at the bottom and he never seems to ask for anything and it's difficult being a parent sometimes when you feel that you almost have to mind read to try and work out exactly what it is that Timmy wanting to do and I find that particularly difficult

therapist: reading Timmy's mind

Mum: yes, yes

therapist: right

Mum: would you agree

Dad: 100% your a good boy Timmy and sometimes your be outside my head

Billy: I want a dragon

therapist: you want a wagon

Billy: Dragon

Dad: a dragon

therapist: oh a dragon

Dad: Timmys got a dragon that's just typical

therapist: Timmy are you good at reading minds

Timmy: yes

therapist: So who's mind are you best at reading

Timmy: I don't know

therapist: is it your brother do you usually know what he thinks

Timmy: yeah

therapists: how helpful do you think Mum and Dad find that do you think they find it helpful that you can read Billy's mind

Timmy: yeah

therapist: do you think let's check it out at two you'd think is Timmy

Mum: erm

therapist: I'm just taking it from what Joanne said about the boys spend a lot of time together and Timmy being the oldest to think is quite good at reading Billy's mind

Mum: erm, he is but also I think Timmy likes it because I think he can play at Billy's level so I think he likes to be quite physical and may be I think he feels that if Billy is doing it and so that's fine
therapist: okay right, it's quite difficult there's quite a big age gap between them is there
Mum: there's 5 1/2 years
therapist: yes Timmy how well have you been sleeping recently I see you've yawning and I can see you've got quite sleepy eyes have you been sleeping badly
Timmy: yeah
Mum: Timmy’s never slept well, he was on melatonin for a while to actually get him into a sleep pattern but Timmy will probably up he's very good Timmy because before we had Billy we have a grandfather clock and we would say to Timmy that you can't come downstairs until it strikes seven so we would sit there or lie in bed and hear Timmy counter to seven and then he would feel happy wouldn't you Timmy you would know that you could go downstairs but I would know he would be up for at least an hour or an hour and half waiting for the clock to strike seven and so Timmy he has always had a poor sleeping habits
therapist: and as he always had have you always had
Mum: yes he has
therapist: So what I think I'm hearing you want to give more time to older son if you can and so the issue that you want us to think about is how you might do that under the circumstances
Dad: probably help mostly, it's about helping Billy do better and we’ve cracked it, it's far easier to put on a video or DVD with Billy we try very hard not to do that I don't it's better to give him the attention. We don't really have the answers we know what the answers should be but it's a case of being as practical as you can when you're out
therapist: and how would you let Billy carry on as he is now or would you described him earlier as wanting him to sit still and behave himself but presumably not at home
Dad: yes at home this is fine normally.....
Therapist.........
Dad: what are you doing Billy
Mum: he won't be happy until everything is out of the boxes
therapist: that's what they're there for. So if you let Billy get on with whatever he's doing at home does it mean chaos will be spread so it's still hard to give Timmy attention
Mum: well yes I think so because this is typical of Billy he will he can't cope with a tidy room everything has to be out and messy and obviously
Billy: it's an owl
Mum: It's an owl good boy. It just gets my stress levels are up because I can't cope with the amount of toys all over the floor and I find that very hard and so I have to and Billy isn't very good at tidy things up either and so I find that really difficult to do with because and then if I try and do something on a one-to-one basis with Timmy Billy will think that he's missing out and intervene and have to sit on my lap Billy would have to sit on my lap and squeezes way in so that he doesn't like me giving Timmy attention so he has to wangle his way in and leave the room and a terrible mess which it is easier for me to put them to bed and then I will have to tidy up toy room as well as all the other things I have to do so I find that particular difficult and then Timmy ends up helping me Timmy is very good at helping me tidying up Billy's mess but they are merely it shouldn't be it shouldn't be Timmy having to do that it should be Billy should be able to tidy things up himself really erm and then I hear Timmy saying don't get things out of the cupboard otherwise mum will get mad and I hear that quite often and I don't want to suppress them playing but what I want is for them to play nicely but to respect toys and put them away rather than chuck them around and break them
Therapist: right
Mum: and it doesn't matter
therapist: it doesn't
Mum: no
therapists: So you get frustrated and annoyed and don't want to be horrible but your tired out
Mum: yes
Therapist: and you don't like the mess and you try to speak to Peter on the mobile and the signal cuts out
Mum: Yes, Peter invariably phones when I'm in the middle of this stressful time and so he will, get an angry wife at the end of the phone and I'm sure you would agree with and Peter will say I'm only phoning to say hello
Dad: and I get told off
Mum: and then he gets told off
Therapist: and how does it affect Peter when he gets told off, are you able to run with it
erm or does he get hurt?
Mum: oh I don’t know I think he gets a bit hurt
Dad: I stay calm, I play it calm
Mum: You are calm, you are calm
Therapist: Do you get hurt?
Dad: Absolutely, it’s typical I phone up to speak to people and get told off, it happens a
lot less nowadays. Sometimes there will be a barrage down the phone.
Therapist: it’s got to come out somehow
Mum: yes
therapist: do you have any other support Louise people you can sound off at what about
your own mother is she
Mum: no my mums always she's been quite difficult from the start really when Timmy
was born. Timmy used to be epileptic he used to attend an epileptic surgery but is not
epileptic anymore which is fantastic and I think because she didn't it's a case of being
ignorant really she didn't understand the epilepsy she was frightened and scared of being
left with a child that could have a seizure and Timmy was diagnosed with autism she
didn't understand what it is and didn't want to find out about it and so she hasn't been
supportive she hasn't listened even though she might agree with me on the phone and I'll
say I'm having a difficult time or please can you come over and she quite often says no to
me whereas and I, we're a great close family but I feel as though my mother doesn't
support me the most it's very hurtful
therapists: yes what about Peter's mum is she available to you Peter’s Mom and Dad
Mum: she's been a lot more helpful than my mom
Dad: she's been very good actually my mum
Mum: she can be good, yes
therapist: it's perhaps for understandable reasons harder to call upon her to sound off at
Mum: yes I certainly do that and so Peter really is my only outlet
therapists: and Joanne
mum: and Joanne Poor Joanne I do we do I don't know you tell me off for discussing things with Joanne don't you sometimes don't you, you think I shouldn't be talking to her about some things and then Joanne doesn't mind and I think that it sometimes is that I need someone to talk to and Joanne happens to be there so therapist: well great and you need to talk and you don't mind. But you do a bit because you feel it's what stuff for you or suffer for adults Dad: just really, I'm not bothered that it happens that Louise chats with Joanne it's just now and again Louise needs to talk to somebody and I think it's not the kind of example really, but it only for a while Mum: do you think it's inappropriate that I Dad: I don't know, I'm trying to think of example but I can't think of an example therapist: well say Louise just wanted to tear her hair out and say actually I've had enough but had up to hear I'm going out which you feel that that was appropriate with Joanne Dad: That's fine, it's very rare Mum: I think that Joanne probably has had a lot to cope with really. I know that Joanne finds, she's just started her senior school with new friends and I know that Joanne is embarrassed sometimes about bringing her friend's home because obviously the boys she feels as if she doesn't want to explain to her friends and she's had difficulties with that and she gets quite tearful about that sometimes that is why us erm and so often we have discussions don't we about trying to, and Joanne knows that she can talk to me about anything, so that's good so that's where I think we have a very close and trusting relationship Therapist: I was just thinking perhaps there is this parallel between having to explain to you all friends and had your mum feels about your grandmother and yet somehow your mother hasn't been able to to get your grandmother on board about your brothers to understand and to love them, love her and be involved I guess it's different from your friends but I suppose when is your mother and grandmother it's a different matter. She looked very sad when she spoke about it. Joanne: yeah well erm nanny and me get along quite well as well that I do agree nanny does seem to get like a bit she talks to Timmy like talking to a baby sometimes and then
but she never gets angry or anything she's all happy and jolly but I'm sure mum and dad gets a bit frustrated with sometimes when she comes round and this yeah I think
therapist: comes round and doesn't help
Joanne: yes
therapist: doesn't give her a break because I was just thinking that if your nanny was able to come round once during the week that that would free Mum up to spend a bit more time with your brother
Joanne: Timmy
therapist: Timmy and that's not an option
Joanne: well nanny does come round some. When mum asked nanny to come round to babysit or any think she's always says yes she is always happy to look after us but I do have you ever asked nanny to just come round and look after us
Mum: yes, yes erm I think my mum her life has changed quite dramatically over the last two years since my grand my dad died her husband died and I think she's become very introverted she did suffer from depression for obvious reasons after losing her husband and she's become very fearful so she doesn't like driving at night time because she is worried about the car breaking down and so I think that any excuse which would prevent her from coming around spontaneously which she used to. I think originally was an escape from my dad because he was quite difficult man so as a she used to keep herself busy and think are going to Louise and the children but now since that has gone she doesn't do that any more she's become quite old very very forgetful. She's only young she's only 68 but she's she's just very old in her ways now and I think that's it's very sad because the children are there to keep her young and they want her attention and one mine but she's not really willing to give it so I think that's very sad really. She does have four other grandchildren and she spent a huge amount of time with them and so for me is difficult because I feel as though my sister and her children are her priority. My sister has four children and none of them have problems and she seems to be there on a daily basis rather than coming out us. Which she would never turn up spontaneous to us I would have to ask her.
Therapist: your wife is so kind and understanding and I was thinking if I was her I would be livid
Dad: Louise does Louise is like, she takes things and doesn’t complain, but what is frustrating is seeing her spend more time with Louise's sister and her family, who is great, but also don't understand why her mom doesn't realise that Louise needs the help and I don't understand what she doesn't tell her sister.

Therapists: have you ever taken her aside and told her Peter

Dad: no I haven't I have thought about it before

therapists: would be able to explain it to her or do you think she is too depressed and forgetful

dad: I would be happy to have a conversation if it's something Louise wanted me to do, I would be happy, I'm not too sure whether it would be a good or bad thing to do.

Therapists: but rightly or wrongly and perhaps I'm completely wrong because I've only known you for a few minutes you've got a very gentle way about you and I wonder whether are you able to assert yourself with your mother

Mum: no I feel as though I'm don't want to upset my mum by rocking the boat at least so I'd much prefer. I have a moan at her and say things are difficult, but I never say can you help I'm never direct I suppose I skirt around the edges but I think even if I was directed she would probably say Oh yes I'll come, but then she won't turn up she won't follow it through, and so I feel as though I’m wasting my time really I don't want to upset her unnecessarily and I think I would do that if I asked her to help me or to baby-sit for me, or you seem to be favouring Angela and her children and I don't want to do that because I do have a good relationship with her

therapists: so it sounds like it's important for you to have a good relationship with her, and I'm wondering how it is to have good relationships when life is so hard how much Peter do you think that intrudes into your relationship with Louise

Dad: I don't understand the question

therapist: the question really is, why Louise isn't more demanding of you

Dad: of me

therapist: yes

Dad: you have been yes we talk about it all the time

therapist: I mean more demanding why doesn't she just I don't know just go absolutely ballistic with wanting more of you
Dad: we do suffer
Mum: I don't, I don't think I ever have, no, have you ever heard mummy and daddy arguing
Joanne: no I haven't actually
Dad: we don't argue very often, we have the odd argument
Mum: I think we've also had very similar outlook on things as in difficult childhoods, so we know the effect it has on children when you've had difficult upbringing, and I think that we probably don't argue for that reason
Dad: both our fathers are alcoholics, were alcoholics, it's pure fate that both of them were alcoholics and as a result we both had a not so balanced upbringing if that's the right word, but unbalanced because your father is an alcoholic, and we both have very similar experiences. And also my brother's Down's syndrome as well and so we both had very challenging upbringing's, and therefore we argue very rare on that
Therapist: and so you're extremely in touch with one another on that then for fear of upsetting the children
Dad: I don't think we analyse it I don't think it's something, is just it is just it's made us what we are as people, so I don't think we necessarily analyse our own lives and the way we are as a couple. We found the last few years very very challenging, I find it as challenging as Louise does, but I have to, for me, you've probably heard it a thousand times, it's my job, what can I do, I'm sure it sounds like the old cliché, but I do think about trying to manage it so I can spend some more time a home.
Therapist: you're getting one evening in a week what about mornings are there any morning's available.
Dad: I normally take Joanne to school in the mornings, I drop her off in the mornings,
Therapist: So if you are it would only be in the holidays
Dad: it wouldn't be quality time, I would literally only be there for a couple of hours, and also Louise's started to do some part-time work now as well
Therapist: doesn't sound like a bad idea
Mum: get me out of the house gives them something else to do
Therapist: So that's good
Mum: well I think so I'm working just as a teaching assistant with children with special needs because I feel as though not I have any formal qualifications but I have a lot of experience so so far I'm not finding it challenging at all because I can relate to those children and the difficulties and I'm enjoying working at the moment and so that's a positive for me.

Dad: you have been happier, which is ironic really because Louise's working for three days a week at a special needs unit for a school you're definitely more relaxed and happy sitting in bed now which makes no difference really is just before you used to get quite stressed before.

Mum: yes

Dad: is just stress at work you're finding very satisfying and relaxing

Mum: yes, satisfying I wouldn't say relaxing, it's satisfying because I feel that I'm helping other people I'm helping other children, that I can relate to I don't find it challenging to me it's just life is my life and I feel as if I can help with those children because I feel as though I'm quite good parent I hope I think I've done okay with the children.

Therapist: So is there a solution to your conundrum, because I've stayed with communication all the time and it seems to be about maybe having, well you're identifying you need to give the family more time, but for Peter you've got a very demanding job that requires you

Dad: I think it's management its managing time me time and work time so from my time if you like I have got to be aware that I should be home more and when I am there its managing that time to affect as well and it's easy, because I am a wine fanatic so I can quite easily I can just sit all day reading books about wine using the time constructively when I am a home so that's my part of it. It is easy to switch off and then suddenly hours have gone by and haven't been any time in the children, so I am aware of it.

Therapist: and from what you were saying earlier you get very tired and just want to flake out after your long

Dad: yes but that's the reality of anyone who works long hours

Therapist: how much time do you well I'll ask Joanne, how much time do Mum and Dad spend on their own

Joanne: not much time I don't think
therapist: are you aware of the last time the two of them went out together
Mum: it was a couple of weeks ago
Joanne: it wasn't that long ago
therapist: right and how often do they do that
Joanne: well it's more often now I think when Billy was born they just stopped going out with each other and just stayed home and looked after us and occasionally Mum would go out with her friends and occasionally Dad would go out and it was a very often but now they seem to have got back into the routine when they go out more often, which I think it's good
therapist: So this time for them to communicate
Dad: it's been very hard with Billy leaving him with babysitters or my mum just basic stuff but were much more relaxed about going out now in the last year shall we say
Mum: yes, we had separation anxiety linked to me and it was very difficult me having babysitter that used to complain about what it was like even though that's what they're paid to do to look after children, but it was just the anticipation for us to go out was I don't know it is ruined it knowing that Billy was going to be difficult and so we had to cancel all turned down a lot of invitations because we found it difficult to find a babysitter that was willing to look after him but that's getting better
Billy: Billy stay
Mum: listen you have made a great mess look at this
therapists: I'm very pleased to notice Billy, you've done very well because we have not been saying the words to you the whole time and you're a very good boy waving to the people behind the window because there are people there and they like to be waved at
Billy: I'm going to get the toys out from in here
therapist: alright then the boy thank you. Before I invite some of them to come in and we listen to their conversation we were speaking about communication mainly in terms of trying to find ways of finding time both for each other as a family particularly with the children for Timmy but also to some extent to support each other as parents as well. We haven't spoken about the other thing that you mentioned which was resources was it
Mum: yes
therapist: I guess being a special needs teacher, actually have a fairly good idea of some resources so I was thinking rather than beating around the bush what do you think you're not getting that you might be
Mum: I don't know
therapist: okay what do you feel you think you're missing what would you like
Mum: I would like really, I feel as though it should be me but I would like either somebody to either come and look after Billy so I could take Timmy somewhere or vice versa some sort of club which I'm sure Timmy would love to do after school club which would involve not necessarily other special needs children but something I could either spend some quality one-to-one time with Timmy or for somebody that would be willing to come and become Timmy's friend because Timmy has no friends outside of school and take him out so it's really resources for Timmy really I feel as though we need.
Therapist: So that's something the team can think about when they come when you're ready team. When they're ready they'll come and knock on the door and I'll move over and join you and we'll listen to what they're saying. I must say from the it's a real conundrum how the one you've identified how you can buy more time with
Mum: yes I know there's not enough hours in the day
therapist: and does it mean that something has to go then and I don't know with two homes and so on does it mean that nothing actually can go because you extended financially I don't know being quite difficult questions
Dad: the second home has actually been, really helped us
therapist: yes I heard that, yes
Dad: Timmy loves going to Seaside, don't you Timmy, he finds a real release down there
therapists: sure no I hear that, it's a time when you're really a family
Dad: a few times I've just taken just the boys down there as well, I probably only did it twice in the last year, just took the two boys down, me and the two boys for the weekend, and Louise was with Joanne and it worked well for everyone.
Therapist: right
Dads: it was quite a lot of work for me but I still enjoyed it in an exhilarating way
Mum: it was also because I was worried Peter wasn't really bonding with the boys and I just felt if you took the boys down to Seaside on its own then he could do it will be forcing him into that situation to start building a relationship

therapists: and it worked

mum: yes it worked yes yes, and I think Peter then understood more about the difficulties I was trying to explain on the phone about how life is how complicated life can be when you're basically a single parent trying to cope with three children with different needs different demands and trying to find time to be you as well

therapist: So you feel that you that Peter understands that is a bit more

James: is now a good time

therapist: yes let me just clear a space

James: hello

Dad: hello

James: we'll just have a little natter but I must admit I've been dying to come in here and play and I would really really enjoyed that but you can't have everything you want. I don't know how you felt but from our position we felt immensely privileged and I don't think that's going to necessarily help the Adam family but I do feel that they have so many strengths and so many qualities, and being able to play I think it's so important to be able to play, where's the knight, because the knight is a heroic character the knight kills the dragon the knight beats all the people that come towards him, the knight wins and I was thinking about sometimes the Adam family tend to be heroes and heroines because they have to face all these difficult dragons not having a good enough services not having support.

Billy: no, I'm going to fight you

James: miss, see this is what I want to do. And there's a fight is going on sometimes isn't there. ... miss miss .... here we go..... and we were wondering also about ... miss miss ... about Joanne and what she does, swimming and the choir she sounds very good at these things, and sometimes being able to play doesn't feel very serious, and we wondered whether is there sometimes a solution to some problems that's ... but we heard Dad say that there's a sense of knowing what to do but sometimes actually being able to do it can be really difficult
Hailey: but I remember we heard Mom and Dad say that actually there are things that they've actually talked about and they've made some choices in the last year to things of the works on which is good and dads acknowledged that he needs to be a home more which is really good.

James: I was thinking about mess and how different people have different tolerances to mess sometimes I like a really tidy desk and sometimes it really winds me up on my desk isn't tidy ....., who is this who's that

Billy: I'm a dragon

James: another dragon go away

Billy: no you go away

James: that sometimes the messy things the uncomfortable chaotic things are sometimes very difficult and I know sometimes that people who are different are viewed in that way as if they should go away which is a great conflict with the reality. So sometimes it's difficult to think when you have a difference and a big difference a colleague mentioned a couple of things that you will ready made now, which is DISS Laura: disability information network, they might have some resources and we also were talking about respite, there's a charity called disability challenges and they're based in Gu***** and we think they might do after school

Mum: yes but it's in Gu***** and that's a problem because we live in Re**** so we need some think Re**** really. Timmy is a member of challenges and he joins the playschemes during the summer and Easter but we were attending family days once a month but that's since we've had the flat in Seaside with how to keep the weekends free for that

Laura: there is a community nurse in your area actually based in little Dorking we could put you, I don't know if you have contact with him,

Mum: I did for a while we had some difficulties with Timmy and he did some home visits so I have met him.

Laura: it's just he will have more information about the area in the service is available because we're obviously based in Ep*** so we know more about this area and what services are available in this area

Mum: okay
Laura: I'm not sure if you have a social worker or sometimes it's just a duty team but that could be away of getting access to services.

Therapist: thank you team very much is there anything else you wanted to say

James: well I was just thinking when people start playing particularly adults is difficult to think of on the one hand the game you're in and then the adult world and that's really difficult thing things and I'm experiencing it slightly at the moment, but I know how important it is for the children to play and sometimes in their play maybe they're working some things out

therapist: So you needed to say that again because that's very important

James: yes yes, communicating with each other as you probably know

therapist: thanks James, and tell and thanks Laura

James: nice to meet you

therapists: okay so a few suggestions about people you might contact about getting some respite and the key message there I think is about play when you are about when you have time it is prioritised in play

Dad: yes

therapists: it's, the brains develop in response to play so you also get good behaviour and manageable behaviour if you're playing more. I think the way James was modelling that by talking and playing, of course is one thing doing that in a professional setting like this rather than when you're actually looking after your kids at home but nevertheless the rule applies. I don't know whether you would like another session here whether you it would be helpful to come back in a month or two or whether you feel that that was enough.

Dad: I don't know I found it quite interesting actually I don't know is strange after talks with other people you realise how you deal with issues and deal with problems. It might be that I think we mean I can only talk for me obviously I can't talk for Timmy or Joanne but I think we're very aware of the issues we have and we're dealing with them. And it's been used for me, I mean I was thinking last night that I would come here is that we think it will be awful that something I wasn't aware of like something would be brought or Joanne would say something. Obviously Timmy is quiet, so for me it's been a very positive session as in a think we're sort of doing pretty well even though there's a lot of work to do, does that make sense
therapists: very much so just a response to what you've just said just one sad thing I guess
I wasn't looking at you careful enough to notice whether it upset you very much wants to
hear how sad your wife is about her relationship with her mum
Dad: yes I'm very aware of that
therapist: yes yes, it's definitely resource that she can't tap into
Mum: yes yes exactly
therapist: what about for you did anything for you resonate
Mum: not really, you know I agree with Peter it's nice to be able to have the luxury of
time to actually sit down and discuss things as we have done but I felt that very helpful
actually. Do you think we will benefit from coming again?
Dad: I'm not sure, but I'm not saying that I'm anti it, I'm not sure I think, I thought
therapist: what I can do perhaps is we can give you a date in say a couple of months and
then you can just cancel it within say 1 months so that we could offer it to another family.
Dad: yes
therapist: then that would give you time perhaps given that you're not sure to talk about it
and see whether you
Dads: but I'm not sure not in a negative way that makes sense
therapist: thank you no I do understand, but that you Joanne how did you find the
conversation
Joanne: I found it really interesting to listen points I didn't know about and to hear how
Timmy feels
therapists: to hear how Timmy feels
Joanne: yes, but I do think I agree with mum and Timmy doesn't say loads but you just
can't, he just feels that he's going to get told off or something like that. But I know I am
it's been quite interesting listening to you
therapist: So you might want to come again if mum and dad feel of calls want to, what
about you Timmy how you found it this session
Timmy: I've been really impressed
therapist: impressed, what impressed you
Timmy: I don't know
Dad: did you enjoy Timmy
Timmy: yeah
therapists: did your mum and dad impress you
Timmy: yeah
therapist: what about your sister
Timmy: yeah
therapist: it sounds like they were impressed by you to do you know why
Timmy: no
therapists: because you let them know well particular sister because she just said how you felt
Billy: what about me, what about me
therapist: I have forgot you, your the last but not least
Dad: why do you sit down and we'll talk about you while you sit down for a minute was talking about Timmy for the minute
therapist: you're the last but not least we talking about Timmy for the minute. So Timmy or family were impressed by you and it sounds as though did you hear that mum wants to try and find time to go out with just you So that's mum and Timmy time which would be nice wouldn't it is but it's also nice because that's what she wants, yeah
Timmy: yeah
Billy: and what about me
therapist: at last but not least can I tell you Billy how really great it was, I thought all is not going to know about finding the night
Billy: finding Nemo
therapist: well I thought you would never find the knight and I thought you would wouldn't even know what my friend James was talking about but you did know what he was talking about and you did find the knight is so that was really good and also you played very nicely and James a man with a dragon his message was that your daddy and you need to play more okay
Mum: okay
therapist: you're very good at playing so you can help Dad to play with you
Dad: okay
Mum: So you say Daddy you be Buzz Lightyear and I'll be serg can't you
Billy: I can play toy story
Mum: you can play toy story
therapist: goodbye
Mum: goodbye
Dad: goodbye
Appendix VI

Pull-out of LACS Definitions
<table>
<thead>
<tr>
<th>Dimension</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaker</td>
<td>Who is speaking and providing the attributions</td>
</tr>
<tr>
<td>Agent</td>
<td>The person group or entity nominated in the cause of the attribution</td>
</tr>
<tr>
<td>Target</td>
<td>The person, group or entity mentioned in the outcome of the attribution</td>
</tr>
<tr>
<td>Stable – Unstable</td>
<td>This dimension is applied to cause element of attributions as to whether the cause of the outcome was due to stable or unstable factors. Stable factors are things that are unchanging about a person or set of circumstances, or factors that will continue to affects future outcomes (e.g. being stupid). Unstable factors are short-term or transitory (e.g. being exhausted).</td>
</tr>
<tr>
<td>Global – Specific</td>
<td>This dimension is applied to the cause element of attributions as to whether the cause of the outcome was due to global or specific factors. Global causes are coded when causes are likely to have a significant impact on several different outcomes (e.g. having a poor relationship with siblings or parents). Specific causes are found in one off events and are unlikely to have repercussions beyond the one identified in the attribution being coded (e.g. having chickenpox).</td>
</tr>
<tr>
<td>Internal – External</td>
<td>Internal causes are factors that originate from within the individual, such as a person's emotions, beliefs or personality characteristics. External causes are factors that originate within the environment, or as a result of circumstance, or as a result of the actions of other people (e.g. a family member failing to visit)</td>
</tr>
<tr>
<td>Personal – Universal</td>
<td>Personal factors must demonstrate that there is something special, unique or different about the speaker, agent or the targets of the attribution (e.g. the person has difficulty making friends, they are experiencing a certain emotion). Universal factors are when nothing in the cause, outcome or link between the two suggest anything distinctive about the person, that is the speaker gives no reason to believe that his/her behaviour is any different from any other person in the reference group.</td>
</tr>
<tr>
<td>Controllable – Uncontrollable</td>
<td>The attribution is coded as controllable only when the person could have realistically affected the outcome without having to exert some exceptional effort. Attributions are rated controllable when there is an indication that the person has chosen to act in a particular way. The behaviour is thought to have been carried out due to factors that are beyond the person's control, the attribution is rated as uncontrollable.</td>
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Appendix VII

Sample Transcript of Therapist Interview
Suzanne: OK, this is interview with Jill regarding family number three, and this Watts family. Mmm, yeah, Jill, what do you remember the concerns were that led the family to be referred, um, to family therapy in the first place?
Therapist: You mean the reason for referral before speaking to the family?
Suzanne: Yeah.
Therapist: Yeah. Mmm, it was around Cara’s aggression, particularly towards Mum, although sometimes Dad, and, um, their worries about managing some of her behaviours, particularly around her losing her temper and not co-operating with their requests to do activities around the house.
Suzanne: Right, OK. Mmm, had you spoken with the family then before they arrived?
Therapist: I hadn’t, no, the, um, a community nurse who worked on the team referred them and she had been involved with Cara, and she had, um, been to Cara’s school and done some observations and also spoken to Mum.
Suzanne: So, as a team, did you had built up a picture of what the issues might be for the family?
Therapist: We had.
Suzanne: So you had kind of an idea about that. And who, when the team were discussing the family beforehand, as I’m aware that you do, who did you expect would attend?
Therapist: I thought that Mum, Dad and Cara would attend, I didn’t think that Kevin would attend because I knew that he was at university, but I assumed that certainly Mum and Dad, and there was also a grandmother who lives a long way away, who’s also quite involved when she’s visiting, um, that she might come too if she had been around, mmm.
Suzanne: OK. And as you know, just Mum and Cara attended the session, um, and how did the team respond to that, do you think?
Therapist: Um, I think we were quite surprised, um, I think it’s always useful to get, where there are two parents living together, to get both perspectives, um, and we were interested to find out a bit more about why he wasn’t able to come, whether he hadn’t wanted to come, whether he didn’t agree with coming to family therapy or whether he, you know, had work commitments and those sorts of things, I think quite interested to get a better picture of why he wasn’t there.
Suzanne: OK. And do you think that that’s something that you managed to explore with them?

Therapist: We did I think in the session, or I think I may have done when I, after we spoke to her about the research, and it was that he had work commitments.

Suzanne: Mmm.

Therapist: And he hadn’t been able to get out of work.

Suzanne: Thinking about the pre-therapy discussion within the family therapy team and our own, um, kind of thoughts about the family, what do you remember your initial hypotheses about the family were?

Therapist: Cara’s adopted, and some of the thoughts we had were around, um, actually we also knew that she had been talking about her other Mum, I think she referred to her as her other Mum or her real Mum, and that we assumed there might be some tension around for Cara around, um, what life might have been like and what life is like now, and fantasies about what her relationship with her real Mum would be like, could have been like, um, they were some of the things we talked about, but also thinking about transitions, and Cara’s coming up to, I think sixteen, seventeen, um, yeah I think she’s fifteen at the moment, um, and so thinking about her identity and her, um, her as a person and how that might, you know, how she’s looking at her adoptive mother and thinking well, ‘how far am I like you and how far am I like my adoptive father?’, and actually what, you know, the absence of her real mother and wondering about that and having lots of ideas about, finding it hard to make links between her real mother and the one that she’s living with and those were the ideas we thought, um, I’m trying to think what else, there was another issue as well actually, sorry, that we knew at the beginning of the referral was that she had been sexually abused by a foster brother in this adoptive family, and, um, we had thoughts around her, again thinking about change and stages in life and her, um, increasing sexual interest and knowledge and whether or not, you know, again thinking about feeling disappointed and letting bad things happen, whether she felt some aggression towards her Mum for in avertedly allowing this foster brother to live with them and, again, exploring issues around sexual abuse and how it felt to be unsafe and in a family home and, you know, not the sort of, um, if you like, given away as a baby of eight months and then given to another family where yet again there was another
traumatic experience, so thinking a lot about trauma and how that might resurface and how she might not be feeling terribly safe or protected.

Suzanne: Mmm. And you mentioned earlier about, kind of, the aggression towards Mum, what were your thoughts around the aggression, and violence towards Mum?

Therapist: Yeah, well again, I think we saw it, we tried to link it to hypotheses around, um, transitions, so, you know, her being an adolescent, and issues around control and wanting to break free, perhaps wanting more independence than her Mum would allow her, so, we were considering issues around that, but we were also considering issues around unspoken anger, particularly around the traumas that I mentioned and, um, yes, and the anger towards being adopted and being abandoned and, you know, and, you know, those sorts of feelings, yeah.

Suzanne: Yeah, yeah, thank you. Um, and just thinking about yourself, did you have any expectations of the family before they came?

Therapist: Um, I wasn’t aware that I had any until I met the family, where I became very aware of my expectations, if that makes sense?

Suzanne: Yeah, do you recall what they were, or...?

Therapist: Well, from the nurse, who joined us in family therapy, who was a regular person in family therapy, the impression I’d, um, created in my head of the family were that, um, they were a very capable family, a very committed family, um, they took very well to all the behavioural techniques, they tried star charts and rewards, and they’ve really taken on board those very practical strategies and worked with them. They hadn’t been terribly successful with them, but they’d responded very well to that way, and that they were, um, yeah, a capable family who were responsive to help and really keen and really driven, um, this is the impression I got, they were really motivated to change and all singing from the same sort of hymn sheet if you like, um, and I got the impression of, um, you know, your fairly dynamic Mum I suppose, somebody who was fairly upbeat and able to be motivating and sees the strategies that she was given and make use of them.

Suzanne: And you said that it wasn’t till you met them that you realised that you’d had kind of, ideas of the family beforehand.

Therapist: Yes.
Suzanne: So how did that differ from when you met them?

Therapist: When I met them, um, the Mum seemed very, very low, if not depressed, um, she looked unwell, she looked incredibly tired, she’s quite a heavy set lady, she had a stick, um, she was limping, she looked slightly bent over, and she was not at all easy to engage, she, um, she looked very angry, very angry, quite dismissive of family therapy and myself as being the main therapist and, sort of, ‘well, how can you help?’, but wanting help, but, that it really was very counter to what I’d expected, she really looked unwell and, um, very tired and, sort of pulled down by the whole situation with Cara.

Suzanne: Mmm, and how did you, just thinking about Cara then, did you have, did you have expectations of Cara beforehand ...?

Therapist: I did, I mean Cara is, well has a lay, has a diagnosis of autism.

Suzanne: Right.

Therapist: So I was expecting somebody quiet, withdrawn, you know, the usual sorts of things, maybe avoiding eye contact, um, difficult to engage, perhaps, or, you know, um, avoiding me generally, and actually she was, you know, sparkly or, you know, very easy to engage, talked the whole session, to the point where Mum said ‘I’ve never heard her say so much, I’ve never actually seen her speak in that way’, so freely, so clearly and, um, you know, putting whole sentences together, um, and talking a little a bit about her feelings and her Mum’s feelings and her worries about her Mum, and I was greeted with a very articulate, or fairly articulate, given my expectations, teenager, who, um, was calm, wasn’t aggressive, was very polite, very charming, very smiley, you know, and not terribly autistic in her manner.

Suzanne: Yeah, so I suppose when we sort of meet people, or before we meet them we think about how we might be with them, so did you, did that change perhaps how you were with the family when you met them?

Therapist: It did, because, um, yes, I, wrongly I think I’d assumed that this family would be easy to engage and nice to work with and motivated, the sorts of families that, you know, are a dream to work with, um, and when I was greeted with, with the Mum who was, as I say, looks very angry, lots of sighing, um, my attempts to engage her were quite, um, were met with, you know, sort of, um, I was going to say she was quite dismissive really, um, and I remember thinking how, you know, sort of focusing more on Cara I
think really, because Mum, um, yes, I don’t, um, she didn’t appear nervous, she didn’t appear, you know, had she, had I thought that her, um, cold sort of quite difficult to engage demeanour was around her anxiety, that would have been easier I think for me to sympathise with and engage, but it was this very cold, flat affect, you know, no, not giving me terribly much in the way of lines to hook into, very difficult to get anything meaty that I could discuss with her for the first few, well, quite a few minutes really. Um, so I did focus more on Cara because she was clearly quite willing to talk, wanted to talk, was quite keen to say what things were like for her, and didn’t show any, um, was very sort of uninhibited although not in an inappropriate way. So it did change the focus of the work slightly, yes.

Suzanne: Yeah, yeah. Well just, I suppose then, thinking about, carrying on from your experience of the family in kind of, how they presented, um, yeah, so, you’ve talked about Mum presenting as, um, very kind of defensive throughout.

Therapist: Yes.

Suzanne: would you say that that was the case the whole way through and Cara’s presentation was the same the whole way through?

Therapist: More or less, Mum did, um, a lot of the, what also made it difficult was a lot of what she said was very, very critical of Cara and incredibly negative, and I was trying to elicit some positive, because I felt I was being drawn into a very hopeless situation, very negative, and all the information I was eliciting were examples of how awful and dire it was at home and how dreadful Cara was, and aggressive, and Mum was this victim, you know, very much a sort of a, she felt very fragile to me, she felt very vulnerable, and I was very keen to try and turn it so that we were looking at some positive things so the team could comment more on those sorts of issues, and not really getting very far, um, and Clive came in at one point and asked about relationships or things that happened I think when Cara would do what she was asked or, a lot of it was about jobs and tasks and chores, and how she wasn’t doing what she was told, and you know, a lot of it, and wanting to kind of normalise it, and actually this is often what teenagers are like, and, you know, um, so some of that did shift and Mum was able to see more from Cara’s perspective, um, so it wasn’t all, um, you know, it wasn’t sort of a very difficult session all the way through.
Suzanne: So there was some change?
Therapist: Mmm.
Suzanne: And you’ve talked a bit about, kind of, how the family saw things, so you were saying that Mum saw herself as a victim and was blaming a lot, blaming Cara a lot for her behaviour, can you say any more about how you saw their attributional style, where Mum saw the difficulties, where did Cara see the difficulties?
Therapist: Yes, I think very much for Mum, this is my own perspective, obviously...
Suzanne: Yes, absolutely.
Therapist: Um, she felt very bullied by Cara, um, she didn’t use that word, but that’s how it came across, and very, um, pushed around, um, you know, Cara wouldn’t do anything she asked, they didn’t have any nice times together, that the family were full of arguments and, um, distress, people feeling very upset and Mum having to kind of escape to her bedroom and her calling her room her sanctuary and she really felt like, and it felt like four individuals living in a house that was full of, um, turmoil, and aggression and anger that was very highly expressed and all very separate, it felt like four very separate individuals that they couldn’t contain, and Mum couldn’t contain these quite negative feelings and took them very personally, I think she felt very...she couldn’t acknowledge that there was some level at which she felt responsible for Cara’s difficulties, responsible for Cara being abused, um, those sorts of issues, that those things couldn’t be talked about, that they were very difficult for her to acknowledge, um, and for Cara, I mean Cara didn’t mention the abuse, she didn’t mention her real Mum, and, um, she, I, again my strong feeling was that she, um, was almost, and it’s a very strong thing to say, but it was almost sort of taking the mothering role a bit, she felt protective over Mum, she was, I felt she was editing some of what she was saying to me, or certainly, you know, in her own, given her limitations, she was being quite careful about what she was saying so as not to upset Mum, and it felt like she was quite used to that way of being, that, you know, you do things, or you don’t do things, or you don’t say things because it will upset Mum, so really taking quite, um, in a way taking quite a mature, quite an adult role towards Mum, but certainly, and she was aware, she knew that some of her actions annoyed Mum and that, you know, refusing to wash up or put the...they were very often the arguments were around, you know, daily domestic things, which, you know, as they often are, and
Cara could recognise the things that she wasn’t doing that would upset Mum, and sometimes said some mean things to Mum, um, and said you know, ‘I’ve really tried to change’ and things had got better interestingly when they came to the session, they had, Cara, they tried a um, a reward, a star chart, and it had worked, but I only really heard that from Cara, I seem to remember Cara saying, ‘but I have got better Mum’, you know, she was able to sort of, um, see the whole picture in a way that I felt Mum couldn’t, she was able to say, ‘well yes I was bad, but actually now I’m better’, and, ‘because of that I’m a bit better’ and she could sort of recognise what had changed in a way that Mum found very difficult and was really stuck in this sort of, ‘it’s all awful and she won’t do anything, and she lies and she calls me dreadful names, and she really upsets me and she’s making me ill’ and they were, that’s, I felt very much that they were the messages that Mum was giving out.

Suzanne: So very emotionally laden kind of stuff?
Therapist: Very, yes.

Suzanne: And, I know that Mum and Kevin, sorry Dad and Kevin weren’t able to attend, or weren’t there, but were there any, did you get a sense that things were being attributed to them at all in any way, or had they been involved in the kind of conversation?
Therapist: They were involved, they were brought in, and, um, Mum said that Dad was very supportive, Dad tried to, um, manage situations, but from what Cara said, I think Dad would get very, very angry, and send her in the garden or send her to her room, or, I think even at times, um, the arguments had become quite aggressive with him sort of almost frog-marching her physically out into the garden, you know, ‘get out and go away, you’re upsetting us, we don’t want to see you’, and things had got quite difficult, so I think Cara felt, again this is my impression, that at times he was a bit heavy-handed, he was a bit, he missed the situation a bit, he kind of, he jumped in too soon and too harsh, um, in order to protect Mum, in order to sort of try and stop a situation deteriorating, but maybe he was sort of a bit heavy-handed at times, um, this is from Cara’s description, um, but there was a general sense that people were not communicating well and that even with her brother Kevin that, um, who isn’t her biological brother, but very often that, you know, when he left for university, that these people are very, um, upset and very sad to see him go, but relieved to see him go because he was also said very upsetting things to
her, very awful things about, 'I hate, you, I wish you'd never adopted me', and really emotive things, um, but it, I felt Dad had almost, again it's a strong thing to say, but the suggestion was that Dad had almost given up with Kevin, that things had got so difficult that he just couldn't, he was beyond, the relationship was beyond repair.

Suzanne: Mmm.

Therapist: Um, but he was still visiting and they were all clearly attached to each other, all these four people, but in a very negative way, um, so they were both brought in, Dad as the sort of protector and, not...trying to mediate, but I think sometimes getting it wrong, and Kevin as being, you know, quite verbally abusive, using them, spending all their money, 'he only wants us when he wants money', um, you know, very much not the loving son that they clearly, you know, were desperate for, but the son who took advantage and was completely ungrateful, and abused them verbally, that was very, very much the language and the messages that they were giving.

Suzanne: You yourself talked about the fact that you tried to, you know, when Mum was being, talking quite negatively about Cara, and that you were trying to kind of look at more positive aspects, aspects that were I suppose an exception to the rule, times when she wasn't that way, when she was a bit more helpful, how do you think, I think, I know you spoke about it earlier, but how do you think that Mum responded to that and Cara responded to hearing that and...?

Therapist: I think for Cara...

Suzanne: Yeah, sorry...

Therapist: That it, um, I think she liked it, I think it was useful, but after the session I felt as if, um, I felt I think quite intimidated by Mum, by the situation, because I felt she was so fragile, that if I'd said something too confrontational, that it could have been too difficult for her, too much for her, um, so I felt that I was very much treading on egg shells around the family, and possibly I worried that I was joining them as I said earlier in their kind of hopelessness. What the team said, I mean, again, maybe they were being nice to me, but what the team said was that what seemed to happen was that I joined the family in this sort of, um, because I was probably the quietest I've ever been in a session I think for a very long time, I felt I didn't say very much, I felt, I asked a few questions trying to drop a few things in and just let them talk a lot, um, and I felt at times, 'actually
I’m not really controlling this session, I’m not being directive enough, I’m not’...but it seemed for this family that that was maybe the right thing to do, and it allowed Cara to really speak about how it felt, what it was like for her at school, what it was like to be a sister of Kevin, what it was like when Dad really lost his temper, and things like that, um, and what it was like for her in her relationship with her grandmother who was quite poorly and worries that Cara has that are very real, um, but that somehow shifted things and my joining them in what felt to me like a rather passive way, that I wasn’t being a strong facilitator that I should have been, somehow helped, um, supported them to say a bit more, and for Mum just to sit and be, was quite useful, and certainly the feedback we heard afterwards was that the session was very, very useful and, you know, that they’d both enjoyed it and wanted to come back, but at the time I thought, you know, gosh I remember thinking, ‘I wouldn’t be surprised if they didn’t come back’, because, you know, but, yes, Cara seemed to respond really, really well to that, and there was a really nice point where they talked about, um, when Cara was a baby and how, um, her and her gran, you know the mother, the grandmother, used to take her out for a walk, and how, nice things, and it did shift a little bit to when she was a baby and how delighted they all were to have her and, um, there was a lot around ill-health as well and Mum having a bad back for a very long time, and she’d been very poorly and bed-ridden for several months when Cara was very little and her own mother had had to step in, um, and, you know, I was again thinking about, you know, if you can’t have your own children and then even when you have got a child, your mother has to look after that child and how that might make you feel, um, so yeah, um, does that answer the question?

Suzanne: Yeah, yeah, that’s lovely, um just thinking, I mean, it sounds like a lot of that, like you being, as you said, quite passive, and letting the family have that space to talk, giving that space for Cara to talk, and just be and hear, that was quite helpful for the family, were there any other things that you felt were helpful for the family?

Therapist: Um, do you want me to talk about when the team came in?

Suzanne: Yes.

Therapist: Yes, um, when the team came in the room the feedback they gave, they obviously had their discussion in front of myself and Mum and daughter, and one of the things that they said was about, um, lots of positive things about how impressed they
were with Cara, how articulate she'd been, how clever she’d been in saying what things were like for her, and how they’d really got an understanding of what things were like for her and how worried she was about her Mum and her Mum’s ill-health and how ill Mum looked, and they were able to say things which I’d felt silenced by their, you know, that were really useful, and one of the things that they said was about how tough Cara was and how Mum’s, um, you know, it must be that Mum has looked after her very, very well, that Cara can be this tough, and be, given what’s happened to her, um, and that, um, they talked about how she’d broken one of Mum’s favourite china dolls and Cara hadn’t felt able to tell Mum and had put it back in the pram and they’d discovered this broken doll, Mum collects these dolls and she was terribly upset, but there was a discussion around why it might be difficult for Cara to tell, and why, um, yeah, just, I think about how, again going back to how able she was to cope with difficult things, and that’s, at that point, Mum and Cara held hands and Mum cried, and I think for Mum, as she said at the end of it, she said, ‘I hadn’t really thought for a very long time how tough Cara is and what she’s been through and how that might, you know, make her at times the person that she is’, and that felt very, very important that Mum was able to acknowledge what Cara had been through and how tough, but also that Mum had had a big part in helping her be strong and articulate these things in such a, um, well-rounded manner if you like. So, yeah, I remember that being quite a powerful…and there were very, that’s when they, I think that, although they did hold hands throughout the session on and off quite a lot, through a lot of the feedback they held hands all the time, yeah, and the team were able to say how connected they were, albeit through negativity at times, but they were very connected to each other and clearly there was, you know, a very strong bond between them and I think that was really useful for them as well.

Suzanne: OK. Was there anything that happened during the session or with the family therapy, um, the rest of the team coming in that you felt was unhelpful for the family?

Therapist: Um, I can’t think of anything, no, Mum didn’t comment on anything that was unhelpful, no.

Suzanne: That’s fine, OK, so I’m going to feedback, um, the attributions, so, um, the therapy session was transcribed and then I went through and extracted all the attributions, and these are, how it’s kind of coded…
Therapist: These are Mum’s attributions that you’re...?
Suzanne: No, no, these are the kind of system that I use, so I differentiate the speaker, agent, target, and then you say whether it’s stable/unstable, and then the definitions say global/specific, um, internal/external, personal/universal, and controllable/uncontrollable, I’ll leave you to just have a quick read of that for a minute while I just find the book so you can get the concept in your head.
Therapist: OK.
Suzanne: Yeah? Um, and I’ve kind of summarised and looked at what were the general trend, or what the general styles of the two members of the family and yourself and the family therapy team that came in. Um, so Mum made the majority of attributional statements, so she made 49% of the attributional statements and Cara, or um...
Therapist: Cara.
Suzanne: Cara made the second most at 38.4%, um, twenty-six of those statements Mum saw herself as being kind of the target, but herself, um, yeah, um, the majority of those were Cara as being the agent and Cara as being the one that was kind of doing...
Therapist: Yes.
Suzanne: Um, and they were generally stable, global, internal, personal and controllable, so you know, kind of seeing them as real aspects of Cara and it was Cara that was doing this to her and Cara was in control and Cara, more or less, she could stop herself from doing it, so quite blaming.
Therapist: That’s interesting exactly what I felt, that’s really interesting.
Suzanne: Um, the second was Kevin, um, where Mum saw Kevin as the agent, um, but Mum, Dad and Cara equally as being targets, so that’s quite split, um, so Kevin, the ones where Mum was the target with Kevin being the agent, they tended to be again stable, global, internal, personal and controllable, and actually that seemed to be the general trend as well when Dad and Cara were the, um, kind of the targets.
Therapist: Yes.
Suzanne: So again seeing as kind of quite blaming. Mum saw herself, in six of the attributions she saw herself as being the agent of her own actions.
Therapist: Right.
Suzanne: Um, but they tended to be, the attributions she made, the majority of them tended to be unstable, so kind of just kind of more, um, transient factors, um, they tended to be specific, so to a specific instance, they were internal to her and personal but uncontrollable, so feeling that she didn’t have much control over her own actions and um it was probably as a consequence of other things happening, um, Kevin and Cara, um, acting as agents against Mum as a target, um, they tended to be the majority stable and global, um, three of them were seen to be internal to Kevin and Cara, whereas two were external, but again personal and controllable, so again quite blaming. Um, there was one attribution with Dad being the agent towards, um, Mum as a target, and that was stable, global, internal, personal and controllable, so, slightly blaming, Cara against herself; Mum saw that as stable, global and internal, personal and controllable, so, that seemed to be her style, quite, I suppose you could say quite blaming and…

Therapist: Yes, she knows what she’s doing and she can do something about it if she wants to.

Suzanne: Yes, and she generally saw that as most people, so attributing a lot of blame, you know…

Therapist: Yes.

Suzanne: In people know what they’re doing, it’s something that’s intrinsic, it’s part of their personality, it’s part of who they are and, um, they’re in control of it. Cara made forty-three attributional statements, um, OK, Cara on, um, Cara made some attributional statements in which she was the agent and Mum was the target, she saw, um, three of each so six attributional statements around that, three were stable, three were unstable, so again some of them, just looking at specific, and I think the unstable ones were, um, were the ones around the doll issue, so there were, um, so three were stable, global and three were unstable and specific, but the majority were internal, personal, and she saw herself as being in control, um, so, um, yeah, I suppose taking some responsibility, or repeating maybe some of Mum’s, um, kind of comments perhaps, I don’t know. Um, there were three attributional statements in which Cara saw herself as being the agent and Dad as being the target, and they tended to be stable, global, internal, personal and controllable, so again blaming herself and taking control for what she was doing, um, there were four statements in which Cara saw Mum as being the agent and herself as being the target, and
they tended to be unstable, specific, but internal and personal and controllable to Mum, so perhaps around specific incidences, um, Cara on herself, um, a mix, but generally unstable, specific, internal, personal, but there was a mix, one was controllable, one where she saw she had control and one where she didn’t, um, and again, Kevin being the agent against Cara as the target, there were two there, stable, global and internal, personal and controllable, so quite blaming in her attributions there and seeing them as kind of characteristic of him. Um, there were five attributional statements in which Mum and Dad were the agents and with Cara as the target, so kind of, and they were stable, global, three of them were external, and two of them were internal to Mum and Dad, but they were personal and controllable, and I think they were around Mum and Dad talking about her, um, the incident with the doll and Dad, you know, those types of things, but seeing them as being quite in control and controlled. Um, yeah, Cara, um, this one was quite interesting, Cara being the agent and Mum and Dad being the targets, stable, that was stable, global and internal and personal, but Cara didn’t feel that she had any control over that, um, and I think again that was around when Mum and Dad talked to her, talk about her, sorry, and she doesn’t feel that she has any control over that and kind of making, um, yeah, not being able to control what’s happening there. Um, and then Kevin on Mum and Dad, and that’s stable, global, internal, personal and controllable, so again, quite, you know, quite blaming and specific. Um, your own attributions, you made five attributional statements, and, um, there was one in which you saw Dad as the agent and Mum as the target, um, and that was stable, global, internal, personal and controllable, and a lot of the attributional statements that you were making you were repeating what the family was saying.

Therapist: Yes.

Suzanne: Um, there was another one with Mum being the agent and Dad, and Cara being the target, and that was stable, global, external, personal but uncontrollable. Cara on herself: unstable, specific, external, personal but uncontrollable. Are these making sense when I’m reading them out like that?

Therapist: Mmm, yeah.

Suzanne: Kevin against Cara, stable, global, internal, universal, uncontrollable, and then Cara against Mum and Cara, and that was stable, global, internal, personal and
uncontrollable. Um, and Clive, when he came in he made um, with the family he made a number of attributional statements, Mum against herself, that was unstable, specific, internal, personal and uncontrollable. Kevin against Mum, that was stable, global, internal, personal, but controllable, um, and Clive against Mum, and I can’t specifically remember what that was about, it was unstable, specific, internal personal and controllable, um, Mum against Cara, there was, um, it was a mix, there were two attributional statements, one was stable, specific, external, personal and controllable, whereas the other one was unstable, global, internal, and controllable, um, and then Mum against Dad, that was, um, Mum and Dad against Mum, that was unstable, specific, internal, personal and uncontrollable. Cara against Mum and Dad, they were all global, personal, sorry, external, personal and uncontrollable. So, a real mix from, I suppose the therapists in terms of, um, what they saw, but they were kind of repeating what the family were saying.

Therapist: Yes.

Suzanne: But perhaps wording them in such a way as to perhaps be more balanced.

Therapist: Yes, that’s what I was trying to do, sort of re-affirm or affirm what they were saying, but, provide a slightly alternative, you know, the alternative perspective, that was maybe more inclusive, more, um, more positive, and more normalised, um…

Suzanne: So, yeah, so trying to, yeah, give more balance…

Therapist: Yes, yes, give a more balanced view, absolutely, that everything wasn’t, you know, because they were adopted, but actually, you know, maybe lots of families with two teenagers have a lot of turmoil and some degree of verbal aggression and lots of families are struggling with that and, you know, that’s not about Cara or Kevin particularly hating the parents or wanting to personally attack them in some very calculated way, it’s just that teenagers have a lot of emotions raging around, and sometimes that spills over, what they actually need is a lot of containment and for parents to be a little bit more forgiving in their style.

Suzanne: Yeah.

Therapist: And actually, it was, I think it was the next session though, but Clive talked about being more forgiving, but I think it was in the second session actually, but forgiving as in, um, you know, let…make the boundaries more fluid, not so black and
white that, you know, if you cross that, then that’s some terrible crime and you’ve personally offended me, but you know we can work with that, I didn’t like that, but, you know, this family felt very, very, they tried desperately to be firm with the children but there wasn’t very much, um, flexibility in that really.

Suzanne: So I suppose just thinking about what I fed back, how, I mean you said earlier that that felt very similar to how you had seen it, I mean what generally did you, um, are they different, were any of them different or similar, what was, how was your feel for...

Therapist: I think certainly the first set that you read out of the families were very, very similar, yes they were...

Suzanne: Mum’s attributions?

Therapist: Yes, yes, Mum feeling, um, that it’s all out there and, you know, there’s not very much I can do about it, and it influences a lot of what happens, um, and it’s in Cara’s personality and Kevin’s personality, and that sort of thing, and that certainly...

Suzanne: In terms of Cara’s attributions, um, did that feel very similar to...?

Therapist: Yes, but I think Cara did feel blamed, and I think she did feel responsible for her Mum’s feelings, and her Mum’s attributions, um, but I think Cara was able to have a more, um, all-round view, that things do get better and could get better and it wasn’t all dreadful, and she really enjoyed shopping with her Mum and she was able to come up with positives that were really nice, um, so I think for her they were less stable, they were less enduring, they were less awful, you know there was some, she could see the other side of it and I think that was picked up in terms of, they weren’t so global and uncontrollable and stable, um, they seemed to be more specific, more controllable, and, from what you were reading out.

Suzanne: Yeah, is there anything in kind of the feedback that strikes you as being different or similar?

Therapist: I was interested in the fact only five attributions, I think, were from me, and I was wondering, and that, again, I don’t know what, you know, not having done this before, what that, it doesn’t seem like a lot, and it’s interesting that it does fit with what I felt I needed to do which was about affirming their position and how difficult things were with them, but also trying to put a slightly more positive perspective on things for them, um, but that doesn’t seem like a lot, and it does, yes, it certainly fits with me feeling, um,
it's quite difficult to penetrate the negativity, quite difficult to, other than to meet them and affirm how they were feeling, um…

Suzanne: Do you think that's different for you from most sessions, that you feel you would be making more attributional statements in the session?

Therapist: I think so, I think I'd be, yes, I think I would be commenting more on what I thought was happening and trying to um, I guess in some ways control the session more and take it where I wanted it to go, it felt like I had to sort of sit back and contain the family and just go where they needed to go, um, which is unusual for me, but that was very much how it felt.

Suzanne: OK. Was there anything else that you wanted to kind of add or comment on about the LACS?

Therapist: No, it's very thorough.

Suzanne: Do you feel it feels like a general reflection of how you saw the session?

Therapist: Yes, it does, I mean I'm quite interested, quite surprised at how it does, it is, it has overlapped, to my mind quite a lot actually, yeah.

Suzanne: Do you think that this information would be useful for, I know that you've had another session with the family but thinking about the family coming back in again, do you think that this information would be useful at all for further sessions with the family?

Therapist: I think it would be, I think Mum, um, second session things felt different, Dad came and they felt as if they'd seized control a bit more, and they brought Kevin with them and it was a very interesting, very different session, um, with Kevin getting very emotional and sobbing a lot at the end, but I think, um, with this family I'm quite keen to give them some control back, allow them to feel that, um, you know, there are patterns to their behaviour, and that the way that they make sense of things can have a big impact on how they, their behaviour and how they feel about things and, you know, giving them some information on this sort of, you know, sort of the bits about, you know, attributing things to inside somebody and it being unchangeable and uncontrollable and how that affects your thinking in quite a negative, how it might affect your thinking in quite a negative way, I think would be useful.

Suzanne: OK, so you think that you, you think this information would potentially impact on the process in terms of, you know, feeding it back and, um, using it?
Therapist: Yes, potentially, yes, definitely, mmm, yeah.
Suzanne: Do you think that this would influence how you are with the family?
Therapist: Um, I don’t think it will, because I think partly because it meets my understanding of what happened so much that, um, that you know, I don’t think it will in that sense, I think it’s, it’s validated, and it’s nice for me to have that, because with this family, I didn’t feel I’d done very well, um, so yes, so, to have that, um, in a way validation I suppose of my understanding of what happened and what’s happening for Mum and what’s happening for Cara, for that to come through in your work has been interesting for me.
Suzanne: Good, good, is there anything else you wanted to add before the end?
Therapist: No.
Suzanne: No? OK.
Appendix VIII

Case Study 1 – Smith Family

Tables of LACS Analysis
Case Study 1 – Smith Family

Table 1: Mrs Smith’s attributions, whom she saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Father</td>
<td>Mother</td>
</tr>
<tr>
<td>Father</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mother</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Joanne</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Timmy</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Billie</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Family</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Children</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Billie and Timmy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Billie and Joanne</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Flat</td>
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<td>0</td>
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Table 1 outlines the overall results of the attributional statements made by Mrs Smith, that is who she identified as being the agents in her attributional statements and those the agents targeted.
Table 2: Mrs Smith’s attributions of the agent

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable/Unstable</th>
<th>Global/Specific</th>
<th>Internal/External</th>
<th>Personal/Universal</th>
<th>Controllable/Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Mother</td>
<td>Stable</td>
<td>Global</td>
<td>4 internal</td>
<td>Personal</td>
<td>7 controllable, 4 uncontrollable</td>
</tr>
<tr>
<td>Joanne</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>1 controllable, 2 uncontrollable</td>
</tr>
<tr>
<td>Timmy</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>7 personal, 3 universal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Billie</td>
<td>Stable</td>
<td>Global</td>
<td>8 internal, 5 external</td>
<td>Personal</td>
<td>10 controllable, 3 uncontrollable</td>
</tr>
<tr>
<td>Family</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>4 controllable, 1 uncontrollable</td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Children</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Billie and Timmy</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Billie and Joanne</td>
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<td>Global</td>
<td>1 internal, 1 external, 1 personal, 1 universal</td>
<td>1 controllable, 1 uncontrollable</td>
<td></td>
</tr>
<tr>
<td>Flat</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Services</td>
<td>Stable</td>
<td>Specific</td>
<td>Internal</td>
<td>Universal</td>
<td>Uncontrollable</td>
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</table>

Table 2 illustrates Mrs Smith’s attributional style regarding the agents in all her attributional statements.
Table 3 outlines the overall results of the attributional statements made by Mr Smith, that is who he identified as being the agents in his attributional statements and those the agents targeted.
Table 4: Mr Smith’s attributions of agents

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable/Internal</th>
<th>Global/External</th>
<th>Internal/Specific</th>
<th>Personal/Universal</th>
<th>Controllable/Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
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<td>Internal Personal</td>
<td>3 controllable</td>
<td>8 uncontrollable</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>Stable Global</td>
<td>1 internal external Personal</td>
<td>1 controllable 1 uncontrollable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joanne</td>
<td>Stable Global</td>
<td>Internal Personal</td>
<td>Controlable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timmy</td>
<td>Stable Global</td>
<td>External Personal</td>
<td>Uncontrollable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billie</td>
<td>3 stable 1 unstable Global 1 specific Internal Personal</td>
<td>Controlable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>Stable Global</td>
<td>1 internal 3 external 3 personal 1 universal</td>
<td>Controllable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist</td>
<td>Stable Global</td>
<td>External Universal</td>
<td>Uncontrollable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td>Stable Global Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother and Father</td>
<td>Stable Global</td>
<td>Internal Personal</td>
<td>1 controllable 4 Uncontrollable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>Stable Global</td>
<td>Internal Personal</td>
<td>Uncontrollable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billie and Timmy</td>
<td>Stable Global</td>
<td>Internal Personal</td>
<td>Controlable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billie and Joanna</td>
<td>Stable Global</td>
<td>Internal Personal</td>
<td>Uncontrollable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Smith’s brother</td>
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<td>Internal Personal</td>
<td>Uncontrollable</td>
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<td></td>
</tr>
<tr>
<td>Flat</td>
<td>Stable Global</td>
<td>External Universal</td>
<td>Uncontrollable</td>
<td></td>
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</tbody>
</table>

Table 4 illustrates Mr Smith’s attributional style regarding the agents in all his attributional statements.

Table 5: Joanne’s attributions, whom she saw as agents and targets

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<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
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<tbody>
<tr>
<td></td>
<td>Father</td>
</tr>
<tr>
<td>Father</td>
<td>0</td>
</tr>
<tr>
<td>Billie</td>
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<tr>
<td>Maternal Grandmother</td>
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<td>Mother and Father</td>
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<td>Children</td>
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</tr>
<tr>
<td>Total</td>
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</table>

Table 5 outlines the overall results of the attributional statements made by Joanne, that is who she identified as being the agents in her attributional statements and those the agents targeted.
Table 6: Joanne’s attributions of agents

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Billie</td>
<td>Unstable</td>
<td>Global</td>
<td>External</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Children</td>
<td>Unstable</td>
<td>Global</td>
<td>External</td>
<td>Universal</td>
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Table 6 illustrates Joanne’s attributional style regarding the agents in all her attributional statements.

Table 7: Lead therapist’s (Clive) attributions, whom he saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Joanne</th>
<th>Timmy</th>
<th>Family</th>
<th>Mother and Father</th>
<th>Billie and Timmy</th>
<th>Total</th>
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</thead>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Joanne</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Billie</td>
<td>0 1 0 0 0 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
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<td>Family</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>0 0 0 1 0 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Billie and Timmy</td>
<td>0 0 0 0 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
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<td></td>
<td></td>
<td>6</td>
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Table 7 outlines the overall results of the attributional statements made by Clive, that is who he identified as being the agents in his attributional statements and those the agents targeted.

Table 8: Lead therapist’s attributions of agents

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Joanne</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Billie</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Family</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Billie and Timmy</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
</tbody>
</table>

Table 8 illustrates Clive’s attributional style regarding the agents in all his attributional statements.
Table 9: James’ (reflecting team therapist) attributions, whom he saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Family</th>
<th>Reflecting team therapist</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>James</td>
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<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Services</td>
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<tr>
<td>Total</td>
<td></td>
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<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 9 outlines the overall results of the attributional statements made by James, that is who he identified as being the agents in his attributional statements and those the agents targeted.

Table 10: James’ attributions of agents

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable/Unstable</th>
<th>Global/Specific</th>
<th>Internal/External</th>
<th>Personal/Universal</th>
<th>Controllable/Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>James</td>
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<td>Specific</td>
<td>Internal</td>
<td>1 Personal</td>
<td>1 Universal Uncontrollable</td>
</tr>
<tr>
<td>Services</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
</tbody>
</table>

Table 4 illustrates James’ attributional style regarding the agents in all his attributional statements.
Appendix IX

Case Study 2 – Jones Family

Tables of LACS Analysis
Case Study 2 – Jones Family

Table 1: Mr Jones attributions, whom he saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Father</th>
<th>Mother and Father</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Mother and Father</td>
<td></td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>GP</td>
<td></td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Neighbours</td>
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<td><strong>Total</strong></td>
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</table>

Table 1 outlines the overall results of the attributional statements made by Mr Jones, that is who he identified as being the agents in his attributional statements and those the agents targeted.

Table 2: Mr Jones’ attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>1 controllable 4 uncontrollable</td>
</tr>
<tr>
<td>Mother</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>2 controllable 1 uncontrollable</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>uncontrollable</td>
</tr>
<tr>
<td>GP</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Universal</td>
<td>Controllable</td>
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<tr>
<td>Neighbours</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
</tbody>
</table>

Table 2 illustrates Mr Jones’ attributional style regarding the agents in all his attributional statements.
Table 3: Mrs Jones attributions, whom she saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Father</th>
<th>Mother</th>
<th>Alice</th>
<th>Helen</th>
<th>Alice and Helen</th>
<th>Members of the public</th>
<th>Mother and Father</th>
<th>Mother and Alice</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>5</td>
<td>11</td>
<td>4</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>Mother</td>
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<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Alice</td>
<td>0</td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Helen</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Nurses</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Alice and Helen</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>23</td>
<td>15</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td>67</td>
</tr>
</tbody>
</table>

Table 3 outlines the overall results of the attributional statements made by Mrs Jones, that is who she identified as being the agents in her attributional statements and those the agents targeted.

Table 4: Mrs Jones' attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>21 Stable</td>
<td>21 Global</td>
<td>19 Internal</td>
<td>Personal</td>
<td>14 Controllable</td>
</tr>
<tr>
<td></td>
<td>1 unstable</td>
<td>1 Specific</td>
<td>3 External</td>
<td></td>
<td>8 Uncontrollable</td>
</tr>
<tr>
<td>Mother</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Alice</td>
<td>17 Stable</td>
<td>17 Global</td>
<td>21 Internal</td>
<td>20 Personal</td>
<td>7 Controllable</td>
</tr>
<tr>
<td></td>
<td>5 Unstable</td>
<td>5 Specific</td>
<td>1 External</td>
<td>2 Universal</td>
<td>15 Uncontrollable</td>
</tr>
<tr>
<td>Helen</td>
<td>Stable</td>
<td>Global</td>
<td>8 Internal</td>
<td>8 Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 External</td>
<td>1 Universal</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>1 Stable</td>
<td>1 Global</td>
<td>External</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td></td>
<td>1 Unstable</td>
<td>1 Specific</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alice and Helen</td>
<td>5 Stable</td>
<td>5 Global</td>
<td>4 Internal</td>
<td>4 Personal</td>
<td>1 Controllable</td>
</tr>
<tr>
<td></td>
<td>1 Unstable</td>
<td>1 Specific</td>
<td>2 External</td>
<td>2 Universal</td>
<td>5 Uncontrollable</td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>Stable</td>
<td>Global</td>
<td>1 Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 External</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 illustrates Mrs Jones' attributional style regarding the agents in all her attributional statements.
Table 5: Clive attributions, whom he saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Father</td>
<td>Mother</td>
<td>Helen</td>
<td>Alice and Helen</td>
<td>Mother and Father</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Helen</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 5 outlines the overall results of the attributional statements made by Clive, that is who he identified as being the agents in his attributional statements and those the agents targeted.

Table 6: Clive’s attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>1 Controllable 2 Uncontrollable</td>
</tr>
<tr>
<td>Helen</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
</tbody>
</table>

Table 6 illustrates Clive’s attributional style regarding the agents in all his attributional statements.

Table 7: Jill attributions, whom she saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Father</td>
<td>Mother</td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alice</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7 outlines the overall results of the attributional statements made by Jill, that is who she identified as being the agents in her attributional statements and those the agents targeted.
Table 8: Jill’s attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Mother</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Alice</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
</tbody>
</table>

Table 8 illustrates Jill’s attributional style regarding the agents in all her attributional statements.

Table 9: Liz attributions, whom she saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Father</td>
</tr>
<tr>
<td>Mother</td>
<td>0</td>
</tr>
<tr>
<td>Alice</td>
<td>0</td>
</tr>
<tr>
<td>Alice and Helen</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 9 outlines the overall results of the attributional statements made by Liz, that is who she identified as being the agents in her attributional statements and those the agents targeted.

Table 10: Liz’s attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Alice</td>
<td>Stable</td>
<td>Global</td>
<td>External</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Alice and Helen</td>
<td>Stable</td>
<td>Global</td>
<td>3 Internal</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
</tbody>
</table>

Table 10 illustrates Liz’s attributional style regarding the agents in all her attributional statements.

Table 11: James attributions, whom he saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alice</td>
</tr>
<tr>
<td>Alice</td>
<td>1</td>
</tr>
<tr>
<td>Alice and Helen</td>
<td>0</td>
</tr>
<tr>
<td>Family Therapy Team</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
</tr>
</tbody>
</table>

297
Table 11 outlines the overall results of the attributional statements made by James, that is who he identified as being the agents in his attributional statements and those the agents targeted.

Table 12: James’ attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable/Unstable</th>
<th>Global/Specific</th>
<th>Internal/External</th>
<th>Personal/Universal</th>
<th>Controllable/Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice</td>
<td>Unstable</td>
<td>Specific</td>
<td>External</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Alice and Helen</td>
<td>Unstable</td>
<td>Specific</td>
<td>Internal</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Family Therapy Team</td>
<td>Unstable</td>
<td>Specific</td>
<td>External</td>
<td>Universal</td>
<td>Controllable</td>
</tr>
</tbody>
</table>

Table 12 illustrates James’ attributional style regarding the agents in all his attributional statements.
Appendix X

Case Study 3 – Watts Family

Tables of LACS Analysis
### Case Study 3 – Watts Family

Table 1: Mrs Watts attributions, whom she saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mother</td>
<td>Father</td>
</tr>
<tr>
<td>Mother</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Cara</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Kevin</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Kevin and Cara</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Grandparents</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Hannah</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cara and Hannah</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nana</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 1 outlines the overall results of the attributional statements made by Mrs Watts, that is who she identified as being the agents in her attributional statements and those the agents targeted.
Table 2: Mrs Watts’ attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>4 Stable</td>
<td>5 global</td>
<td>Internal</td>
<td>Personal</td>
<td>2 Controllable</td>
</tr>
<tr>
<td></td>
<td>4 Unstable</td>
<td>3 Specific</td>
<td></td>
<td></td>
<td>6 Uncontrollable</td>
</tr>
<tr>
<td>Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Cara</td>
<td>18 Stable</td>
<td>18 Global</td>
<td>20 Internal</td>
<td>24 Personal</td>
<td>24 Controllable</td>
</tr>
<tr>
<td></td>
<td>7 Unstable</td>
<td>7 Specific</td>
<td>5 External</td>
<td>1 Universal</td>
<td>1 Uncontrollable</td>
</tr>
<tr>
<td>Kevin</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Kevin and Cara</td>
<td>Stable</td>
<td>Global</td>
<td>2 Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td></td>
<td>Stable</td>
<td>Global</td>
<td>3 External</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Grandparents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hannah</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>1 Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 Universal</td>
<td></td>
</tr>
<tr>
<td>Cara and</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Hannah</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nana</td>
<td>Unstable</td>
<td>Specific</td>
<td>1 Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 External</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother and</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 illustrates Mrs Watts’ attributional style regarding the agents in all her attributional statements.

Table 3: Cara attributions, whom she saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mother</td>
<td>Father</td>
</tr>
<tr>
<td>Mother</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Father</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cara</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Kevin</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kevin and Cara</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other Children</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Thieves</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hannah</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nana</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>World</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mother and</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>3</td>
</tr>
</tbody>
</table>
Table 3 outlines the overall results of the attributional statements made by Cara, that is who she identified as being the agents in her attributional statements and those the agents targeted.

Table 4: Cara attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable/Unstable</th>
<th>Global/Specific</th>
<th>Internal/External</th>
<th>Personal/Universal</th>
<th>Controllable/Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Unstable</td>
<td>Specific</td>
<td>Internal</td>
<td>Personal</td>
<td>3 Controllable/1 Uncontrollable</td>
</tr>
<tr>
<td>Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Cara</td>
<td>10 stable</td>
<td>10 global</td>
<td>14 internal</td>
<td>16 personal</td>
<td>11 Controllable/6 Uncontrollable</td>
</tr>
<tr>
<td></td>
<td>7 unstable</td>
<td>7 specific</td>
<td>3 external</td>
<td>1 universal</td>
<td></td>
</tr>
<tr>
<td>Kevin</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Kevin and Cara</td>
<td>Stable</td>
<td>Global</td>
<td>External</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Other Children</td>
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<td>Specific</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
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<td>Thieves</td>
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<td>Specific</td>
<td>External</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
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<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>1 Controllable/1 Uncontrollable</td>
</tr>
<tr>
<td></td>
<td>1 stable</td>
<td>1 global</td>
<td>1 internal</td>
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<td>1 universal</td>
<td>1 Uncontrollable</td>
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<tr>
<td>World</td>
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<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Mother and</td>
<td>4 stable</td>
<td>4 global</td>
<td>3 internal</td>
<td>5 personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Father</td>
<td>2 unstable</td>
<td>2 specific</td>
<td>3 external</td>
<td>1 universal</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 illustrates Cara’s attributional style regarding the agents in all her attributional statements.

Table 5: Jill attributions, whom she saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Mother</th>
<th>Cara</th>
<th>Mother and Cara</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cara</td>
<td></td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Mother and Kevin</td>
<td></td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Mother and Cara</td>
<td></td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 5 outlines the overall results of the attributional statements made by Jill, that is who she identified as being the agents in her attributional statements and those the agents targeted.
Table 6: Jill’s attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Stable</td>
<td>Global</td>
<td>External</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Father</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Cara</td>
<td>Unstable</td>
<td>Specific</td>
<td>External</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Mother and Kevin</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Mother and Cara</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
</tbody>
</table>

Table 6 illustrates Jill’s attributional style regarding the agents in all her attributional statements.

Table 7: Clive attributions, whom he saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Cara</th>
<th>Clive</th>
<th>Mother and Father</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Cara</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Kevin</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mother and Cara</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Clive</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mother and Cara</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 7 outlines the overall results of the attributional statements made by Clive, that is who he identified as being the agents in his attributional statements and those the agents targeted.

Table 8: Clive’s Attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>1 stable</td>
<td>1 global</td>
<td>2 internal</td>
<td>Personal</td>
<td>1 controllable</td>
</tr>
<tr>
<td>Cara</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Kevin</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Mother and Cara</td>
<td>Unstable</td>
<td>Specific</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td>Clive</td>
<td>Unstable</td>
<td>Specific</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td>Mother and Father</td>
<td>Unstable</td>
<td>Specific</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
</tbody>
</table>

Table 9 illustrates Clive’s attributional style regarding the agents in all his attributional statements.
Table 9: Liz attributions, whom she saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother and Cara</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 9 outlines the overall results of the attributional statements made by Liz, that is who she identified as being the agents in her attributional statements and those the agents targeted.

Table 10: Liz’s attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother and Cara</td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
</tbody>
</table>

Table 2 illustrates Liz’s attributional style regarding the agents in all her attributional statements.
Appendix XI

Case Study 4 – Harris Family

Tables of LACS Analysis
Case Study 4 – Harris Family

Table 1: Mrs Harris’ attributions, whom she saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Mother</th>
<th>Father</th>
<th>Conner</th>
<th>Neil</th>
<th>Tara</th>
<th>Doctors</th>
<th>Children</th>
<th>Georgia</th>
<th>Family</th>
<th>People</th>
<th>Mother and Father</th>
<th>Maternal Grandmother</th>
<th>Mother and Georgia</th>
<th>Mother's brother</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
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<td>Father</td>
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</tr>
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<td>Tara</td>
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<td>0</td>
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<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Mother and Father</td>
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<td>0</td>
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<td>0</td>
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</tr>
<tr>
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<td>0</td>
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</tr>
<tr>
<td>Conner and Mother</td>
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</tr>
<tr>
<td>Conner and Neil</td>
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<td>0</td>
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<td>1</td>
<td>1</td>
<td>68</td>
</tr>
</tbody>
</table>
Table 1 outlines the overall results of the attributional statements made by Mrs Harris, that is who she identified as being the agents in her attributional statements and those the agents targeted.

Table 2: Mrs Harris’ attributional style

<table>
<thead>
<tr>
<th>Agent</th>
<th>Stable /Unstable</th>
<th>Global /Specific</th>
<th>Internal /External</th>
<th>Personal /Universal</th>
<th>Controllable /Uncontrollable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother</strong></td>
<td>6 stable 2 unstable</td>
<td>7 global 1 specific</td>
<td>5 internal 3 external</td>
<td>Personal</td>
<td>6 controllable 2 uncontrollable</td>
</tr>
<tr>
<td><strong>Father</strong></td>
<td>4 stable 1 uncontrollable</td>
<td>4 global 1 specific</td>
<td>3 internal 2 external</td>
<td>3 personal 2 universal</td>
<td>2 controllable 3 uncontrollable</td>
</tr>
<tr>
<td><strong>Conner</strong></td>
<td>21 stable 1 unstable</td>
<td>21 global 1 specific</td>
<td>Internal</td>
<td>21 personal 1 universal</td>
<td>4 controllable 16 uncontrollable 2 uncodable</td>
</tr>
<tr>
<td><strong>Neil</strong></td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>6 controllable 5 uncontrollable</td>
</tr>
<tr>
<td><strong>Conner's Diet</strong></td>
<td>Stable</td>
<td>Global</td>
<td>External</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td><strong>Maternal Family</strong></td>
<td>Stable</td>
<td>Global</td>
<td>External</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td><strong>Tara</strong></td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td><strong>Children</strong></td>
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<td>Global</td>
<td>1 internal 1 external</td>
<td>1 personal 1 universal</td>
<td>1 controllable 1 uncontrollable</td>
</tr>
<tr>
<td><strong>Georgia</strong></td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>2 controllable 1 uncontrollable</td>
</tr>
<tr>
<td><strong>Georgia's School</strong></td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td><strong>Family</strong></td>
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<td>Global</td>
<td>1 Internal 1 external</td>
<td>1 personal 1 universal</td>
<td>1 controllable 1 uncontrollable</td>
</tr>
<tr>
<td><strong>Mother and Father</strong></td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>1 personal 1 universal</td>
<td>1 controllable 1 uncontrollable</td>
</tr>
<tr>
<td><strong>Cushion</strong></td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Universal</td>
<td>Controllable</td>
</tr>
<tr>
<td><strong>Maternal Grandmother</strong></td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
<tr>
<td><strong>Conner and Mother</strong></td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td><strong>Family therapy team</strong></td>
<td>Unstable</td>
<td>Specific</td>
<td>External</td>
<td>Universal</td>
<td>Uncontrollable</td>
</tr>
<tr>
<td><strong>Conner and Neil</strong></td>
<td>Stable</td>
<td>Global</td>
<td>Internal</td>
<td>Personal</td>
<td>Controllable</td>
</tr>
</tbody>
</table>
Table 2 illustrates Mrs Harris' attributional style regarding the agents in all her attributional statements.

Table 3: Clive attributions, whom he saw as agents and targets

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Clive</th>
<th>Connor</th>
<th>Mother and Father</th>
<th>Clive and Jill</th>
<th>Family therapy team</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mother</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Father</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
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Table 3 outlines the overall results of the attributional statements made by Clive, that is who he identified as being the agents in his attributional statements and those the agents targeted.

Table 4: Clive attributional style

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Table 4 illustrates Clive's attributional style regarding the agents in all his attributional statements.
Table 5: Jill attributions, whom she saw as agents and targets

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Table 5 outlines the overall results of the attributional statements made by Jill, that is who she identified as being the agents in her attributional statements and those the agents targeted.

Table 6: Jill’s attributional style

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Table 6 illustrates Jill’s attributional style regarding the agents in all her attributional statements.

Table 7: James attributions, whom he saw as agents and targets

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Table 7 outlines the overall results of the attributional statements made by James, that is who he identified as being the agents in his attributional statements and those the agents targeted.

Table 8: James’ Attributional style

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Table 8 illustrates James’ attributional style regarding the agents in all his attributional statements.
Table 9: Liz attributions, whom she saw as agents and targets

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Table 7 outlines the overall results of the attributional statements made by Liz, that is who she identified as being the agents in her attributional statements and those the agents targeted.

Table 10: Liz’s attributional style

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Table 10 illustrates Liz’s attributional style regarding the agents in all her attributional statements.

Table 11: Viv attributions, whom she saw as agents and targets

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Table 11 outlines the overall results of the attributional statements made by Viv, that is who she identified as being the agents in her attributional statements and those the agents targeted.

Table 12: Viv’s attributional style

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Table 12 illustrates Viv’s attributional style regarding the agents in all her attributional statements.
Appendix XII

Additional IPA Quotes
5a. Hypothesis/Expectations

i) Initial hypothesis

Clive: Wooster-Drought Syndrome

Jill: OCD and depression

Jill: Autism

Clive: Biological link between his affective and relational disconnection as perceived by Dr Phil and that of the girls? ... Dad is emotionally absent...

Jill: Cara's aggression, particularly towards Mum, although sometimes Dad ... worries about managing some of her behaviours, particularly around her losing her temper and not co-operating with their requests to do activities around the house.

ii) Disconfirming initial hypothesis

Clive: It did change in that one hypothesis was disconfirmed, that is, that the little girl did not seem autistic at all.

Clive: He was the very opposite of 'bloke syndrome' and disconnected emotion, it was him the children were going to, it was him that was seeing to their needs.

Jill: Very easy to engage, talked the whole session, to the point where Mum said 'I've never heard her say so much, I've never actually seen her speak in that way'.

Clive: So that together .... in consultation with my team made us all feel, well, you know, is this autism?
iii) Therapist's expectations of the family

Clive: I don't think I did, it's a sort of grey area between having expectations and making initial hypotheses, so on the whole I tend to try to do neither and just see what comes, but I'm descending a little bit because I do enjoy the team having lots of ideas, and then I cherry-pick those that I find interesting.

Jill: I wasn't aware that I had any until I met the family, where I became very aware of my expectations, if that makes sense? .... I got the impression of, um, you know, your fairly dynamic Mum I suppose

5b. Experiences of the Family
i) Therapist's experiences of family members

Clive: See, I didn't believe him. I felt well ok, but then if you didn't have your second house in seaside, then maybe you could have a slightly lower salary, I mean be earning less money, but being away less often, and give more time to your family, so

Clive: I felt he was, too sort of nice and defensive

Clive: I could been your speak awake machine but I don't think she did really respond to me

Clive: Well, I was interested in the caring but...I don't mean this rudely but purely descriptively, the caring but ignorant concern Mum had about Helen's wishing she could throw Alice away in the rubbish bin.

Jill: Mum seemed very, very low, if not depressed, um, she looked unwell, she looked incredibly tired
**Jill:** There was just something about her that didn't, something a bit, yeah personality difficulties, just felt like she wasn't quite in touch with the children and the enormity of the situation

**ii) Dynamics**

**Jill:** I, again my strong feeling was that she, um, was almost, and it's a very strong thing to say, but it was almost sort of taking the mothering role a bit, she felt protective over Mum,

**Clive:** I noted that um he would sometimes time his interruptions when for example I was praising Timmy or whatever,

**Jill:** And even when the team came in she sat hugging the little girl, or chat, or kept dialoguing with the girl and not really engaging with what was happening in the other side of the room.

**Clive:** Dad had been sort of quiet and withdrawn, and throughout he's sort of passive and very frightened to say what he thinks and feels....

**iii) Family scripts**

**Clive:** She's was very loyal to her husband so she wasn't going say it's ya know coz he's not here or he's always asleep when he is here

**Clive:** As if they kind of have a shared family myth about their roles in relation to one another and to the children,

**Jill:** Son who took advantage and was completely ungrateful, and abused them verbally, that was very, very much the language and the messages that they were giving.
Jill: My thoughts were around her religion and whether it you know, one of the, you know, it might difficult to actually criticize your lot and say actually this is all hopeless and rubbish,

Jill: Somehow this family were defined by illness and that she felt quite comfortable with that

iv) Changing family scripts

Clive: Only liking to wear skirts, and I was thinking, many three year old girls are exactly like that, they don’t want to wear trousers.

Jill: I was very keen to try and turn it so that we were looking at some positive things so the team could comment more on those sorts of issues, and not really getting very far,

Jill: Wanting to kind of normalise it, and actually this is often what teenagers are like, and, you know, um, so some of that did shift

Clive: I think just getting some positive affirmation of what they had been doing as parents was quite special for them...

v) Barriers to Engagement

Clive: I felt he was, too sort of nice and defensive

Clive: The fact that her husband and her children and not even Georgia had come ... even possibly at times um actively deciding to be disengaged from it

Jill: It was very difficult to get the sense of what she wanted help with, where she saw things, the areas that she thought where things were difficult she could change and how we could help her, and what sense she made of why things were so difficult, she was quite
passive, you know these things have just happened they were born with it, in a way quite accepting

\textbf{Jill:} She was very distracted, and again to me I, I thought her daughter was a useful distraction for her, that she, it was a barrier to engaging with us,

\textbf{Jill:} She was not at all easy to engage, she, um, she looked very angry, very angry, quite dismissive of family therapy and myself as being the main therapist and, sort of, ‘well, how can you help?’, but wanting help,

vi) Empathy

\textbf{Clive:} Timmy had been dealt with, because he’d had his brain done and poor thing he wasn’t sleeping, and so there was something about poor Timmy that made Timmy easier to deal with.

\textbf{Clive:} I thought Mum presented as very nice and rather desperate for a more collaborative parental relationship with her husband,

\textbf{Jill:} If you can’t have your own children and then even when you have got a child, your mother has to look after that child and how that might make you feel,

\textbf{Jill:} How mom was coping with four children, one of them who doesn’t sleep very well, father’s on does shift work. Just you know what is it like for this family for this mum to be incredibly stretched and pushed and, with four and you know with difficulties.

5c. Internal/External Processes

i) Self-reflexivity

\textbf{Clive:} It was interesting looking at myself in the video last night, I’m often more sort of proactive than I was in that session
Jill: I was probably the quietest I've ever been in a session I think for a very long time, I felt I didn't say very much

Clive: I was going along with the feedback and responding to that, but perhaps I was more controlled than then I was aware of. So, um, I suppose next time I will also be more aware of how, yeah, the attributions I make and how I get drawn in, or not, yeah, so more sort of self-reflective.

Jill: I felt at times, 'actually I'm not really controlling this session, I'm not being directive enough, I'm not'...but it seemed for this family that that was maybe the right thing to do, and it allowed Cara to really speak about how it felt,

Jill: sometimes your not sure your whether your just asking the wrong questions or, is it something about your style that doesn't work with that person,

ii) Reflecting Team

Clive: I suppose I felt a bit abandoned with them

Clive: So this is something about my team, because, you know, I'm not an expert in LD and, I was thinking, you know, I'm going to involve my colleagues in play with these children probably, so that was kind of my semi-conscious rationale for not interacting with the kids as much as I might have otherwise.

Jill: They were able to say things which I'd felt silenced by

Jill: And hearing about her and her relationship with her husband and keeping that, you know for them to have some time together and talking about the children and what there going to do when Conner does that or whatever, they need to set some time aside for that
5d. LACS Feedback

i) Fitting in with perceptions

Clive: The attributional coding has affected my perception of the family and I guess of my experience of the family.

Jill: That's interesting exactly what I felt, that's really interesting.

Jill: It's interesting that it does fit with what I felt I needed to do which was about affirming their position and how difficult things were with them.

Jill: I think it's, it's validated, and it's nice for me to have that, because with this family, I didn't feel I'd done very well.

Clive: Perhaps I'm not thinking, just reacting, yeah, I'm quite surprised about some of it... I was thinking earlier that you miss a lot in terms of seeing what was going on and who was more emotionally available and so on, but actually that didn't matter.

Clive: It's very counter-intuitive; you'd have thought it would well be the other way around.

Clive: Well again, overall, my impression was, um, how different looking at them in this way is to my subjective experience and perception.

Clive: It seems to me that perhaps mum did make more appropriate use of it then I experienced at the time or indeed experienced last night as I viewed it and tried to stay awake, yea.
ii) Utility of information for future sessions

Clive: It would affect me in terms of my thinking and might have helped me stop just reacting

Clive: Yes I think it would spur me into being much more proactive in trying to help them, I dunno maybe make the attributions a little more varied.

Clive: I would want to be asking questions of Dad that would enable him to make more attributions

Jill: I don't think it will, I think partly because it meets my understanding of what happened so much that, um, that you know, I don't think it will in that sense,

Jill: but feeding back she is possibly overwhelmed by the children and their needs, and it's difficult for her to get some distance on, how she can get her needs, and how she can think about what the children's needs are and prioritize and then take a more proactive approach to getting help.

Jill: Giving them information .... Attributing things to inside somebody and it being unchangeable and uncontrollable and how that affects your thinking in quite a negative way ... I think would be useful.

iii) Future utility for Family therapy

Jill: I think would be useful.

Jill: Yes, potentially, yes, definitely, mmm, yeah. ...having that corroborated, that actually you know, sometimes your not sure your whether your just asking the wrong questions or, is it something about your style that doesn't work with that person,
Clive: I think it really, really could be, erm, if it was kept nice and simple .... Because the notions, the ideas, the concepts are yeah, really you know, useful

Clive: I'd like a sort of permanent erm, LACS person on the team...and then yes, maybe every twenty minutes of so, summing up, you know, what the scores are, who's seeing each other

Clive: would be helpful at the time of the therapy being ongoing ya know

Clive: But yea because from a clinicians points of view the practicalities of it I can't see, unless its seriously adapted and modified how it can be practically, practically useful, although actually its extremely interesting and potentially extremely useful.

Clive: You missed a lot in terms of seeing what was going on and who was more emotionally available