Mothers’ Experiences of Solution Focused Brief Therapy in a Child and Adolescent Service: An Interpretative Phenomenological Analysis

by

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Volume 1

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Adult Mental Health Essay:

“Beating the Blues” is a cognitive based computerized package for depression. It is currently used in primary care to address the ‘Step One’ need of the NICE guidelines for depression. It is delivered primarily, but not exclusively, by Graduate Mental Health Workers. Critically discuss the use of computerized packages in Primary Care with specific reference to ethical and professional dilemmas.

December 2005

Year 1
INTRODUCTION

This essay captured my attention as I have worked as a Graduate Mental Health Worker and used computer therapy packages with patients. I often contemplated the concept of using a computer to deliver therapy and I felt that this essay would give me an opportunity to formally link my ideas and experiences with existing literature.

The scope of this topic is vast and I have not addressed issues such as risk, the specific role that Graduate Mental Health Workers or NICE guidelines play, and the context of primary care is merely assumed without being described or explicitly linked. I have chosen to narrow my thinking to three main areas, which were salient to my ideas and clinical work. My aim is to focus on three ethical and professional dilemmas: whether computer therapy is effective; the importance of the therapeutic alliance; and access to therapy. I present relevant literature and indicate my point of view, which is supported by my own experiences of using computer therapy.

The broad definition of computer therapy that I have used throughout this essay is, “… any system that aids psychological treatment by making at least some computations and decisions without any interaction with a human.” (Marks et al., 1998, p.152).

IS COMPUTER THERAPY CLINICALLY EFFECTIVE?

The current culture of the National Health Service is one that aims to deliver high quality treatment that is effective and appropriate for patients (Department of Health, 1999). It is therefore important to consider whether computerised therapy
is effective. I offer a brief review of the effectiveness literature and highlight some of its strengths and limitations.

**Current Literature**

Wright *et al.* (2002) tested the first multi media program for computer assisted psychotherapy. 96 inpatients and outpatients used treatment as usual (TAU) alongside the computer therapy. A variety of self-report measures were administered and scores improved significantly following completion of the program. As the impact of the treatment as usual and the freedom that participants had to complete the program at their own pace was unknown, randomized controlled trials were recommended to determine the efficacy of the program.

Marks *et al.* (2003) evaluated the use of four computerised CBT (CCBT) packages in a primary care clinic. Patients selected the most appropriate package from *Fear Fighter, Cope, Balance* or *BTSteps* and these were accompanied by some phone or face to face contact with a therapist. Improvement from pre to post therapy scores for the Work and Social Adjustment scale (WSA) were significant for *Fear Fighter, Cope* and *Balance* users, but not *BTSteps*. Significant differences were found between appropriate pre and post measure scores for all packages except *Balance*. Satisfaction data was available for 70 out of 108 patients and it was concluded that patients were fairly satisfied with their computer therapy and more satisfied with their live support. Marks *et al.* (2003) acknowledge that it is difficult to establish the impact of the passage of time, contact with a service and time with a clinician on self report scores. Given the rate of non-completion and missing post treatment data, we are advised by the authors to view the results with caution.

Proudfoot *et al.* (2004) completed a randomized controlled trial (RCT) of the CCBT package *Beating the Blues (BtB)*. 274 adults experiencing anxiety and/or
depression were randomly allocated to receive TAU or BtB, along with pharmacotherapy and GP and practical/social support. The BDI, BAI and WSA were administered pre treatment, two months later and then at one, three and six months later. There were significantly greater reductions of BDI and WSA scores for BtB compared to TAU. Although the BAI scores were less for BtB than TAU, this was not statistically significant, and pre treatment BAI scores needed to be higher (more severe) in order for BtB to be beneficial.

There was no significant interaction between treatment and duration of illness or whether patients were taking medication for anxiety and/or depression. Therefore, the authors state, "The overall conclusion is clear: computerised cognitive-behavioural therapy is generally a suitable treatment across the range of patients presenting with anxiety and depression in primary care..." (Proudfoot et al., 2004, p.52).

Van Den Berg et al. (2004) aimed to address the real world value of BtB and reported their experiences of using it in a community mental health team. Using data obtained from 13 patients, they found significant improvements after treatment, but not at 6 months post treatment.

Grime (2004) conducted an RCT of BtB in the workplace. 48 employees, who had had time off work due to stress, depression or anxiety, were allocated to receive conventional care alone or with BtB. At the end of treatment, and one month post treatment, Hospital Anxiety and Depression Scale scores were significantly lower in the BtB group. However, the differences were not statistically significant 3 and 6 months following treatment. It was suggested that BtB might facilitate a faster recovery in this population.

A systematic review of CCBT completed by Kaltenthaler et al. (2004) identified 16 studies (11 RCTs and 5 non-RCTs) of variable quality. The studies drew on a
range of patient groups and presenting problems. Four studies showed that CCBT was more effective than TAU (including Proudfoot et al., 2003) and five studies showed CCBT to be equally effective as therapist led CBT (TCBT). One study demonstrated that TCBT was more effective than CCBT, one study showed that CCBT was no more effective than TAU and another showed CCBT was no more effective at 3 and 6 months post treatment. The authors conclude, "The results show that, although there is some evidence that CCBT may be as effective as TCBT and better than TAU, the evidence is by no means conclusive." (Kaltenthaler et al., 2004, p.53).

The National Institute for Clinical Excellence (NICE, 2005) considered the effectiveness of CCBT and drew on 11 RCTs and four uncontrolled studies. Five RCTs found no difference between CCBT and TCBT for depression and anxiety, but most were inadequately powered to demonstrate these differences. One RCT with inpatients found CCBT was inferior to TCBT, and four RCTs found that CCBT was more effective than TAU. Two RCTs found no difference between CCBT and TAU, and one found bibliotherapy for generalised anxiety disorder to be superior to CCBT and TAU. It was felt that the evidence supported the potential value of delivering CCBT, but that the evidence base is underdeveloped and requires further research. NICE (2005) also highlight a number of issues that require clarification, such as where to deliver CCBT, how to identify suitable patients and the level of facilitator involvement.

**Limitations of Research**

In the main, research suggests that CCBT is equivalent to, or more effective than, TAU and in some cases TCBT. However, the studies vary in quality and there are limitations that I would like to highlight.
Samples:
Some research applied rigid inclusion criteria and used recruitment methods that I believe restricts the extent to which the results can be applied to everyday clinical practice.

Proudfoot *et al.* (2004) had a large sample, but excluded patients if they had active suicidal ideas and had been taking medication for anxiety or depression for 6 months. The patients in Marks *et al.* (2003) had similar inclusion criteria, and would have been highly motivated given that their participation was self-initiated and carefully screened for factors such as motivation. In my experience, these high levels of motivation, absence of suicidal ideas and controlled use of medication do not seem representative of the patients with whom I worked in primary care, yet these are the people who would receive CCBT. This limits the generalisability of this research.

NICE (2005) recommend that high quality naturalistic research be conducted, as the results from RCTs may be less generalisable outside the trial environment. In order to increase the applicability of research to routine clinical practice Kaltenthaler *et al.* (2004) suggest that future research should include patients with co-morbidities.

I believe that the data may also be misleading, given the patient drop out rate or refusal to provide post treatment data. In Marks *et al.* (2003) study 29% of the sample dropped out early or gave no post treatment data. Main reasons for this included that the therapy was not helpful, wanting face-to-face help and low motivation. Proudfoot *et al.* (2004) also lost 32% of patients at follow up. Reasons for this were obtained from two thirds of these patients and included physical ill health and unhappiness with treatment, along with a reduction in symptoms. 21.9% of patients dropped out of Wright *et al.*'s (2002) study and reasons for this were not given.
If data is missing from the patients who found CCBT unhelpful, and presumably less effective, samples may over-represent patients for whom CCBT is effective. If this is the case I believe we cannot draw accurate conclusions from the research.

Researchers:
It is also interesting to note who has conducted the research. Two minority partners and two consultants to Ultrasis, who developed BtB, coauthored Proudfoot et al (2004). Marks et al.'s (2003) article includes one author who shares intellectual rights in CCBT packages, and one author who has declared an interest in Fear Fighter. Four researchers from Wright et al. (2002) receive royalties from the CCBT packages used. I wonder whether they would have published research that did not support the effectiveness of CCBT? In addition, NICE (2005) uses evidence from CCBT manufacturers and sponsors. An allegiance to a therapy method has an impact on the findings of research trials (Luborsky et al., 1999, as cited in Kaltenthaler et al., 2004). Independent research needs to be conducted to avoid conflict of interest (NICE, 2005; Kaltenthaler et al., 2004).

Measurement of outcome:
Measures, such as the BDI, are standardised and enable comparisons to be made across studies. However, they have limitations as they rely on self report. Kaltenthaler et al. (2004) highlights that the research only uses measures of symptom reduction and that future research should consider quality of life gains, subjective well being and improved functioning as outcomes.

Measurement of outcome is limited to six months post treatment. Future research might look at the long-term impact of CCBT, and whether patients maintain their therapeutic gains. I believe that the impact of other influences,
such as the support that patients received alongside BtB in Proudfoot et al.'s (2004) study and the therapist contact in Marks et al. (2003) study, requires additional investigation. These aspects alone could reduce symptoms measured and the extent to which they impact on how effective CCBT is needs to be established.

**Summary**

In summary, the research presented varies in quality and outcome. The efficacy of BtB has been reasonably well established, but its effectiveness in routine practice remains to be demonstrated. Other CCBT packages seem to vary and may be equally, or more, effective than TAU. It is clear that more comprehensive research is needed before a firm decision about how effective CCBT is can be made. CCBT has the potential to be effective for some patients and I would argue that, in terms of the dilemma of effectiveness, it is ethical to use CCBT in routine practice if caution is exercised. Ongoing monitoring and evaluation will enable the effectiveness literature to be added to and clearer ideas about who CCBT is most suitable for to be established.

**THE ROLE OF THE THERAPEUTIC ALLIANCE**

One of the most striking, and perhaps controversial, aspects of CCBT is the absence of human interaction. Wright and Wright (1997) highlight concerns about the dehumanising effects of interacting with a computer and the ability of a computer to understand communication and give accurate feedback. This section looks at the dilemma of providing an intervention that excludes a key component of face to face therapy – the therapeutic alliance.

Wright et al. (2002) are clear that their CCBT program “*does not attempt to substitute for the critical features of clinician-administered therapy, such as rapport, empathy, or clinical judgement.*” (Wright et al., 2002, p.78). Marks et al.
(2003) use CCBT to extend, not replace, clinicians, yet some patients had no contact with clinicians. Patients in Proudfoot's (2004) study received no more than 5 minutes at the beginning and end of their session with a nurse who was present to check that they had logged on and had the necessary handouts.

Some CCBT packages are clear that they are not intended to provide a substitute for a clinician or replicate therapist qualities and it is interesting that they do not discuss the potential impact of this.

Therapeutic Alliance: A Definition
The concept of the therapeutic alliance originated in psychoanalytic thinking. Current ideas about therapeutic alliance have been influenced by Bordin's (1979) definition, which includes, "Three features: an agreement on goals, an assignment of task or series of tasks, and the development of bonds." (Bordin, 1979, p.253). Bordin (1979) believed that the therapeutic alliance is key to the change process.

Current literature
Martin et al. (2000) reviewed 89 studies spanning 18 years and found that therapeutic alliance is moderately related to outcome. It was found to be consistent regardless of factors such as the type of measurement used, who rated the alliance, when alliance was measured and the type of psychotherapy used.

Ackerman and Hilsenroth (2003) examined the positive influence of therapist qualities and use of techniques on therapeutic alliance across schools of psychotherapy. The therapists' personal attributes that contributed to the alliance included being trustworthy, honest, affirming, warm, competent, respectful, flexible, interested and open. Therapist techniques identified as making positive contributions to the alliance included exploration, making accurate interpretations,
reflection, noting past therapy success, willingness to accept criticism, facilitating
the expression of affect and noting progress. An explanation to account for the
influence of therapist qualities was that they enable the patient to have
confidence in the therapist's ability to understand and help with the difficulties
they bring to therapy. A supportive environment and collaborative relationship
increases the opportunity for greater change and increased patient investment in
the therapeutic process.

Waddington (2002) looked more specifically at the therapy relationship in
cognitive therapy and supported the association between therapeutic relationship
and outcome. Krupnick et al. (1996), as cited in Waddington (2002), found that
the therapeutic relationship had an impact on the outcome of pharmacotherapy
as well as psychotherapy, which implies that the therapeutic relationship can
have more influence than the technical intervention utilised.

Waddington (2002) drew on various theoretical orientations when considering the
mechanisms of how relationship effects outcome. Social influence theory
suggests that positive therapist attributes increases the therapist's social
influence and □omputeri the patient's compliance. Similarly, Beck et al. (1990),
as cited in Waddington (2002), suggest that the therapist provides an important
source of positive reinforcement when rewards in therapy are less immediate.
Attachment theory can also be used to explain the importance of the relationship
as a safe base from which to explore. Waddington (2002) provides ideas to
enable cognitive therapists to □ompute the therapeutic relationship, which
include eliciting the client's views of the therapy, attending to ruptures in the
relationship, generation of hope, aiming for positive therapist qualities and use of
individual □omputerizedtions.

Pointon (2004) asks why we would want to leave out the factor that we know
makes a contribution to clients' healing. Cavanagh, as cited in Pointon (2004)
believes that BtB does have the capacity to respond with empathy, as it asks the patient whether they have experienced any upsets or disappointments and responds with “I’m sorry to hear that” if they have. Cavanagh also highlights that there might need to be a change in view from the use of the therapeutic alliance to thinking about the client as a change agent who computer tools to facilitate change.

Cavanagh et al. (2003) believe that “it would be unwise to reject computerized therapy a priori on the basis of a definition of psychotherapy that requires interpersonal contact between therapist and client: a restrictive semantic quibble.” (Cavanagh et al., 2003, p.168). They conclude that the therapeutic alliance literature does not provide good reason to reject the idea that computerized therapy can enable clients to make the same improvements gained from face to face therapy. It is suggested that, by viewing therapeutic outcome as a patient driven process, an insistence upon a dyadic human relationship is unnecessary.

**Clinical Practice**

As a Graduate Mental Health Worker I supported patients to complete Beating the Blues and other computer therapies. My remit was to briefly meet the patients before and after their BtB sessions and to monitor their risk and progress. I found myself spending increasing amounts of time with the patients. This seemed to serve a practical function – it enabled patients to discuss their homework and check their understanding of the material covered. However, it also enabled them to develop a relationship with someone and feel supported and understood, which BtB could not provide. I believe that this was a crucial factor in their decision to keep attending sessions and complete their homework.

One patient with whom I worked attended the first few sessions of BtB sporadically. We discussed her reasons for this she explained that she already felt isolated and that sitting in a room alone with a computer compounded these
feelings. She told me that the most useful part of the process was talking to me. We renegotiated the treatment plan with the referring clinician and the patient undertook some guided self-help for depression instead.

Summary
The literature suggests that there is a link between therapeutic alliance and outcome across therapeutic schools – a more positively viewed alliance is related to therapeutic improvements. There are various therapist qualities and therapeutic techniques associated with a positive alliance. Whether this relationship is viewed as necessary or sufficient condition for change, its influence cannot be denied. Knowing this, I wonder if it is ethical to offer CCBT as a stand-alone treatment, or even with minimal therapist contact? I believe that CCBT should only be used with the support of a trained mental health professional. This would enable the patient to develop a relationship with a clinician and benefit from the therapeutic alliance. I believe that this will complement the technical interventions that CCBT can offer, enhance patients’ motivation and facilitate the change process. As already suggested, “Just a few minutes of contact with someone encouraging may be a key catalyst.” (Marks et al., 1998, p.152).

ACCESS TO THERAPY

The Problem
The Psychiatric Morbidity Survey (2000), as cited in NICE (2005), found prevalence rates in England of 108 per 1,000 people experiencing mixed depression and anxiety and 27 per 1,000 people experiencing a depressive episode. It is estimated that 20% of people will experience depression and/or anxiety in any given year (Van Den Berg et al., 2004). Many people do not seek treatment and anxiety and depression are often undiagnosed (NICE, 2005). The impact of depression and anxiety include personal distress, occupational
disadvantage and suicide. The economic weight associated with depression is estimated to directly cost the UK £220-400 million annually, with indirect costs estimated at seven times this (NICE, 2005). The impact of depression and anxiety on individuals, families and communities is immense and it is vital that access to appropriate treatment is relatively quick and easy.

The Solution?
CBT has been identified as an effective intervention and is recommended in the treatment of anxiety and depression (NICE, 2004a, 2004b). However, there is a shortage of CBT therapists in England and Wales, which is exemplified by the long waiting time for a first appointment (Shapiro et al., 2003). There are large geographic inequalities in the distribution of accredited cognitive behavioural therapists, with nearly one third of accredited therapists working in areas inhabited by 10% of the population of England and Wales (Shapiro et al., 2003).

Shapiro et al. (2003) make suggestions to overcome the post code availability of CBT. These include using video or telephone conferencing, redistributing expertise across the UK and using modes of delivery that reduce therapist input, such as self help material and CCBT. It is stressed that, "The inequity highlighted here intensifies the need for alternative delivery modes if CBT is to fulfil its public health potential." (Shapiro et al., 2003, p.191). If the reliance on one-to-one therapy for the majority of clients remains, demand for therapy will continue to be greater than supply (White et al., 1999).

Access to effective treatments is a standard set out by the Department of Health (1999). A dilemma is whether CCBT is one way of working towards achieving this. Could access to therapy really be enhanced using CCBT and would this be an acceptable and appropriate treatment modality?
Reducing Waiting Times

CCBT may well have an important role to fulfil in meeting this need. White et al. (1999) and Cavanagh and Shapiro (2004) identify computerized therapy as a way of relieving waiting list pressures and reaching more people than is currently possible.

Van Den Berg et al. (2004) used BtB as one option for reducing waiting times in their Community Mental Health Team. Patients were supported by administrative staff, which was thought to further promote a non-professionalized, self-help atmosphere. It enabled the team to offer immediate help and reduce numbers entering the CBT waiting list. BtB was also offered as an interim treatment to patients on the waiting list. Their experience of using BtB was deemed positive.

Thinking more systemically, widespread dissemination of CCBT might reduce demand on GPs and secondary care services. Marks et al. (1998) identify that computer therapy might be able to provide more time than a clinician and enable easier access to treatment. This could therefore mean earlier access to care thus computerizing severity, duration and cost to sufferers and health services.

Physical Access

There are also some positive aspects that are uniquely associated with computerised therapy. Computerised therapy that can be used as a stand-alone treatment can be accessed outside of working hours and therefore be more acceptable for patients who work. Patients can access the therapy at a variety of locations and at their own pace, for example Marks et al. (2003) and Wright et al. (2002), which also reduces stigma and increases practical access. It might also be able to be utilised at home, and therefore benefit patients who are socially anxious, or are experiencing agoraphobia (NICE, 2005).
Unique Benefits
Increased confidentiality, reduced stigma and enhanced consistency of treatment are also highlighted as advantages of computerised therapy (Marks et al., 1998). Other potential strengths of computer therapy include giving the patient systematic feedback, promoting self-monitoring, encouraging self help and the ability to function reliably without fatigue (Wright and Wright, 1997). If this is the case, CCBT not only increases patient access to therapy, but also provides access to other potential benefits not necessarily available through other therapeutic modalities.

Cost
Cost effectiveness is an important aspect to consider when thinking about service provision and access to treatment in the context of a resource limited health service. Only BtB has undergone an economic analysis and, compared with TAU, appears to be cost effective for treating patients with depression and anxiety (McCrone et al., 2004; Kaltenthaler et al., 2002). Other CCBT packages Cope and Fearfighter are reported to cost less than TCBT and drug therapy, whereas Stresspac is more costly and no more effective than TAU (Kaltenthaler et al., 2002). NICE (2005) highlights the lack of reliable information about cost effectiveness of BtB and emphasise the differing costs across packages of acquisition fees, resources required and method and setting of delivery. It is difficult to predict how cost will impact on access to therapy, particularly given the lack of research and the complicated nature of measuring the real costs of therapy and the wider benefits – financial or otherwise – that can be gained.

Acceptability
CCBT may also increase access to therapy by increasing patient choice, which is important given the current climate of the NHS (Department of Health, 2003, 2004). Some patients may even prefer to engage in computer therapy rather
than talk to a person (Graham et al., 2000) particularly if the subject is a sensitive one (Nadelson, 1987; Pointon, 2004).

However, patient views about the use of CCBT are not reported. Measures of patient satisfaction with CCBT, where used, are crude, for example Proudfoot et al. (2004) and Marks et al. (2003). Graham et al. (2000) found that the majority of responders to their survey welcomed computer therapy. However, they advertised on BBC teletext, had only a 35% response rate and asked people with obsessive-compulsive disorder and phobic anxiety disorders. This is a very specific sample, which would be difficult to generalise. Perhaps people with these difficulties would find it more difficult to attend a service that might involve travel to an unfamiliar place and interaction with new people. This alone might explain the preference for computer therapy.

**Barriers**

There are clearly some aspects of CCBT which increase access to therapy, as discussed in the preceding text. However, it is also important to recognise the barriers that computer therapy might create. There are identified factors which may limit the uptake of CCBT including ethnicity, language, cultural differences, language problems and age (NICE, 2005).

**Culture**

Psychologists are professionally obliged to provide services that are acceptable and accessible in relation to patients’ gender and racial and cultural background (Division of Clinical Psychology, 1995). I would question whether BtB is able to meet this requirement. All the characters depicted in BtB are white, which was highlighted by some of the patients I worked with. Even the title ‘Beating the Blues’ is culturally bound. I worked with one patient who asked me why BtB was so called. We discussed the associations of colour with mood, and they told me that in their culture blue was associated with happiness, as it was reminiscent of
clear, blue, sunny skies. Can a therapy with a title that is meant to be self-explanatory and indicative of its purpose be accessible if this is not always apparent?

**Literacy**
In order to complete *BtB*, along with other CCBT packages, patients need a good level of literacy. *BtB* requires reading of unfamiliar text and concepts, writing and a small amount of typing. 1.7 million (5%) adults in England have literacy levels below standards of 11 year olds, defined as understanding short, straightforward texts on familiar topics, and 5.2 million (16%) adults have literacy levels below that of a GCSE pass (Department for Education and Skills, 2003). Due to the unfamiliarity of the topics presented in *BtB*, I would question whether 16% of adults would be able to access *BtB* effectively. Literacy levels are associated with social deprivation (Department for Education and Skills, 2003) and are therefore likely to be lower in the populations which mental health services serve.

**Language**
The patients I supported who spoke English as a second language found *BtB* more difficult to undertake, and may have been a factor in some patients' premature termination of computer therapy. They needed more time to complete their sessions and more support to discuss the material covered and homework tasks. This led to increased levels of frustration and, at times, a reluctance to attend sessions.

**What works for whom?**
Zarr (1984) makes suggestions regarding patient selection for computer therapy. However, it is yet to be established whom CCBT is most effective for. It would be unhelpful to provide access to a therapy if it is only effective for patients with high levels of motivation, low levels of social/economic deprivation and some social
support. Based on my own experiences, these are the kinds of patients I believe CCBT is most useful for.

Summary

Computer therapy appears to meet the practical need to increase access to therapy. It may be accessible at home thereby reaching more people and avoiding the stigma attached to using mental health services. It may also reduce waiting times, increase the availability of CBT and allow patients to gain more of a sense of autonomy and take ownership of their change. However, there are also barriers that are created with the use of computerized therapy, which need to be acknowledged and managed. Little is known about the acceptability of this therapeutic modality for patients, which needs to be addressed. Again I find myself drawing the conclusion that CCBT should be used in conjunction with face to face therapy or support.

CONCLUSION

In conclusion, it appears that additional research is needed to establish the effectiveness of CCBT, that the absence of the therapeutic alliance needs to be addressed and that CCBT may increase access to therapy, but may also create barriers.

Throughout this essay I have struggled to remain open and receptive to literature and new ideas, whilst holding on to my existing computerized computerized therapy. I found that CCBT was useful for a minority of patients with whom I worked, and it is interesting to reflect that I have not included examples of these successes in this essay.

I would conclude that CCBT can be useful, but that the way in which it is used and who uses it (both professionals and patients) needs to be clear. This
requires additional research to be conducted and anecdotal data to be gathered. It feels as though I may be at risk of falling prey to the CBT thinking errors of black and white and all or nothing thinking with regards to computer therapy. However, this does not need to be the case – I do not have to choose between face to face and computer therapy – the two can be amalgamated and complement each other to provide a range of interventions that can be tailored to the individual. This, in my opinion, constitutes the most ethical and professional response to some of the dilemmas with which we are faced.

REFERENCES


Adult Mental Health Essay


Professional Issues Essay:

Critically discuss some of the theoretical tensions and dilemmas faced by the clinicians in the treatment of borderline personality disorder in a multidisciplinary team setting.

January 2007

Year 2
INTRODUCTION

Whilst working with a patient with a diagnosis of borderline personality disorder (BPD) I experienced a number of tensions and dilemmas. This essay has provided me with a useful space in which to consider some of these. Reflecting on my experiences, coupled with reviewing existing literature, has served as a reminder of the complexity of the notion of BPD and the challenges posed by it.

This essay aims to identify and explore some of the theoretical tensions and dilemmas faced by clinicians in the treatment of BPD. Rightly or wrongly, I have assumed that these tensions and dilemmas are universally faced by all clinicians in a multidisciplinary team setting. I have maintained this position throughout, believing that clinicians with different professional backgrounds will all be affected by these tensions and dilemmas, but to a greater or lesser extent depending on their level of experience and role within a team.

I have organised the essay into five main sections, beginning with a definition and the prevalence of BPD. The concepts within the following sections are inextricably linked, but have been separated in an attempt to present tensions and dilemmas in a more coherent fashion. I have heavily drawn on literature which discusses the issues of diagnosis. I have assumed a stance which positions diagnostic issues as central to the treatment of individuals with BPD in a number of ways. My experience of working with a patient with BPD highlighted the centrality of diagnosis and the importance of addressing it within treatment.

The first tension I have explored is how clinicians conceptualise BPD and whether it can be constructed as a distinct clinical syndrome. The tensions associated with providing an individual with a diagnosis of BPD are then discussed in the section entitled ‘diagnosis versus label.’ The tension of how to understand the development of BPD and the impact on clinicians’ responses is
then considered. The notion of BPD as untreatable is presented as another tension. Finally, the tensions associated with managing risk of suicide, and the dilemma of hospitalisation, are highlighted.

**DEFINITION AND PREVALENCE OF BORDERLINE PERSONALITY DISORDER (BPD)**

According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association [APA], 1994), a personality disorder (PD) is a pattern of inner experience and behaviour that deviates from cultural expectations, is pervasive and inflexible, begins before early adulthood, is stable over time and leads to distress or impairment. The DSM-IV defines ten PDs, and represents a categorical approach that views each PD as a distinct clinical syndrome. These ten PDs are organised into three clusters; A (odd or eccentric types), B (dramatic, emotional or erratic types) and C (anxious and fearful types). This grouping makes clinical sense and simplifies the myriad of categories (Holmes, 1999). BPD sits within cluster B, accompanied by histrionic, narcissistic and antisocial personality disorders.

BPD as a formal concept is relatively new. It did not appear in the DSM until 1980 and reaching this status caused controversy (Linehan, 1993). To reach diagnostic criteria for BPD an individual must have, “A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts...” (APA, 1994, p.654).

Individuals must possess five or more of the following:

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships.
- Identity disturbance.
• Impulsivity.
• Recurrent suicidal/self mutilating behaviour, gestures or threats.
• Affective instability
• Chronic feelings of emptiness
• Inappropriate, intense anger or difficulty controlling anger
• Transient, stress related paranoid ideation or severe dissociative symptoms.

From a Psychiatric perspective, DSM-IV makes a distinction between an illness axis and a personality axis, which helps clinicians to think about the relative contribution of each to the clinical presentation (Holmes, 1999).

The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organisation, 1992) also provides useful definitions. Due to the prominence of DSM-IV definitions in current literature and its use in my work settings, I have used DSM-IV definitions throughout this essay.

It has been found that 27% of all psychiatric inpatients have BPD (Loranger, 1990). Research estimates that BPD represents 15-25% of all reported psychiatric illness (Kaplan et al, 1994).

There are gender and ethnicity biases in those diagnosed with PD. The majority (70-77%) of individuals diagnosed with BPD are female (Swartz et al, 1990; Widiger & Weissman, 1991); “BPD is a gendered diagnosis.” (Shaw & Proctor, 2005, p.484).

Black people in the UK, compared to their White counterparts, attract a diagnosis of PD relatively infrequently in the National Health Service (Ndegwa, 2002). It is unclear why this is so. It may be due to true differences in prevalence or a bias in assessment and diagnosis of Black service users (Ndegwa, 2002).
THE CONCEPT OF BPD

An important aspect that, in my experience of working with an individual with BPD, requires addressing in treatment is the issue of diagnosis. Whilst some might view this as separate entity to treatment, I would argue that the two are linked. Some of the tensions in treating BPD are linked with the clinicians’ views on the concept of it as a distinct clinical syndrome.

As a systemic practitioner, Allen (2004) is reluctant to use definitions of distinct clinical syndromes. The use of the term BPD makes her uncomfortable, as it implies something fixed, global and a deficiency of the self. This is exacerbated by its pejorative overtones, that it is used frequently, often applied to women and carries a pessimistic prognosis. Allen (2004) considers shying away from using pathologizing distinctions, but acknowledges that this may not be helpful when working in a health system that is based on diagnosis.

In describing some of the difficulty systemic practitioners have in engaging with the concept of BPD, Allen (2004) draws in the work of Gaines (1992). Gaines (1992) suggests that the DSM is linked to a Germanic Western model of the self, assuming a core personality which remains constant across contexts. He highlights the emphasis placed on stoicism and independence in the culture, rather than emotional expressiveness and interdependence.

Allen (2004) reiterates the consequences of this culturally biased manual for women and members of other cultures in relation to BPD. This western way of thinking values attributes likely to bring success in a capitalist economy. Success is thus viewed as being a stable, autonomous, controlled and a goal directed self. The features of BPD include instability, insufficient autonomy, and inadequate self control and goal orientation. Allen (2004) highlights that these differences, if they exist, are of degree and not category membership.
As women often define themselves through relationships and may have less of a distinct sense of self than men, BPD is essentially intensely feminine. Allen (2004) suggests that women who can only empathise or nurture others only with the expectation that the other will be there in return (APA, 1994) is viewed as pathological in a society where women are expected to selflessly nurture. "Their 'inappropriate, intense anger' and reckless risk taking may also fail the femininity test." (Allen, 2004, p134). In her analysis Allen (2004) also highlights the professional discourse. She suggests, "...the text (DSM-IV) echoes to the outrage of the psychiatrist and therapist whose patient is not grateful and will not play by the rules." (Allen, 2004, p 134). The use of BPD also acts as clinical shorthand for difficult therapy and as a protection for clinicians or services against angry attack or frustration.

Another construction is, "...that a diagnosis of BPD is the latest manifestation of historical attempts to explain away the strategies which some women use to survive and resist oppression and abuse, by describing these strategies as symptomatic of a disturbed personality/pathology." (Shaw & Proctor, 2005, p.484). From a social constructionist model, BPD is viewed as a deviation from concepts of rationality and individuality, and a diagnosis of BPD is made according to a psychiatrist’s judgement of emotions against the norm of these concepts. Anger and fear of abandonment are judged as inappropriate rather than understandable in the context of an individual’s history (Shaw & Proctor, 2005). By diagnosing an individual with BPD, their link with a history of trauma and abuse is severed and the cause can be located within the individual, rather than in systems. The status quo of a society where sexual violence against women is endemic is thus protected (Shaw & Proctor, 2005).
Another potential tension is the process and impact of diagnosing an individual with BPD. Clinicians in teams may hold varying views about the method, validity and ramifications of officially giving this diagnosis. An individual's response to such a diagnosis will influence their approach to teams and the treatment available, as well as influencing clinicians' approach to the individual and the treatment that they may or may not offer.

One service user described the diagnosis of BPD as "a very sticky label." (Haigh, 2002, p.1). Service users reported widespread unhelpful attitudes from mental health staff who would see them as just a label (Haigh, 2002). However, one service user did find having a diagnosis of PD useful. They found it helped them to understand themselves and the culture and system that labelled them (Haigh, 2002).

Nehl (1999) presents the voice of service users who reported experiences of being labelled, not diagnosed. They found that services had preconceived and negative opinions of people with BPD and found it a pejorative label that perpetuated a sense of being marginalised and potentially maltreated. One participant described BPD as being labelled and judged versus diagnosed and treated...Once given that label, you can never argue or get rid of it." (Nehl, 1999, p.288).

Zimmerman (2003) asserted that, based on common sense, greater diagnostic precision should improve outcome. Indeed, it would seem that BPD is actually under diagnosed in clinical practice compared to research practice. The method of diagnosis employed (semi structured diagnostic interview, compared to unstructured clinical interview) has an impact on the rate of diagnosis (Zimmerman & Mattia, 1999). PD was more frequently diagnosed when
information was presented from the semi structured diagnostic interview more readily employed in research than clinical practice.

Contrary to Zimmerman's assertion, "The result [of diagnosis] was a paradoxical situation for participants: they believed the criteria for borderline personality disorder fit, yet they experienced the diagnosis as having no beneficial purpose in guiding treatment." (Nehls, 1999, p.288).

An interesting quote represents some service users approach to diagnoses: "The main thing diagnoses are good for is sussing out what your shrink thinks of you – Bipolar affective disorder means they like you, Unipolar means you're boring, Borderline Personality Disorder means they hate you and Schizophrenic means you scare the shit out of them because they can't keep up with your thinking." (Epstein & Olsen, 2001, p.17).

Nehls (1999) found, "Participants did not deny their diagnosis but deplored the stereotypes and stigma attached to this particular diagnostic category. Thus, while the controversy within professional circles centers on whether the borderline personality diagnosis should exist and, if so, based on what criteria, those living with the illness contend that the diagnosis and the current criteria are not as problematic as the prejudice of providers." (Nehls, 1999, p.291).

The insights above highlight the dilemma of whether to provide patients with a diagnosis of BPD and may contribute to some clinicians' reluctance to do so. There are a number of reasons why clinicians may be reluctant to diagnose BPD. These include fear of being held responsible for the patients behaviour, lack of confidence, feeling overwhelmed, disliking the patient and concerns that there are inadequate resources to manage the patient (Davison, 2002). Tensions also exist around how transparent to be regarding the diagnosis. Clinicians may use
the term about patients without formally recording it or sharing it with the patient (Allen, 2004).

UNDERSTANDING THE DEVELOPMENT OF BPD

Another tension that clinicians may face is that of how to understand the development of BPD. There are various paradigms which can shape understanding and thus perceptions of the cause and maintenance of the behaviours that characterise BPD, if such a concept exists. This understanding will effect the treatment that clinicians may offer. In my experience, the dominant model is often the medical model, which locates difficulties within individuals.

Clinical staff can often describe patients with BPD as manipulative and attention seeking, and can respond to such patients with anger and frustration. If a way of understanding the development of behaviours is not introduced, therapy and management can become reactive, disciplinarian and even abusive (Zulueta, 1999). Research in attachment and complex trauma can offer an alternative approach for understanding some of the terrifying and destructive behaviours (Zulueta, 1999; Pearlman & Courtois, 2005).

Most of the characteristics of BDP can be understood as a result of damage to the attachment system or as a manifestation of post traumatic stress disorder (Zulueta, 1999).

Bowlby (1980) presented attachment behaviour as an integral part of human life. The desire to form attachments is seen as innate and fundamental to life. Attachment behaviour provides an infant with protection, teaches social interaction, and enables psychological and physiological development and regulation. A secure attachment provides the basis for healthy development and

1 Also referred to as the biological model and disease model, this approach holds that mental disorders are caused by somatic, biological or bodily processes (Davison & Neale, 1998).
a safe base from which to explore the world. Disruptions in these highly attuned bonds with a sensitive attachment figure lead to psychological, relational and social difficulties.

Bowlby's work has since been refined and his attachment categories expanded. This has occurred as attachment research has been combined with findings from the posttraumatic aftermath of childhood abuse and neglect. (Pearlman & Courtois, 2005). Fonagy et al (1995), for example, found an association between unresolved adult attachment status and BDP.

Pearlman & Courtois (2005) draw on constructivist self development theory, which identifies key domains about self and others: trust, safety, esteem, intimacy and control. These are influenced by early attachment experiences, but can change as a result of experiences such as trauma. They result in schemas which influence an individual's interactions and relationships and remain resilient even in the face of contradictory evidence, but can be updated with new experiences. With an absence of positive early attachment experiences, individuals are unable to regulate inner states and this in turn can lead to a sense of desperation. Individuals who have suffered trauma may then use dissociation or other defences, and engage in behaviours aimed to self soothe and contain distress. These are often paradoxical as they may be self destructive, such as self harm, suicide, risk taking behaviours. The similarities with BPD are notable.

Zulueta (2005) highlights how the ability to hold the 'other' in mind enables us to manage temporary loss. People with BPD lack this ability and experience the loss of an attachment figure as an attack on the self; hence the frantic efforts to avoid real or imagined abandonment. The links between attachment as a modulator of physiological arousal and BPD are explained.
Shaw & Proctor (2005) argue that although this approach recognises the impact of trauma, survivors are still pathologised by describing their responses as symptoms of a disorder. They also argue that at a service level the focus remains on the disorder and there is no systematic link between the abusive experiences and diagnostic criteria of BPD.

Although the majority of people with BPD have experienced trauma, and this can be a useful way to understand behaviours and internal states, not all individuals have diagnosed with BPD have experienced trauma. 88% of people diagnosed with BPD have experienced abuse (Castillo, 2000). Although the enormity of this figure is compelling, I wonder how the 12% of people with BPD who have not experienced abuse can be thought about. People with BPD are a heterogeneous group (Allen, 2004) and this creates the dilemma of how to develop generalisable best practice. Clinicians need to understand and effectively treat individuals in a manner that enables a compassionate, and not reactionary, response.

Allen (2004), in her use of a systemic approach, highlights the issues of power and gender in the understanding of BPD. Repeated experiences of powerlessness may manifest in patterns that seem manipulative, and can be reframed as survival strategies. Patterns that are seen clinically can be normalised as strong forms of gendered behaviour. Perhaps these ideas can offer a more useful way of conceptualising some of the features of BPD.

Tensions may occur when clinicians hold vastly different views on the development of BPD. “From what we know relating to the development of patients suffering from a borderline personality disorder, it is clear a fresh new approach to their management and treatment is required if we wish to help those who suffer from this disorder to cope better with life.” (Zulueta, 1999, p.251). Working alone or individually may not always feel safe for the therapist or patient
(Zulueta, 1999). Thus, to truly work in a helpful way, clinicians need to have a shared understanding. This could create massive tensions if this is not possible.

TREATABILITY

Another tension faced by clinicians' is the notion of whether BPD is treatable. Adshead (2001) reminds us that treatability is a confused and confusing concept, and makes the distinction between the legal (in relation to involuntary admissions) and clinical applications of it. The issue of treatability is related to the controversial status of PD as a mental illness or disease; whether you use descriptive or normative accounts of disease and illness; and whether it can be usefully viewed as a disability (Adshead, 2001).

Adshead (2001) contemplates what it means to be able to treat any clinical disorder. She draws on court judgements which have ruled that treatment for physical diseases includes a broad range of interventions aimed at change in symptoms, enhanced quality of life, or prevention of further damage. Adshead (2001) uses a seven factor model to suggest that treatability is based on seven functions operating simultaneously. These factors are the: nature and severity of pathology, involvement of other systems, patient's previous health/comorbidity, timing of intervention, experience and availability of staff, availability of specialist units and state of knowledge/cultural attitudes.

Adshead (2001) applies this model to the treatment of cancer, previously viewed as untreatable and a term that attracts fear and stigma. Treatment is affected by the availability of staff, and whilst a cure is often not available, therapy which enhances quality of life is still offered. Few treatments have been exposed to randomised controlled trials, but that they are still used to good effect. This has parallels with the treatment of PD.
In applying the model to PD, Adshead (2001) suggests that clinicians who do not accept it as a pathological disorder, or who do but have little experience in treating it, may well be justified in saying that it is untreatable. It is factors outside of the disorder that therefore may make it untreatable. As with the treatment of cancer, the treatment of BPD is reliant on the access to and availability of staff and specialist units. "There is therefore no justification for global assertions that personality disorder is untreatable – a view that is still taught to trainees, asserted in journals and stated as expert evidence in court. There is equally no evidence that all personality disorders would be treatable if only clinicians’ attitudes were right and there were enough facilities.” (Adshead, 2001, p.412). The availability of resources, education and training are highlighted.

Treatability can be used as an exclusion criteria from hospital admission and accessing services (Davison, 2002; National Institute for Mental Health in England [NIMHE], 2002). When the debate is polarised into treatable versus untreatable it is simplistic and may mask moral judgements about who is deserving of treatment; nowhere else in medicine does treatable equate with curable (Davison, 2002).

BPD is one of the most widely researched PDs, but empirically based treatment research is sparse (Louw & Straker, 2002). Knowledge of effective psychological treatments for PD is rudimentary (Bateman & Fonagy, 2000). Treatment approaches are generally disappointing (Kerr, 1999). There are also problems associated with research on treatment outcomes for patients with PD. These include differences in case identification, comorbidity, difficulties using randomised controlled studies and lack of specificity of psychotherapeutic approaches (Bateman & Fonagy, 2000).
Whilst recognising the need for more research, a combination of psychological treatments for PD that is at times reinforced by drug treatments is recommended (NIMHE, 2003).

Features of successful treatment and management of people with BPD include a plan tailored to the individual, explicit and realistic goals clearly formulated, long term time frame, reaching shared expectations, consistent and tolerant approach that is multidisciplinary (Davison, 2002). Common therapeutic ingredients shown to be effective in the treatment of PD are structure, compliance enhancing, focussed, theoretical coherence, long term, encouraging of powerful attachment and those that are integrated with other services available to the patient (Bateman & Fonagy, 2000). Kerr (1999) emphasises the importance of a shared understanding of BPD by team members and other agencies. He describes how community mental health teams face enormous pressures, have responsibility for large numbers of patients and have little back up from specialist psychotherapy services. Staff are rarely trained to deal specifically with people with BPD. Kerr (1999) describes the power of introducing a conceptual framework that the team could use to think about BPD. Kerr (1999) recommends the creation of a contextual reformulation which describes organisational responses, along with additional staff support and education.

MANAGING RISK

Managing the risk of self harm, suicide and risk taking behaviours associated with individuals diagnosed with BPD is a major tension in a multidisciplinary team. “Clinicians working with clients with a diagnosis of borderline personality disorder are frequently faced with complex dilemmas around issues of life and death.” (Krawitz et al, 2004, p.11). When I worked with a patient diagnosed with BPD, I
found managing their risk of suicide incredibly challenging and highly anxiety provoking.

Chronic suicidality is a feature of BPD (Paris, 2004). Suicidality can include patients who consider suicide, self harm or carry out life-threatening acts. Paris highlights that these are very different things and using the same word to encompass them can lead to confusion. 9-10% of patients with BPD will commit suicide and it is difficult to identify who is at greater risk of this (Paris, 2002).

Paris (2004) highlights chronic suicidality as a clinical challenge. He cites Maltzberger & Buie (1974) who indicate that chronic suicidality can wear down therapists, causing them to emotionally withdraw, which increases the patient's sense of abandonment. Chronic suididality requires a different approach from acute suicidality. Risk of completion must be continuously assessed, but the difficulty lies in the lack of solid evidence to show that measures designed to prevent completion are effective (Paris, 2004). Interventions used in acute suicidality may be inappropriate or counterproductive to use in chronic suicidality (Paris, 2004). Working with high levels of risk without interventions shown to be effective is another tension for clinicians.

A major dilemma faced by clinicians when managing risk is whether to admit individuals with BPD who are actively suicidal to hospital.

Linehan (1993) recommends that the least intrusive method of intervention should be used when the threat of suicide is imminent. She states, "DBT\(^2\) does not have a specific policy regarding involuntary commitment of individuals at risk for suicide. Some therapists are more willing than others to use this option; opinions differ as to its ethics and efficacy. The important point in DBT is that

\(^2\) This refers to Dialectical Behaviour Therapy, a treatment approach for BPD developed by Linehan (1993).
therapists absolutely must know where they stand on this issue before patients become suicidal.” (Linehan, 1993, p.488).

Prolonged inpatient care for patients who are chronically suicidal can reduce their autonomy and increase their dependence on hospital (Maltsberger, 1994). Maltsberger (1994) also highlights the anxiety in the USA with the increasing litigious climate and Rudd et al (1999) refers to the litigation determined standard of care that has emerged in the USA over the last several decades. Although maybe to a lesser extent, the legal ramifications of accountability for suicide apply in the UK and feel very real as dilemmas within clinical practice.

Krawitz et al (2004) summarise research that suggests that there are medicolegal pitfalls in working with patients with BPD and that a lack of understanding about optimal treatment may lead to clinicians being blamed when treatment was in fact satisfactory. They highlight that when working with chronic suicidality “…there is no risk free pathway, the balance between clinician and client responsibility is finely tuned and a precise risk calculation is not usually possible.” (Krawtiz et al, 2004, p.15). They emphasise the need to demonstrate reasonable standards of practice, and advocate obtaining a second opinion, presenting material at forums, keeping abreast of clinical developments and thorough documentation.

As a result of these pressures, clinicians can respond with defensive practice. Krawitz & Batcheler’s (2006) work in New Zealand highlights that patients with BPD need to survive short-term crises and learn strategies to reduce future crises, thus reducing long term risk. Defensive practices can actually increase long term risk. These may include prolonged acute hospitalisation, one-one observations of patients and use of mental health legislation. Factors contributing to defensive practice may include medicolegal concerns, inadequate resources, anxiety about wider consequences and the emotional weight of wanting to reduce short term risk.
Krawitz & Batcheler (2006) report that clinicians are aware of these dilemmas in providing effective care. However, despite knowing that a patient’s recovery might be undermined, clinicians still make defensive decisions in their own interests. In their survey, 85% of the 29 clinicians surveyed had taken a treatment approach not in the best interest of the patient, but which protected them from medicolegal repercussions. Whilst the sample is small and may be biased, the majority of clinicians were operating in their own interests.

Krawitz & Batcheler (2006) emphasise the need for short term crises to be survived, but opportunities for learning about and changing chronic patterns. There needs to be a balance between an environment that protects in the short term and one that promotes longer term change. Support is vital, yet clinicians perceived a lack of support for risk tolerant practice. This needs to be addressed. The courts need to acknowledge the unique nature of the clinician’s dilemma in working with chronic suicidality (Guthiel, 1992, as cited in Paris, 2004).

There are clearly implications, both professional and personal, for therapists whose patients commit suicide. Knox et al (2006) summarise literature investigating the impact of client suicide on credentialed therapist in the USA. Common reactions from therapists included anger, sadness, guilt, anxiety, shock and doubt about competence. It also changed the way that some therapists practiced, including taking more notes, seeking second opinions, increased vigilance and faster hospitalisation of patients. Therapists in training have more pronounced responses and may attribute the suicide to their personal qualities rather than their technique. Formal training for mental health professionals on client suicide is limited (Knox et al, 2006).

Working with patients with BPD who have chronic suicidality presents multiple challenges to clinicians. There are therapist qualities that are necessary to
enable management of these challenges. "The management of the person for whom suicidality has become a way of life requires a willingness to take risks and an acceptance of the fact that one cannot prevent all suicides. Those are two qualities which not all therapists have." (Schwartz et al., 1974, as cited in Paris, 1993, p. 45).

An associated tension is whether clinicians are able to decline working with a patient with BPD, given the need for these unique qualities. In the context of a pressurised and resource limited service which may have long waiting lists, this may be difficult to achieve. In addition, an MDT may only have one clinician from a specific professional background and their input might be necessary. Some clinicians might not possess the necessary qualities to work with chronic suicidality and would be best placed not to work with patients with BPD. McHenry (1994) recommends that therapists working with patients with BPD are aware of their own interpersonal issues, as their influence in countertransference can impede, halt or damage the process of therapy if unacknowledged.

The tension of resource limitations should also be recognised. "Resource limitations may also shape service responses: just as a crying child is most likely to evoke anger when the parent feels least resourceful, so service providers may be most likely to blame and punish a demanding service user when they feel they have nothing to offer." (Allen, 2004, p. 138). The recommended ways of working previously highlighted require resources to provide such support and protected time to enable clinicians to utilise them.

**CONCLUSION**

The complexity of BPD has been evident throughout this essay. The very idea of BPD is controversial. Whether clinicians ascribe to the notion of BPD as a distinct clinical syndrome, as defined by the DSM-IV, is a massive theoretical
tension faced by clinicians. The idea that BPD acts as a label rather than a diagnosis is problematic and leads to the dilemma of whether to apply such labels within clinical practice. It has been highlighted that it is not the diagnosis per se that is a problem, but more clinicians’ responses to the label of BPD that can be detrimental. BPD carries with it perceptions of individuals as potentially difficult to manage, demanding and manipulative. Along with this is the common misconception that BPD is untreatable. This is an issue that is further complicated by the dearth of research and the methodological difficulties that are evident in existing research. The major tensions associated with managing risk are hugely challenging, along with the dilemma of whether to admit individuals to hospital.

There are themes that permeate the categories that I imposed on the literature. The idea that staff responses to the label of BPD can be unhelpful is one theme. The centrality of therapist qualities became apparent. The most prominent and recurring theme that I found was that of the need for staff education, training and ongoing support. This requires resources to be available and is one of the major tensions that clinicians in the National Health Service constantly face.

REFERENCES


Problem Based Learning Reflective Account

March 2006

Year 1
Problem Based Learning Reflective Account, Year 1

Introduction

The following text is a reflective account of my experience of participating in a problem based learning exercise. It is based on a reflective journal that I kept throughout the process and on my subsequent thoughts and clinical experience on placement. It also draws on some psychological theory. I have tried to write in a frank manner and in such a way that engages you, the reader, with my experiences.

In the beginning...

So. I had arrived! Here I was at the University of Surrey about to embark on my first day of clinical training. I had braved the application process and finally made it. Then it was suddenly the afternoon. I was in an unfamiliar room and an unfamiliar person told me that I would be part of a “case discussion group.” That I would undertake a “problem based learning exercise.” And then my friend the worry beast kicked in. I think all I heard after that were a series of muffled sounds much like those produced by the teacher in the cartoon Charlie Brown (Schulz, 1983).

I was feeling disoriented and confused. I was unsure of the terminology being used and of the expectations placed upon me in my new identity as a trainee clinical psychologist. This is useful when contemplating the experience of accessing a mental health service. Braving the application process could be likened to negotiating the referral pathway, undertaking an assessment and being deemed suitable to use a service. Service users may have to attend an unfamiliar setting, be unsure about professionals’ expectations of them and be exposed to jargon.

Reflecting on this experience serves as a useful reminder to pay attention to what it might initially feel like to be a service user. It emphasises the importance of not
using jargon, being clear about the purpose of the first therapeutic meeting, displaying an empathic approach and exploring expectations.

The Task

I was assigned to a group comprised of seven first year trainees. A course tutor acted as a facilitator who attended some of our meetings. We were asked to think about the relationship to change and present our ideas to other trainees, course staff and regional supervisors. We were also required to assign roles to group two group members who would act as chairperson and scribe.

After several meetings involving much discussion we chose to focus on models of change that we used to understand our own experiences of change. This was particularly relevant when we thought about making the transition to being a trainee.

We considered various models, including Prochaska and DiClimente's (1983) model of change. However, we decided that Hopson's cycle of transition aptly reflected our experiences, so used this as a basis for our presentation.

Selecting the most appropriate model was actually quite difficult. I had to resist the overwhelming temptation to select a neat model and then fit our experiences accordingly. Thinking about experiences and then applying a relevant model meant that I could organise and make sense of my experiences. I don't think I would have experienced this benefit had we selected a model and then manipulated our experiences to fit it. This has been useful to remember when working with service users. I aim to select models that fit with the service user's experiences and add a useful dimension to the therapeutic work.
The task concluded with a presentation that reflected our experiences of the transition to becoming a trainee. Using our creative skills we presented our ideas in a somewhat lively and interactive fashion.

The Process

Only a few months prior to this exercise the group members would have been competing against each other for a place on the course. Through discussion with others I realise that this was a difficult transition for some to make. I found it relatively easy to move into a more collaborative relationship with the group members. However, there still was a competitive element in terms of whose ideas took precedence and, at times, this was difficult to negotiate.

I think the competition within our group rapidly moved to competition between groups. Two weeks into the process I was comparing our work with that of other groups. I wonder whether this is similar to the rivalry that can occur between departments and teams within the NHS.

One process issue that I want to focus on is the development of trust within the group. Moreland and Levine (2002) summarise that, "Put more simply, trust is the willingness of one group member to 'take a chance' on another." (Moreland & Levine, 2002, p.189). This felt a useful definition for me to think about trust.

I felt that it was important to establish trust in order for me, and others, to work effectively, share experiences of change and connect with our task. It is interesting that we did not establish ground rules or boundaries, which may have been a more explicit way of managing the issue of trust. I may advocate explicitly discussing these issues in my subsequent group work. I know that trust is important in developing a sound relationship with service users, for example Bordin (1979), but at the time I did not think about this in the context of our group
formation and development. Perhaps I assumed that as we had a task to complete – the primary aim of which did not seem to be about expressing feelings – the issue of trust was less important.

I believe that in the process of working together I did gain a sense of trust and increase my willingness to take chances on others. We shared our experiences of the transition of gaining a place on the course and the associated highs and lows. I initially spoke about general examples of this, and as I felt more able to share more meaningful and personal experiences I talked about more specific and difficult examples. We shared quotes of our thoughts at the time, which did mean I had to trust the group and feel that I wouldn't be judged or criticised.

Looking at some literature about how service users test trust in therapy, I began to think that the way in which we tested trust in our group mirrored this. Fong and Gresbach Cox (1989) identified six common types of client tests of trust. These were requesting information, telling a secret, putting oneself down, asking a favour, inconveniencing the counsellor and questioning the counsellor's motivation and dedication.

Requesting information from each other was, I believe, a major test of trust in the beginning stages of our group. After the second meeting group members were assigned the task to obtain information on models of change. I think, in addition to fulfilling a practical function, this served as a test – would group members prove to be reliable and trustworthy? In my eyes, everyone did prove to be trustworthy and simultaneously demonstrated their motivation and dedication to the group. As we developed a shared sense of safety and trust I felt able to disclose feelings that I might not have shared with other trainees, which is similar to telling a secret. There were also incidents of group members putting themselves down ("I can't act!") and testing the group's acceptance, particularly as the presentation deadline loomed. I was able to work as part of the group.
because I did feel able to trust all members and take a chance on everyone. This was a major strength of our group.

This is useful to bear in mind when working with both colleagues and service users across contexts. I have experienced that the development of trust is vital. Trust will inevitably display itself in a variety of ways, whether this is through explicit conversation or behaviours that are intended to test it.

Our facilitator had a unique position in terms of trust in the group. A helpful concept that assisted my thoughts about this was that of quasi group members. Moreland and Levine (2002) make a distinction between full and quasi group members. As I look back, it feels like our facilitator was initially a quasi group member. This was because they did not attend all our meetings and held a more peripheral role, which supported the process rather than instigated it. This was a role that the group had agreed, but I think it has interesting implications for trust. Moreland and Levine (2002) suggest that full members worry about the other group memberships that quasi members may have, particularly if the other membership may cause harm to the group. I think this is particularly pertinent, given that our facilitator also belonged to a very powerful group – the course staff group. This did effect my sense of trust and the willingness to take a chance with the facilitator.

I was able to have honest discussions with our facilitator present. However, the conversations that involved more self-disclosure about personal feelings and concerns – and therefore involved taking more of a chance – were more likely to occur when only the full members were present. This higher level of trust involving the facilitator did develop, but I think it was once I viewed the facilitator as a full member. Thinking about how service users may view my membership, both with themselves and with other groups is something I will consider in my
therapeutic relationships. If my membership with a community mental health team is viewed as potentially harmful this could have a detrimental impact.

Another issue that I have since reflected on was the diversity of our group. We were a diverse group on many dimensions. We were different genders and ages, with different personal and professional backgrounds. We had different cultural and social heritages and had established different professional identities in a variety of domains. I believe that this had an impact on our expectations, style of interaction with each other and the way in which we related to the group.

An important aspect for me was that I would remain in the same group for the rest of my training. The future purpose of the group was to provide a safe space in which to discuss difficult clinical cases. This influenced how I viewed the group and how I presented my ideas. I saw the group as an important potential source of support. Therefore I sometimes considered the risk of offending the group members whose support I might need before expressing an opinion. This did not prevent me from talking, rather encouraged me to present my ideas in a less confrontational manner.

I believe that my gender, along with individual personality factors, played a part in this style of relating to the group. Seeley et al (2003) showed that there are gender differences in the way that men and women relate to groups. In their research men tended to value relational and collective attachments to groups, whereas women valued only the relational attachment. Thus, men valued the identity that group membership afforded, and women valued closeness towards members.

This relates to our group interactions. Sometimes it felt that male members were willing to pursue their ideas in order to develop the presentation at the cost of group relationships. As a female member I think I was more aware of the
relationships within the group. I was more compromising with my ideas if I believed that it was for the good of the group and promoted working relationships. It would have been interesting to compare my experiences of this element of diversity to working in a multidisciplinary team. I have been unable to attend team meetings to date, but I will pay attention to this in future settings.

This account has highlighted the value of monitoring my own experiences and associated responses. Drawing parallels between my experiences and those of service users helps to develop my empathy whilst maintaining curiosity about individuals' unique experiences. Change and fulfilling a new identity as a trainee or service user can be anxiety provoking. The development of trust and appreciation of diversity can facilitate this process.

1,998 words

References


Problem Based Learning Reflective Account

March 2007

Year 2
Introduction
The proceeding text contains my reflections on a problem based learning (PBL) exercise that I participated in. It is based on reflections that I recorded at the time, along with retrospective contemplation and thoughts drawn from subsequent clinical experiences on placement.

The Problem
The problem we were presented with was relevant to the placements that we would complete over the next year – working with people with learning disabilities and children and families. It was entitled “Child protection, domestic violence, parenting and learning disabilities.” We were presented with a genogram, a diagram of the professional network and some text detailing the Stride family.

The Stride family were experiencing some difficulties. Mr and Mrs Stride’s twin daughters had been placed in short term foster care following a child protection case conference. The twins were deemed to be at risk in the care of their parents. Mr and Mrs Stride were described as both having a learning disability, White English and living on state benefits in conditions of deep poverty. Domestic violence between Mr and Mrs Stride was also reported.

Three perspectives were presented to us. The Local Authority wanted to swiftly place the children for adoption. Mr and Mrs Stride were passionate about their commitment to having their children returned to their care. The children’s Guardian was presented as having approached us, the Psychologist, to conduct an assessment and develop a rehabilitation plan for the children. The aim of the PBL was to explore whose problem it was and why, to make recommendations about where the children should be placed and present this to the course staff and local service users and carers.
The Process

The first reflection I had was the group’s reaction to the problem. Initially I felt quite overwhelmed by the enormity of the problem. I think this was felt throughout the group. We quickly became task oriented and rapidly moved into an action phase. The end product resulted in a video to show the audience, accompanied by a script to read. I think we did not pay as much attention to our emotional reactions to the problem, which we would usually do in our case discussions. At the time I did not consider this, but it seems quite apparent in retrospect. I wondered about some of the possible reasons for this.

Timing
The PBL came at an interesting time for us both in terms of our own stage of training and the group development. On the one hand, there was something quite familiar about the task. We had completed two PBLs already and we had been members of the same group for one year. We were more familiar with individuals’ preferred working styles. On the other hand, it was also a time of considerable change. We were entering into our second year of training – no longer the somewhat naïve first year trainees, but second years with additional experiences and academic knowledge. Perhaps I felt that this new position brought with it a new sense if identity and increased pressure and expectations. Perhaps these pressures were imposed by myself, or perhaps they were based in reality. I did not raise this in the group and it could have been useful to explore whether other people felt this way. This was also a time of transition, with new placements on the horizon. This meant new, and possibly unfamiliar, client groups to engage, new supervisory relationships to negotiate and new teams to work within.
I was about to embark on a placement working with people with learning disabilities. I was nervous about doing this, and being presented with a complex case such as the Stride’s increased my fears about working with this client group. I did have concerns about my ability to work with this new client group, and the complexity perpetuated my sense of reduced competence. The desire for a concrete and solid task to complete was thus appealing for me.

This context of familiarity within the group coupled with uncertainty outside of the group may have contributed to the way we responded to the task. We began by acknowledging the vastness of the task, but then rapidly became focused on concrete task assignment. We quickly came up with the idea of using a court room to play out some of the tensions and dilemmas we, as clinical psychologists, were facing. We assigned tasks to each other, such as collecting relevant journal articles. We subsequently discovered that other groups were using a court room format to present material, and decided to present our material in a News Night style television debate.

It is interesting that the group rapidly moved into an action phase. We did not spend much time thinking about our responses to the Stride family, or what the problem evoked in ourselves. We were very much task oriented and focused on executing our decision regarding where the children should be placed.

This fits with some of my experiences of working in a service for people with learning disabilities. There is an emphasis in the various organisations and services which work with people with learning disabilities to focus on doing rather than simply being with clients. This is reflective of the historical input of psychologist in learning disability services. There has, until recently, been an emphasis on measuring cognitive functioning, modifying behaviour, treating challenging behaviour and normalisation and only now is the emotional lives of people with learning disability being addressed (Arthur, 2003).
I wonder whether maintaining a task oriented ethos in the group was a way for myself and other group members to manage our anxiety. Sometimes setting a task to achieve can provide a sense of certainty and control which is often less present in my experience of the role of a trainee clinical psychologist.

Humour and creativity
As our ideas developed we changed our presentation to something capturing more of the group’s creativity. We decided to produce a video in order to represent the views of the different people involved, including the young twins. We acted out the roles of the Stride family members (parents, grandparents, twins), foster mother and the children’s advocate.

Interestingly, I think this idea emerged from our conversations in the group about the use of humour in therapy. Perhaps the prospect of working with people with learning disabilities and children and families on placement prompted us to tap into more creative and playful ways of thinking.

In our group we discussed Lemma’s (2003) ideas about the use of humour in therapy. Lemma draws parallels between therapists and comedians; both want to relieve psychic pain and are expected to soothe and comfort. Tragedy and comedy are also connected. As Lemma points out ‘make me laugh’ and ‘understand me’ are both huge asks. The importance of timing in both fields is also vital – effective interpretations in therapy and good punch lines in comedy rely on this.

When thinking about our group, I realised that we did laugh a lot and use humour in our discussions about the PBL material. Lemma’s (2003) insight, “Just like play and other forms of pleasurable activity, humour binds groups together. It is a form of communication that encourages closer participation than many other forms if group behaviour” (Lemma, 2003, p16) seems particularly pertinent. I
think it did help to maintain our group’s cohesiveness in the face of uncertainty regarding placements and difficult material about the Stride family.

One group member was more cautious about incorporating humour into our presentations. This encouraged interesting discussions about how we could present our material in a sensitive and appropriate manner, whilst still having humorous and enjoyable elements. This prompted me to consider Lemma’s (2003) ideas about humour as a weapon or a shield, and the aggression that can be present. I felt that we were using humour in a sensitive way which enhanced, rather than denigrated or belittled the topic. However, I was reminded that humour can be used as defence against pain, and this was a painful topic.

My recent clinical experience has afforded me the opportunity to work with people with learning disabilities. At times the difficult emotions experienced by people with learning disabilities seem to be belittled or laughed off by some of the people who care for them. One client I am working with often smiles when she is talking about difficult emotions. Hollins & Sinason (2000) talk of compliance and excessive smiling of a false kind as possible responses of people with a learning disability to an unconscious fear of annihilation (fear of death or murder as part of a group that society wishes to eliminate).

Another concept that the PBL prompted me to think about, related to the use of humour, is that of emotional intelligence. There is often a focus on cognitive functioning and everyday living skills in learning disability services. I have undertaken such assessments on placement. Our PBL talked about parenting assessments – how able Mr and Mrs Stride are to carry out caring tasks and their capacity to learn new skills.

We did not discuss the Stride’s emotional intelligence. This is broader than the traditional concept of cognitive intelligence and seems to be a key factor in
academic, occupational and interpersonal success (Reiff et al, 2001). Emotional intelligence is the skilfulness in the ability to mediate and regulate emotions in oneself and others (Reiff et al, 2001). I think this can sometimes get overlooked in services, and this was mirrored in our approach to the exercise. Again, there was a focus on doing, for example completing skills assessments with Mr and Mrs Stride. However, at no point did we consider spending time with the family in order to gain a sense of their emotional intelligence as part of their capacity to parent.

**Tensions**

The PBL also highlighted some tensions that we are faced with. One of the tensions that I felt faced with was the pressure to assess an individual's competence in my role as a psychologist. Undertaking this whilst withholding preconceptions and judgements is sometimes difficult. This is particularly difficult when in a legal framework and in a culture of accountability (both in Western culture and that of the National Health Service). This also touches on the issue of transparency in clinical practice. The PBL served as an important reminder for me that I wish to remain transparent in my clinical practice and inform clients about the process of my work. It is also a reminder of the power that psychologists can hold within society and the responsibility that accompanies this.

Another tension that has been recently highlighted in my clinical work is feeling the pressure of doing rather than being. Often, in my experience, people with learning disabilities are done to. There is pressure on services to encourage people with learning disabilities to be autonomous and independent in order to lead fulfilling lives. Whilst I agree with this in principle I believe it has to be flexibly applied. As psychologists it is important to step back and contemplate this. Sometimes it is valuable to provide a space where people with learning
disabilities, as indeed everyone, should have the opportunity to just be. Just as I found myself being pulled into an action phase in the PBL, where the completion of concrete tasks was inviting, I have to avoid this temptation in my clinical work. This raises important questions about my own, and services, expectations of my role as a trainee clinical psychologist and what constitutes a successful intervention.

In conclusion, this reflective account has highlighted my desire to act and do when faced with a context of uncertainty and possibly anxiety. It has reminded me of some of the qualities that I value in my work, namely: humour; providing clients with a space to feel listened to and accepted; and thinking about the person as a whole, rather than focusing on just cognitions or just behaviours. I have also been reminded of the tensions that can arise when psychologists are expected to make recommendations about complex issues in a culture of accountability.

2,000 words

References


Problem Based Learning Reflective Account

February 2008

Year 3
Introduction
The following text contains an outline of the final problem based learning (PBL) exercise that I completed with my fellow case discussion group members. I describe the problem that we were asked to address, the presentation that we gave and my reflections on the process related to my experiences on placement.

The Problem
We were presented with a problem entitled "Working with Older People" in which the difficulties of Mr Khan – a 72 year old Pakistani man with memory problems – were depicted. Mr Khan's youngest daughter had contacted Social Services about her concerns for her father's health and memory problems. She had also asked her older sister to return from Pakistan to help make decisions about his care. Mr Khan's wife had died only 9 months previously. Mr Khan is Muslim, but has fallen out with his mosque and no longer visits, choosing to pray at home.

The Presentation
When contemplating the final presentation, we wanted something that might sensitively capture the issues involved, but that would also engage our audience. We bore this in mind when considering the format and the content. Initially we collected relevant articles and chapters that focused on memory difficulties and the cultural factors that were pertinent to the problem we were faced with.

Ultimately we decided to present the problem and our thoughts about it using the family therapy technique of sculpting. This is a technique whereby a family member conveys their relationships with others and way of being in a family through spatially positioning the members in relation to themselves and others, and potentially sculpting members' postures (Carr, 2006). We demonstrated how Mr Khan might position his daughters, the Imam from his mosque, Social Services and Mental Health Services in relation to himself and each other. We felt that placing Mr Khan as the central component of the presentation was
Problem Based Learning Reflective Account, Year 3

paramount. This meant that we did not lose sight of Mr Khan's perspective. We enacted the sculpt as Mr Khan might have done and narrated his decisions along with the possible responses of his family members and service representatives (a Social Worker and a Psychologist).

The Process

Stages and Transitions

Whilst working with older adults on placement, and having worked with clients across the lifespan, I have come to realise the importance of stages and transitions.

One stage that I was reminded of during this PBL was the stage of my training that I am at. This was the last PBL that we would complete, as this is the final year of training. This prompted me to contemplate what I had completed and achieved, but also where I was heading and what I will do when I qualify as a clinical psychologist. It also reminded me that this is part of a larger, ongoing process, and that I have the next professional transition of becoming newly qualified to manage.

A common theme that seemed to be shared across groups was the way that we approached the task in relation to our stage in training. As a group, we felt able to take a more relaxed approach to the PBL exercise. It was a familiar concept and a process that we had experienced before with pleasing results. I believe that we were comfortable with using triggers from the problem scenario to define our own learning objectives (Wood, 2003), which may have felt somewhat anxiety provoking in the past. I think that I was more able to manage multiple demands and be realistic about the time we should spend on the task. Our group had reached the point where we could orient towards meaning making rather than fact finding (Rhem, 1998) once we had a rudimentary grasp of the literature regarding older people, dementia and ethnicity. Managing competing demands
of clinical and academic work will, I believe, be a great skill to have developed when working as a clinical psychologist. This will hopefully assist me in making the transition to a qualified clinical psychologist.

An even wider context that I considered was my own life stage and this prompted me to think about my own lived experiences. Working with older adults has encouraged me to face my own ideas, and indeed fears, about what becoming an older adult might be like. My clients on my older adult placement have highlighted to me the differences in our ages and stages, and in some cases world view. This has, at times, been a challenge to the therapeutic relationship. Whilst some clients have accepted our age differences and continued to work therapeutically with me, others have found this more challenging.

Our group made an additional transition that we had not encountered before. Our case discussion group had a new constellation as one group member left and a new member joined. I have reflected on this in previous arenas, so I will not dedicate much text to this issue. However, I had assumed that our group would remain the same for the whole duration of training, and this was not the case. The group member who left had spent some time making the decision to remain in the group or leave, so it was a relief to have a definite decision which enabled me to consider the future direction and compilation of the group. Whilst it was sad that the group member felt unable to remain within the group, I had found them challenging to work with. The PBL was timely in giving us a focus to facilitate the joining of the new member. I have enjoyed having the new member join and have found them to be thoughtful and reflective.

**Working with difficult dilemmas – diagnosing dementia**

One issue that has been challenging for me, both in the PBL and on placement, is that of diagnosing dementia. There is a fine balance to be struck in not assuming that an older person has dementia, but at the same time remaining
open to it as a possibility and part of a formulation. There also needs to be high levels of sensitivity when discussing the possibility of dementia as a diagnosis and careful preparation when assessing an individual. The issue of informed consent is paramount along with discussing the level of information that a client would like to receive. As it can be a potentially painful process to go through, we have to reflect along the way in order to respond appropriately and provide support. The support needed by ethnic minority groups appears to be in the main similar to those from the white population (Dementia Plus, 2002). However, this is a complex issue as people from minority populations may be underrepresented in older adult services and residential homes as these may be viewed as unacceptable (Milne & Chryssanthopoulou, 2005).

Clearly it is important for health professionals working with people with dementia, or providing assessments investigating the possibility of dementia, to consider their own responses to their clients. It is crucial that professionals reflect on their own attitudes towards aging as this can impact the decisions that they make about patient care (Golden & Sonneborn, 1998).

Professionals remain reluctant to share a diagnosis of dementia with someone, despite research that shows sharing this information can enhance psychological well-being and adjustment (Keightley & Mitchell, 2004). Research has suggested that professionals worry about whether the person with dementia wishes to know their diagnosis and that they may harm them if they do not want to know, and that professionals feel a sense of hopelessness towards the person with dementia (Keightely & Mitchell, 2004). As suggested by Kaplan (1990), being with people with dementia is challenging as one is forced to “face the loss of what makes us uniquely human.” (Kaplan, 1990, p81).

Keightley & Mitchell (2004) also talked of the issue of the confidence that professionals had in their diagnosis – it was important for them to feel confident
that the diagnosis was correct. This is something that resonated with me when I have thought about sharing a diagnosis of dementia with clients. Diagnosis is often an arena that psychiatrists take a lead in, so the opportunities for sharing a diagnosis for something as fixed and permanent as dementia have been rare, and a taxing venture, for me.

**Ethnicity and the NHS**

One of the main points for reflection that was much discussed within our group was that of ethnicity and the cultural competence of the NHS workforce. It was a hard balance to strike when engaging with the PBL; acknowledging Mr Khan's culture and religious beliefs and forming loose hypotheses, but not stereotyping or making judgements based upon our own values or biases when utilising the limited information we had.

Our group was divided in whether we proposed that Mr Khan had dementia or not. Some members assumed that he had, whereas others wanted to emphasise the importance of Mr Khan's recent bereavement and other losses, such as the role of the Mosque in his life. Perhaps this was reflective of possible service responses. Patel *et al* (1998) suggested that mainstream dementia services are colour blind whilst ethnic minority communities may be dementia blind, which may lead to delayed referral to services.

It was sobering to revisit documents such as Inside Outside (National Institute for Mental Health in England, 2003) that suggest pervasive inequalities in the provision of and access to mental health service for minority ethnic communities exist. This document states that we have to begin by acknowledging that there is an overemphasis on institutional and coercive care, that professional and organisational requirements are given priority over needs of individuals and that institutional racism exists within mental health care (NIMHE, 2003). It is painful
to acknowledge such a reality when training and working within this organisation. It also a concept that is easy, and sometimes preferable, to avoid thinking about.

Bhugra & De Silva (2007) acknowledge that cultural competence is essential for assessing and managing patients. They suggest using the media of film and literature to invite trainees to consider ideas about culture and difference. By engaging with appropriately selected material, trainees can develop discussions and potentially insight into how cultures approach mental illness and abnormal behaviours in a non-threatening way. I would argue that through engaging with the PBL in the safety of the academic setting, my cultural competence has been enhanced.

Summary
Writing this account has served to remind me of a number of themes. The first is the importance of recognising the stage that I, my clients and my colleagues are at. Related to this is the importance of transitions that one experiences at a number of levels and within different contexts. Completing this final account is a reminder of my stage in training, and working with older adults has highlighted my life stage.

Recognising my own position in relation to clients, along with acknowledging and managing their perceptions of me, has also been emphasised. This is in relation to beliefs and views about age, culture and religion. The work of a clinical psychologist involves managing difficult dilemmas and challenges. It is vital to remain reflective during these processes and it is dangerous not to recognise the impact of one’s own values and beliefs. The needs of an individual in receipt of any sort of care should remain paramount.

There are difficult realities surrounding the issues of ethnicity and culture. These should not be avoided, but embraced, if a culturally competent NHS is to emerge.
There are creative and less threatening ways to engage in discussions about these issues, such as the use of PBL exercises and utilising media such as films and literature.

I hope to remain thoughtful, reflective and acknowledging of my own beliefs and values as I negotiate various transitions and throughout my practice as a clinical psychologist.

References


Case Discussion Group Process Account 1 Summary

This account contains my reflections on the process of participating in a case discussion group (CDG), of which I had belonged to for one year. I considered my position within the group, along with the group's formation and development over the course of the year. I considered the psychodynamic concept of the "good enough" group and how this applied to our CDG. I also drew on Foulke's (1964) way of understanding groups to take into account the complexity within the group. I reflected on the diversity represented within the group in terms of gender, ethnicity and previous experiences and the impact of the facilitator. Contemplating other models of supportive groups was also included. The account was a useful space in which to reflect in the complex and dynamic nature of groups and identify valuable learning experiences gained.

Case Discussion Group Process Account 2 Summary

Within this second process account I share the dilemma of using the space to write in a vague non-commital way or take risks and write explicitly. The parallel dilemma that may exist with clients and their therapist was highlighted. The similarities between the unreliability of the British weather and the unpredictable nature of the group were drawn out. The challenges of being a member of the group were highlighted and the processes of sub-grouping and forming of anti groups were identified. The process of taking risks within the group and the possible defence mechanisms that were employed were also outlined. Attention was paid to the notion of containment and the importance for professionals and clients to feel contained was emphasised. The account reminded me of the importance of containment, timing and the creation of a safe space for both qualified and trainee Psychologists and their clients.
Cognitive Behavioural therapy with a 45 year old man presenting with depression and anxiety

Referral
Derek Olawu was referred to the Community Mental Health Team by his GP for symptoms of depression and anxiety.

Presenting Problems
An assessment revealed that Derek was low in mood, had difficulty sleeping, experienced headaches and had intense feelings of anxiety. He had a strong desire to die and risk was monitored throughout. Standardised measures, along with Derek’s subjective reports, suggested that he was severely depressed.

Background History
Derek was born in Nigeria and moved to the UK when he was 3 years old. His father was physically and emotionally abusive towards him. As an adolescent Derek was involved with the juvenile justice system and he left school with minimal qualifications. Since the recent death of his mother Derek had been unable to work. Derek was socially isolated.

Formulation
Derek’s difficulties were conceptualised using a cognitive behavioural approach. This suggested that his early experiences of abuse and academic underachievement led to his bottom line, which led to the development of dysfunctional assumptions. Following the critical incident of the death of his mother and Derek’s grief rendering him unable to work, he could no longer meet his standards. This resulted in Derek feeling depressed and anxious and was maintained through a cycle of altered behaviours, thoughts, feelings and physical sensations.
**Intervention**

Derek attended seven sessions of cognitive behavioural therapy. This included: psycho education; sharing the formulation; completing a goal list, thought records and behavioural experiments; and reflecting on how his culture influenced his beliefs.

**Outcome**

Derek developed insight into how his difficulties were shaped by his early experiences and maintained by current patterns of thoughts, feelings and behaviours. Whilst he was still depressed and anxious, Derek was less hopeless and was able to engage in more activities. He was referred to another professional with the team for further input. A reformulation drawing on grief and attachment literature was developed. The intervention was reflected on and critiqued.
Adult Mental Health Case Report 2 Summary

Short term Psychodynamic Psychotherapy with a 32 year old woman
presenting with depression and anxiety

Referral
Marie was referred by her GP to the Primary Care Psychological Therapy Service for depression and poor sleep.

Presenting Problems
Marie was experiencing low mood, feelings of worthlessness and reduced activity levels. She was isolated and felt very anxious. She was experiencing difficulties at work and was concerned with the end of her six year relationship. Marie had elevated scores on the General Health Questionnaire.

Background History
Marie grew up with France and was looked after by her family of origin and a second family, which were very different in many ways. The father of the second family died suddenly and contact/care was cut abruptly when she was 11 years old. Marie was bullied at school and felt bullied by university tutors throughout her academic career in France and the UK.

Formulation
Marie’s difficulties were considered using Coren’s (2001) therapeutic triangle, using the themes of history and content, therapeutic process and recurring motifs. Using Fairburn’s object relations theory, Marie’s sense of self was hypothesised as oscillating between a conflicting need for closeness and need for separateness.
Adult Mental Health Case Report 2 Summary

**Intervention**
Marie attended 10 sessions of brief psychodynamic therapy. Given Marie's split sense of self I tried to foster her ability to reflect on her sense of self – to begin to make connections with her self and patterns of relating and develop a narrative of herself. This used the external focus of work and relationship experiences and the internal focus of experiences in the room.

**Outcome**
Marie was able to develop a meaningful relationship with me and she reported that her mood had improved. She was less paranoid about work and felt better about the end of her relationship. Longer term therapy was discussed and Marie intended to access this privately. The formulation was further developed using theories from Klein, Winnicott and Steiner. The dilemma of offering a time limited intervention to an individual who would benefit from longer term work was discussed.
An integrative intervention with a 39 year old with mild learning disability and epilepsy drawing on Cognitive Behavioural and Solution Focused Brief Therapy principles

Referral
Maria Gillimore, a White British Roman Catholic woman with Italian heritage, was referred by her Care Manager to the Community Team for People with Learning Disabilities.

Presenting Problems
Maria was stressed about caring for her mother and was concerned about her anger. A support worker, with whom she had a close relationship, had ceased contact due to Maria’s angry outbursts and this distressed Maria. With support, Maria completed the BDI (in the normal range) and BAI (mild anxiety range)

Background History
Maria was living at home with her family. Her mother had chronic mental health difficulties along with possible learning disabilities. Maria’s family were reported to have a fraught style of interaction. Maria had previously met with a Clinical Psychologist and had learned strategies to reduce her anger and increase her social skills. Maria was limited in her autonomy by her epilepsy.

Formulation
An integrative formulation was devised in order to encompass Maria as an individual located within her family and wider social context. This focused on different levels of analysis (individual and systemic), various events/factors (triggering and maintaining) whilst drawing on different therapeutic models.
Intervention
Maria attended six sessions which drew on cognitive behavioural and solution focused techniques. Maria reinstated her mood diary which she went on to share with support workers. We compiled a list of difficulties and prioritised her angry outbursts as a focus for the work. This was most likely to occur when Maria needed to make decisions and, by using strategies that already aided Maria in making decisions and applying them to new situations, we were able to reduce Maria's frustration and outbursts.

Outcome
Maria's scores on the BDI and BAI were reduced. Maria felt that the sessions were helpful and reported that she was less angry. Maria had been able to maintain relationships with her support workers and had not had angry outbursts. Maria was referred for longer term counselling, which she had requested following discussions with her family and care manager. A reformulation was presented using attachment theory related to people with learning disabilities and the work was critically evaluated.
Child and Family Case Report Summary

Cognitive Behaviour Therapy, integrating Systemic theory, with an 11 year old girl experiencing depressive symptoms and self-harm

Referral
Hannah Bowman was referred by her GP to the Child and Adolescent Mental Health Service following concerns that she had harmed herself.

Presenting Problems
Hannah had harmed herself on three occasions at home and school. She reported feeling sad and angry, particularly about her father’s absence. She had recurrent thoughts about harming herself and felt that she was a horrible person. Standardised measures and reports from Hannah indicated that she was experiencing elevated levels of depression.

Background History
Hannah lived with her mother, sister and step father. Her parents separated following episodes of domestic violence which Hannah witnessed. Hannah had not seen her father for six years. Hannah was doing well academically at school, although there were periods of time where she fell out with her friends. Hannah’s mother had resumed taking antidepressant medication.

Formulation
A formulation was devised using a cognitive behavioural framework, which incorporated Hannah’s early experiences and the development of her core beliefs and assumptions. It conceptualised the difficulties as arising from the assumptions not being met which led to negative automatic thoughts and associated changes in feelings and behaviours.
**Intervention**

We used cognitive behavioural therapy alongside the systemic technique of externalising Hannah’s negative thoughts (these became Colin the monster). We explored thinking errors, behavioural strategies, relaxation and problem solving. Hannah attended 13 sessions and we had two family sessions. Risk was monitored throughout and systemic theory was employed to incorporate family relationships in the work.

**Outcome**

Hannah’s scores on standardised measures and reports from herself and her family indicated that her mood had improved. Hannah reported that she could now share her worries with her family and that she would not use self harm to manage her distress. Hannah’s family were spending more time together and enjoying this and she was less concerned by her father’s absence. The therapeutic work was reflected on and evaluated.
A neuropsychological assessment for dementia with a 62 year old man

Referral
Mr John Wilson was referred to the Older People Community Mental Health Team by his GP regarding concerns about his memory.

Presenting Problems
Mr Wilson was worried about his memory. He felt that whilst his long term memory had remained intact, his short term memory had deteriorated. He would forget where he had put things, forget what he had said and relied more on writing tasks down. This had impacted on his work as an accountant.

Background History
Mr Wilson had a kidney transplant operation requiring a long general anaesthetic. He was diagnosed with hypertension in his early 20s and this had been subsequently managed. Mr Wilson described a period of being mentally confused after receiving an ill calculated elevated dose of medication. Mr Wilson was taking immunosuppressant medication, had cataracts in both eyes and an aneurism in his abdomen.

Assessment
Hypotheses were devised and tested regarding whether Mr Wilson’s neuropsychological profile was consistent with age appropriate memory impairment, cognitive impairment and, based on epidemiology, Alzheimer’s Disease or Vascular Dementia. A battery of tests was selected in order to assess all cognitive domains. The tests all had appropriate norms, reliability and validity, were tolerated by Mr Wilson and were readily available in the service. Mr Wilson
received pre assessment counselling and gave his full consent for the assessment process.

**Outcome**

Mr Wilson's performance on the tests varied. They revealed high pre morbid intellectual functioning and current varied intellectual functioning. Mr Wilson performed below the expected level in a number of areas, with deficits in his memory and speed of processing highlighted. It was hypothesised that Mr Wilson may have been in the early stages of dementia. Given his physical health presentation, which included risk factors for Vascular Dementia (hypertension, aneurism, changes shown by CT scan) it was possible that Mr Wilson had Vascular Dementia. The results were fed back to Mr Wilson and his wife and recommendations were made. The assessment was considered to be comprehensive and ethically conducted, although limitations and omissions were acknowledged.
Adult Mental Health Placement Summary

Setting:
Specialist Psychotherapy Department, split with concurrent 6 month placements in a Community Mental Health Team and Primary Care Psychological Therapies Service.

Dates:
02.10.05-22.09.06

Models:
Psychodynamic Psychotherapy (long term and brief), CBT, Systemic.

Range of experiences:
Clinical work was undertaken with clients with a range of presenting problems, including OCD, agoraphobia, schizophrenia, depression, anxiety, bereavement, relationship difficulties with domestic violence, vomit phobia. Clients with difficulties adjusting physical health diagnoses (multiple sclerosis, COPD) were also seen. Long term psychotherapy was undertaken with a female with a diagnosis of borderline personality disorder. Clients were diverse in age, sexual orientation and cultural background. Observations of, and joint work with, other professionals in multidisciplinary teams was undertaken, along with independent clinical work in a range of settings. Assessments, formulations and interventions were completed which drew on CBT, systemic and psychodynamic models. Standardised measures were used, including the HADS, BDI, BAI, CES-D, Lebowitz Social Anxiety Scale, Y-BOCS, CORE and GHQ. Individual and group supervision was attended, along with meetings with other services in the trust to gain knowledge of additional services available to clients. A leaflet was produced to provide service users with information about psychological therapy in primary care. I completed a service evaluation of patient drop out from the Psychotherapy Department, which was presented at a team meeting.
People with Learning Disabilities Placement Summary

Setting:
Community Team for People with Learning Disabilities

Dates:
11.10.06-23.03.07

Models:
Systemic, CBT

Range of experiences:
Clients were seen who varied in age, level of functioning and needs. I worked with clients who were referred for difficulties including severe obsessions and compulsions, challenging behaviour, making a transition to new accommodation, bereavement, anger and depression. Assessments were undertaken to establish whether a new client met classification for learning disability (WAIS-III, assessment of activities of daily living) and to complete a follow up assessment for dementia (Dementia Rating scale-2). Other standardised measures were used to form parts of assessments. Direct work with clients and indirect work with other professionals and carers was completed. A 10 session group for 8 adults with a diagnosis of Asperger's Syndrome was co-facilitated. A case presentation was made to the Psychology and Challenging Needs Team and challenging behaviour training was delivered to staff of a residential home. Work was carried out within a variety of settings, including day centres, clients' homes and at the team base. I also acted as a member of the reflecting team in the family therapy clinic, following attendance at workshops on working systemically with people with learning disabilities. I also returned to an adult service to complete a psychometric assessment with an adult mental health forensic patient (WAIS-III,WTAR).
Child and Family Placement Summary

Setting:
Child and Family Consultation Service

Dates:
04.04.07-21.09.07

Models:
CBT, systemic, developmental.

Range of experiences:
Clients were seen who varied in age from two to 17 years old and presented with difficulties including behavioural problems, attachment difficulties, trichotillomania, school difficulties, Asperger's syndrome, depression and self harm, encopresis and enuresis, eating difficulties, microcephaly and ADHD. Two children were adopted and all were from different social, economic and cultural backgrounds. Psychometric assessments were undertaken with one child with Turner's syndrome and one child with Ehlers Danlos syndrome to assess their intellectual functioning (WPPSI-R, WISC-III). Individual and family assessments and interventions were undertaken drawing on CBT, systemic, developmental and attachment models. An attachment intervention was jointly undertaken with a social worker. Liaison with schools, health visitors and other services also formed part of assessments and interventions. I was able to observe the trauma clinic which used EMDR. Conferences on the therapeutic relationship and early interventions in young people with psychosis were attended. I delivered a presentation on attachment theory and associated interventions to the multidisciplinary team. An extended assessment was also completed in the primary care service. Standardised measures were used, including the parenting stress index, SDQ, Adolescent emotional eating scale, childhood measures of depression and anxiety. Two team away days were also attended.
Older People Placement Summary

Setting:
Older People Community Mental Health Team, with half a day in a physical rehabilitation unit.

Dates:
10.10.07-28.03.08

Models:
CBT, psychodynamic

Range of experiences:
Clinical work was undertaken with older people who ranged in age from 62 to 93 years. A variety of presenting problems, including depression, adjustment difficulties, physical health difficulties, anxiety disorders and bereavement were seen within the placement. I met with clients at the outpatient hospital, mental health ward, day centres and physical rehabilitation unit. I undertook individual clinical work, presented a talk on psychological adjustment to physical health problems to a group for patients with COPD and co-facilitated a memory group. I also co-presented an interactive talk on working with older adults to Graduate Mental Health Workers. I undertook an observation on the organic ward and presented a policy document on safeguarding vulnerable adults to the Psychology Department. RiO training, breakaway techniques and the use of CBT techniques with older adults were events attended whilst on placement, along with an away day on New Ways of Working. I also completed two extensive assessments for dementia, using a battery of psychometric assessments, which were completed in an ethical fashion.
<table>
<thead>
<tr>
<th></th>
<th>RESEARCH LOG CHECKLIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
</tr>
</tbody>
</table>
Qualitative Research Project Abstract

Rationale
Representations of mental illness, specifically schizophrenia and psychotic illness in the print media did not match the understanding of the authors. Research such as the SHIFT Report (2006) indicate that this is widespread. We hoped to generate a conceptualisation of the power differentials between people with mental illness, the general public and the media.

Methodology:
We opted to use critical discursive psychology, combining discursive psychology with Foucauldian discourse analysis to facilitate an understanding of how texts depict issues of power using language (Coyle, 2006).

Sources:
Stories from 6 newspapers on one case during a specific time period were selected.

Analysis:
We each analysed a portion of the articles by identifying common themes and discussed our findings with the rest of the group.

Results:
Our analysis yielded five categories of discursive patterns: ‘Mad or bad’, ‘blame’, ‘medication’, ‘outgrouping’ and humanising / dehumanising’. We focused our discussion on this last theme based on the culture of our work as this seemed particularly relevant to the issue of power.
Discussion:
Media reporting was found to support hypothesised prejudices, using sensationalist language and drawing on categorisations such as 'good versus bad' so removing the need for readers to generate their own views. Language seemed geared to strengthening the reader's emotional reaction, implying the inevitability and enjoyment of violence in psychosis. The positioning of these themes visually and conceptually led the reader to dismiss the individual's identity beyond his behaviour. This occurred at a time of public concern surrounding mental illness.
Service Related Research Project:
An Investigation of Dropout in a Psychotherapy Department

July 2006
Year 1
INTRODUCTION

Drop out of patients in psychotherapy is common and an important issue. Wierzbicki & Pekarik's (1993) meta analysis reported that the mean drop out rate from psychotherapy was 46.86%. Previous research has indicated even higher psychotherapy drop out rates (Blakeland & Lundwall, 1975; Garfield, 1994).

Self et al (2005) emphasise the increasing attention paid to the effectiveness of psychological therapies. They highlight that the introduction of clinical governance (Department of Health, 1997) has promoted the evidence-based philosophy in the NHS. However, ‘The finding that drop-outs are ubiquitous in psychotherapy is very damaging, for if patients do not stay in treatment, then there is little point in developing effective treatment.’ (Hunt & Andrews, 1992, p.275). Indeed, the high proportion of outpatients who drop out of treatment presents, ‘…one of the greatest single obstacles to the effective delivery of mental health services…’ (Pekarik, 1985a, p.114).

Dropout is detrimental to the systems that deliver services. Drawbacks of dropout include: reduced treatment cost effectiveness and efficacy; lowered community credibility of services; and reduced job satisfaction and performance for clinicians (Pekarik, 1985a; Garfield, 1986).

Treatment outcome is poorer for patients who drop out of therapy because they are dissatisfied (Pekarik, 1992). Patient satisfaction is also typically lower in those who drop out (Lebar, 1982).

Research has investigated the impact of a range of variables on drop out, with inconsistent findings reported. Dropout does seem to be related to socio economic status, level of education and ethnicity, but not related reliably to other variables, such as age and gender (Baekeland & Lundwall, 1975; Garfield, 1994;

Self et al (2005) looked at dropout from psychotherapy at various stages of the healthcare pathway in Yorkshire. They found those patients with higher levels of social deprivation were less likely to attend their initial appointment and more likely to terminate therapy in the early stages. Self et al (2005) suggest that this might provide an explanation for conflicting findings and that socio economic status effects only initial and early therapy attendance.

Research investigating more complex variables has found more powerful relationships. Clients' expected treatment duration was a better predictor of actual treatment duration than other variables (Pekarik, 1991; Pekarik & Stephenson, 1988; Beck et al, 1987; Pekarik & Wierzbicki, 1986). Patients are also more likely to dropout if the therapist does not recognise patients' problem definitions (Epperson et al, 1983; Pekarik, 1988). This effect is more pronounced for experienced counsellors (Eperson et al, 1983).

Whilst ethnicity and socio economic factors are important, the findings of much dropout research are weak and inconsistent. Pekarik (1985b) partly attributed this to the different definitions of drop out used in the research. Wierzbicki & Pekarik (1993) found that drop out differed significantly as a function of the definition of drop out employed by investigators. Therapist judgement, rather than using a duration criteria, was suggested as the best method of defining dropout (Pekarik, 1985b; Wierzbicki & Pekarik, 1993).

Much of the dropout research has been conducted in the USA. The research is also conducted across a range of psychotherapy services operating in unique settings and offering different models of psychotherapy. Garfield (1994) recommends each service should evaluate its own unique patterns of
continuation and outcome order to provide meaningful data and improve service delivery. This was the intention of the Psychotherapy Department.

The Psychotherapy Department offers psychoanalytic psychotherapy to adults in three different modalities. Patients are referred to the department by GPs or other mental health services. Patients are asked to opt in by completing and returning a questionnaire that requests demographic information and descriptions of the patient's background and current difficulties. On receipt of this questionnaire the patient is added to the assessment waiting list and subsequently offered an appointment.

On completion of the assessment process a decision is made regarding the most appropriate form of therapy. The patient may be offered long term (40 sessions) or brief (15 sessions) individual therapy or group therapy. Patients may also be referred on to a more appropriate service. They are then placed on the therapy waiting list and offered an appointment when the next available therapist has a vacancy. The patient then attends a business meeting where the framework of therapy is explained and therapy subsequently begins.

The Psychotherapy Department was interested in identifying factors which influenced dropout during these stages. Patient and therapist factors were highlighted as of interest. Through discussion, these factors were reduced to: patient gender and ethnicity; level of patient motivation, insight and personality resources; therapist gender and level of experience; and the stage of the pathway that dropout occurred.

The aim of this service evaluation was to evaluate the impact of these variables on dropout from psychotherapy. The hypotheses were that there would be relationships between patient gender, ethnicity, level of motivation, insight,
personality resources and dropout from psychotherapy. Also, that there would be a relationship between therapist gender and level of experience and dropout.

**METHOD**

The sample consisted of 132 adults referred to the Psychotherapy Department between April 2003 and March 2004. The sample was obtained from a Departmental database, which routinely records all clinical activity. This sample was approximately half the usual number of annual referrals, which is typically in the region of 250. Two factors accounted for this diminished number of recorded referrals. The first is that during 2003 the current database was introduced as a new way of routinely recording patient information. Some data may not have been entered during this transition when staff negotiated this new process. In addition, it seems that only patients who attended an assessment appointment have been recorded. Therefore data about patients who dropped out prior to an assessment appointment allocation, or who did not attend an allocated assessment appointment, have not been captured. Despite this, it was felt that data collected during 2003-2004 was the most useful as a sufficient amount of time would have elapsed in order for patients to have completed long term therapy of 40 sessions.

The database provided patients' demographic data, stating address, ethnicity and gender. Further information was obtained from individual patient assessment reports, discharge summaries and notes and correspondence. Assessment reports and discharge summaries are kept in the Department, along with some patient files. Information was also obtained from files stored in Medical Records. These information sources provided details about diagnoses; patients' motivation, insight and resources; outcome of assessment; number of sessions attended and missed; the clinician who conducted assessment and provided therapy; and the outcome of therapy.
Information about patients' motivation, insight and resources (whether it was strong, moderate or poor) was subjectively measured by the assessing clinician. The outcome of assessment was defined as whether the patient was placed on the waiting list for therapy (long term, brief, group), deemed unsuitable for psychodynamic therapy, referred on, moved out of area or dropped out of the assessment process. Outcome of therapy (terminated prematurely or completed satisfactorily) was assessed by the clinician who provided therapy.

However, many of the patient assessment and discharge reports were either missing or did not contain the desired information. Therefore a subset of patients was selected and additional information sought. These patients were selected on the basis of whether a basic level of information was currently accessible. If information about patients’ demographic details and an assessment report stating their level of insight, motivation and resources were available then they were selected for further investigation. This basic level of information was necessary in order to look at patterns of dropout. The Psychotherapy Drive on the IT network was then searched for documents and correspondence related to each patient. This detailed searching enabled most of the required data to be collected for this subset of patients. Analysis of this smaller sample was then made possible using Chi Square (selected as categorical data was collected) to look at the relationships between patient and therapist variables and dropout.

RESULTS

Demographics
The initial sample consisted of 132 patients. 36 patients were selected from this to comprise the smaller sub sample. Figure 1 displays the demographic information for the overall and smaller sub samples. The smaller sub sample was similar to the larger sample in terms of patient gender, ethnicity and
diagnoses. Gender composition was comparable in both samples, with over 60% of both samples being female. Ethnicity was also similar, with the majority of the samples categorising themselves White British. Diagnoses of various types of depression and borderline personality disorder dominated both samples.

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Large Sample (n=132)</th>
<th>Smaller sub sample (n=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>48 (37%)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>81 (63%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td></td>
<td>80 (61%)</td>
</tr>
<tr>
<td>Any other White background</td>
<td></td>
<td>12 (9%)</td>
</tr>
<tr>
<td>Caribbean – Black/British Black</td>
<td></td>
<td>11 (8%)</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td></td>
<td>5 (4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 (2%)</td>
</tr>
<tr>
<td>African – Black/Black British</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other mixed background</td>
<td></td>
<td>5 (4%)</td>
</tr>
<tr>
<td>Mixed White &amp; Black African</td>
<td></td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Mixed White &amp; Black Caribbean</td>
<td></td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Pakistani – Asian/Asian British</td>
<td></td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Patient declined to state</td>
<td></td>
<td>6 (5%)</td>
</tr>
<tr>
<td>Missing</td>
<td></td>
<td>6 (5%)</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Large Sub Sample</td>
<td>Small Sub Sample</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>8 (15%)</td>
<td>6 (17%)</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>6 (5%)</td>
<td>6 (17%)</td>
</tr>
<tr>
<td>Recurrent Depression</td>
<td>14 (10%)</td>
<td>5 (14%)</td>
</tr>
<tr>
<td>Depressive Episode</td>
<td>6 (5%)</td>
<td>4 (11%)</td>
</tr>
<tr>
<td>Depressive Disorder</td>
<td>2 (2%)</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Depression with Anxiety</td>
<td>3 (3%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>1 (1%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>1 (1%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Other Personality Disorders</td>
<td>3 (3%)</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol Dependency</td>
<td>1 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Prolonged Depressive Reaction</td>
<td>1 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Other Depressive Episode</td>
<td>1 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Mild Depression</td>
<td>1 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Bipolar Affective Disorder</td>
<td>1 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Grief Reaction</td>
<td>1 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Dependence Syndrome</td>
<td>1 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Missing</td>
<td>69 (37%)</td>
<td>10 (28%)</td>
</tr>
</tbody>
</table>

*Figure 1*, demographic information for large and small sub sample.

**Stage of Dropout**

The data obtained from the Department only contained information of patients who opted in and attended an assessment appointment. Therefore patients who dropped out before this stage cannot be accounted for. *Figure 2* displays the available data for dropout following assessment and the numbers of patients...
allocated to therapy waiting lists. Out of 132 patients, 23 dropped out prior to being allocated to a therapy waiting list. 24 were allocated to the long-term waiting list, 23 to the brief waiting list and 23 to the group waiting list. Data was missing for 39 patients; therefore it is difficult to highlight any patterns.

**Assessments**

n=132

- Dropped out n=8
- Unsuitable n=8
- Onward referral n=3
- Patient moved n=4

(total n=23)

- Long term waiting list  
  n= 24
- Brief waiting list  
  n= 23
- Group waiting list  
  n= 23

Missing data n=39

*Figure 2*, early stage of dropout

Figure 3 displays dropout figures from the sub sample of patients. More patients were referred for long-term therapy, followed by brief therapy and group therapy having the least referrals. Both long term and brief individual therapy had similar rates of dropout (around 40%). However, group therapy had proportionally higher rates of dropout (78%). However, these results are not necessarily indicative of a trend. The numbers are small and the sub sample may not be representative of the larger overall sample. There may be many patients who completed group therapy but were not represented within the sub sample.
Selected cases n=36

Long term individual therapy n=15
  Dropped out n=6 (40%)
  Completed therapy n=8 (53%)

Brief individual therapy n=12
  Dropped out n=5 (42%)
  Completed therapy n=5 (42%)

Group therapy n=9
  Dropped out n=7 (78%)
  Completed therapy n=1 (11%)

Figure 3, Stage of dropout from the sub sample of patients

Patient Variables
The relationships between the patient variables of gender, ethnicity, levels of motivation, insight, resources and the variable of outcome of therapy were explored using chi square tests of independence. Due to the small numbers of patients (n=36), it should be noted that therapy outcome was reduced from 8 variables, detailing stage of drop out and whether it was negotiated, to 2 variables of complete or did not complete therapy. Although this was a crude reduction of the data it meant that statistical analysis could then be conducted. Frequencies and results of analysis can be viewed in figure 4.
<table>
<thead>
<tr>
<th>Patient Variable</th>
<th>Complete or did not complete therapy</th>
<th>Total</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete</td>
<td>Did not complete</td>
<td></td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>8</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Black &amp; Minority Ethnic</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td><strong>Motivation:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong</td>
<td>5</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Moderate</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td><strong>Insight:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Moderate</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td><strong>Resources:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Moderate</td>
<td>7</td>
<td>12</td>
<td>19</td>
</tr>
</tbody>
</table>

*Figure 4*, frequencies of patient gender, ethnicity, motivation, insight, resources and completion/ non completion of therapy.

There was no significant relationship between patient gender and therapy outcome, $\chi^2 (1, n=32) = .847, p>.05$.

The assumption of minimum expected cell frequency was violated for the variable ethnicity. This variable was condensed from all the options for ethnicity to White or Black and Minority Ethnic communities. Again, this was crude but was to enable basic analysis. Even when this variable was summarised the assumption was still violated.

There was no significant relationship between motivation and outcome of therapy, $\chi^2 (1, n=32) = 1.914, p>.05$. However, It is interesting to note that there
was a large number of patients (n=12) who had strong motivation but did not complete therapy, rather dropped out prematurely.

The assumption of minimum cell frequency was violated for chi square investigating the relationship between insight and therapy outcome. There was no significant relationship between personality resources and therapy outcome, \(\chi^2 (1, n=31) = .727, p>.05\).

**Therapist Variables**

The relationships between therapist variables of gender, whether therapist and patient gender were the same or different, level of experience and the variable of outcome of therapy was investigated using chi square tests of independence. Frequencies and Chi Square results can be viewed in figure 5.

<table>
<thead>
<tr>
<th>Therapist Variable</th>
<th>Complete or did not complete therapy</th>
<th>Total</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete</td>
<td>Did not complete</td>
<td></td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td><strong>Gender same/diff:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Different</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td><strong>Experience:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Medium</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

*Figure 5, frequencies and chi square analysis for therapist gender and level of experience*

Due to low numbers the assumption of minimum expected cell frequency was not met and chi square could not be utilised for therapist gender or level of experience. Female therapists seemed to have a higher completion rate, although it is unclear if this is a significant difference.
DISCUSSION

There were no significant relationships found between patient and therapist variables and outcome, where analysis was possible. This is consistent with some existing literature which has found weak or inconsistent results when investigating single, less complex variables (Blakeland & Lundwall, 1975; Garfield, 1994; Wierzbicki & Pekarik, 1993). The finding that dropout is related to ethnicity was not replicated. However, the variables could not be analysed in relation to stage of dropout, which Self et al (2005) identified as important.

There are many limitations that caution acceptance of these results and indicate that further investigation is warranted.

The sub sample of selected patients was small and still contained missing data. This meant that variable categories (i.e. for ethnicity and therapy outcome) had to be condensed in order to enable analysis using chi square. This lost the fine grain detail which is important and potentially meaningful. It also meant that analysis using chi square could not be conducted for some variables as the assumption of cell frequency was violated. General patterns could also not be detected due to the small numbers of patients.

The sample was also not a random selection and may not be generalisable. Selection occurred on the basis of whether information was easily accessible and may have resulted in a biased sample. The patients for whom information was available may have been assessed and treated by particular therapists. These could have been more experienced therapists who are familiar with the departmental systems and documenting information, or indeed less experienced therapists who are more concerned with, or have more time, to record such information. The sample could also have been comprised of patients who had
less complicated patterns of attendance which made recording of and interpretation of information from correspondence less complex.

This highlights the limitations of retrospective data collection. Whilst this was necessary in order to investigate whether patients had completed therapy it meant that data not recorded at the time could not be captured. The department has many honorary therapists who were no longer present at the time of the research and therefore could not elaborate on absent data.

Dropout is a complex and important issue and one that requires further investigation if useful results, which can enhance clinical practice, are to be yielded. In order to provide more meaningful results this service evaluation needs to be repeated with a larger, more representative sample. Data for patients who dropped out prior to assessment could also be captured.

Ways to reduce missing data need to be implemented before additional data collection takes place. Assessment reports should be completed for every patient who attends an appointment. These were not always present, or if they were present did not always contain the necessary information. The same applied for discharge summaries. Templates exist for these reports which stipulate the information required (see appendix i). Perhaps therapists need to be reminded of these templates and be given a clear rationale for documenting such information. It is also possible that these reports were completed but not filed in the department. The importance of correctly filing these documents could also be emphasised.

If future evaluation of this area is proposed then a simple form which collates all the necessary information could be developed and given to clinicians. In a busy NHS department this would need to be brief and accompanied by clear rationale to ensure its completion. Regular reminders, for example at department
meetings and through memos, could also increase the consistency of its completion.

Once sufficient data has been collected the service evaluation could be repeated. This would then enable potential dropout trends to be highlighted and current practice to be amended in response to the findings.

REFERENCES


Appendix I

Discharge Summary Template

DEPARTMENT OF PSYCHOTHERAPY
Final Summary of Treatment

Patient's name:
Hospital No. PO
Therapist: Dr and title
Treatment
Supervisor: Dr
First Session:
Total No. of sessions:
Sessions per week
Number of sessions missed:
Place of treatment: Psychotherapy Department,
Last session:

Main Issues in Treatment

Dynamic Understanding

Experience of being with the Patient

Changes

1. Any changes in symptoms and behaviour?

2. Any changes in intimate personal relationships?
3. Any changes in social life or at work?

4. Any changes in the therapeutic relationship as a whole?

**Area of Concern for the Future**

**Plan**

**Supervisor’s Comments**

**Outcome Code**

- TTFN  Treatment terminated satisfactorily.
- TDOP  Patient dropped out of treatment prematurely.
- TNBC  Treatment terminated satisfactorily but referred on.
- TTBT  Termination premature but negotiated, therapist’s action.
- TNBC  Termination premature but negotiated, patient’s action.

Please indicate code.

Dr.  
Specialist Registrar  
In Psychotherapy  

Dr.  
Consultant Psychotherapist
To Whom it May Concern:

Date: 20th February 2008

This is to confirm that Claire Edwards, Trainee Clinical Psychologist, presented the findings of her service related research project that looked at drop out from psychotherapy, to the Audit Meeting at the Psychotherapy Department, Springfield University Hospital, whilst on her placement here in 2007.

K. Golynkina

Dr Katya Golynkina C.Psychol., PhD
Consultant Clinical Psychologist and Psychoanalyst

Service Related Research Project

Evidence of feedback to service
Major Research Project

Mothers' Experiences of Solution Focused Brief Therapy in a Child and Adolescent Mental Health Service: An Interpretative Phenomenological Analysis.

July 2008

Year 3
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ABSTRACT

Objective: To explore mothers’ experiences of attending solution focused brief therapy (SFBT).

Design: This was a qualitative study employing Interpretative Phenomenological Analysis. Semi structured interviews were conducted in order to access mothers' accounts of their experiences of SFBT.

Participants: Seven mothers who had attended, or were currently attending, a SFBT clinic at a Child and Adolescent Mental Health Service in the south of England participated.

Results: Mothers brought qualities to the therapy, such as a desire for change, taking responsibility for change and tolerating the difficult times in therapy. Mothers found that they needed to overcome some initial challenges in SFBT, such as feeling fearful about what might happen at appointments, concealed reactions from a therapist behind a screen and learning the approach of SFBT. The therapeutic relationship was valuable for mothers, with the qualities of the therapist, the support that was provided outside sessions and both the expert and collaborative stance used at different times by the therapist highlighted as important aspects. Positives were central to the process of therapy. These came from the therapist, were created by the tasks mothers undertook and became an anticipated and valued aspect of SFBT. Mothers were also able to become their own therapist by continuing to use the techniques and generate positives for themselves. Belief that change was possible was vital for mothers and observing changes as therapy progressed facilitated this. The power of therapy was evident in mothers’ accounts, with SFBT creating meaningful changes for mothers and their families. Mothers valued SFBT highly and for some this was reflected in their anxieties about ending therapy.
INTRODUCTION

Children, adolescents and their families can experience distress that prompts them to seek support from Child and Adolescent Mental Health Services (CAMHS). In 2004, 10% of British children and young people had a clinically diagnosed mental disorder (Green et al, 2005). There are multiple, and often long term, economic and social implications of childhood mental health disorders (Knapp, 1997). Children's and adolescents' mental health is the future adult generation's mental health (Health Advisory Service, 1995).

There are many interventions offered within CAMHS. The debate regarding those that are most effective continues. The perspectives of clinicians, funders and researchers vary in their competing needs (Fonagy et al, 2005). Parents bring another perspective as consumers of these services. Cognitive behavioural, psychodynamic, systemic and multimodal interventions have been shown, to varying degrees, to be effective for treating some disorders (Fonagy et al, 2005).

Solution Focused Brief Therapy (SFBT) is a new approach offered in CAMHS. Its emphasis on positives is appealing for families, brief approach appealing to funders and clear techniques helpful for clinicians. Exploring mothers' views of SFBT is particularly relevant given the ethos of service user inclusion in the National Health Service (NHS) (Department of Health, 2002).
What is solution focused brief therapy (SFBT)?

The development of SFBT
SFBT was pioneered by de Shazer (1985, 1988, 1991, 1994), Berg (Berg, 1994; Berg & Dolan, 2000; Berg & Kelly, 2000) and colleagues, who set up the Brief Therapy Centre in Milwaukee, USA. O'Hanlon, Lipchik, Miller, Hubble and Duncan also made significant contributions to the development of SFBT (Carr, 2006). SFBT began to develop in 1980 and was given its name in 1982 (de Shazer & Berg, 1997). Solution Focused centres have since been established in the UK (George et al, 1990) and Ireland (Sharry et al, 2003).

Steve de Shazer worked with the Mental Research Institute (MRI) and was influenced by the focus on current interactional patterns rather than historical predisposing factors (Carr, 2006). He was inspired by the brief therapy model developed by Weakland et al (1974) (Wheeler, 2001). De Shazer moved away from the MRI approach which focused on identifying and disrupting problem maintaining interaction patterns. By 1984 de Shazer and colleagues had shifted to a solution focused, rather than problem focused, approach (de Shazer & Molnar, 1984). De Shazer's approach was distinct, emphasising exceptional interactions where the problem did not occur, aiming to increase the frequency of these exceptions (Carr, 2006; de Shazer, 1985, 1988).

Assumptions
SFBT adopts a reflexive orientation, in which social realities are interactively constructed, rather than merely described, between therapist and client (Miller, 1997). de Shazer (1991) advocates a deconstructionist perspective on therapeutic processes and realities; the meaning of any reality rests between the interpretations made by the author (the claim maker) and the reader (the recipient). At most, these interpretations in sessions are misreadings (almost misunderstandings), as no one can determine the ultimate meaning of clients'
lives (de Shazer, 1991). Thus, "The issue is not discovering ultimate truth, but developing effective strategies for misreading clients' lives and troubles in change oriented ways." (Miller, 1997, p11).

George et al (2000) summarise the assumptions useful for SFBT practitioners to bear in mind:

- Understanding the cause of a problem is not necessary in problem resolution
- Successful therapy is dependent on what clients want to achieve.
- However fixed a problem pattern, there are always times when the client is doing part of the solution.
- Problems are not indicative of an underlying pathology.
- Sometimes only a small change is needed to set a solution in motion.
- Therapists should discover ways in which clients are able to cooperate in therapy; the concept of resistance is not helpful.

Other assumptions are that problems are seldom static, exceptions are waiting to be found, and the clinician's responsibility is not to provide solutions but help clients find their own (Wheeler, 2001).

Techniques

De Shazer & Berg (1997) highlight the key characteristics of SFBT. These include asking the miracle question\(^3\), using scaling questions, taking a break, giving the client compliments and often a suggestion with which to experiment.

\(^3\) The miracle question asks, "Suppose you went home and went to bed and to sleep. While you were sleeping a miracle happened. The problem that brought you to therapy in the first place is solved, completely. But you couldn't know that it happened, because you were sleeping at the time...when you wake up tomorrow, how will you know, how will you find out that there has been this miracle?...what would you do? How would you feel?" (de Shazer, 1994, p163-164).
Scaling questions are designed to facilitate treatment by measuring the clients' perception, to motivate, encourage and elucidate goals and solutions (de Shazer, 1994).

SFBT practitioners use problem free talk, clarify goals, consider pre session change and enquire about exceptions (times when the problem does not occur) (Wheeler, 2001). This builds up a picture of the clients' preferred future (Lethem, 2002).

In practice, assumptions and techniques are linked – assumptions can be tested using techniques, which may not be of benefit without the assumptions (Wheeler, 2001).

**Applications to families**

SFBT is a relatively new approach for CAMHS in the UK. It lacks the support of outcome studies compared with more conventional approaches, but it does offer some advantages (Wheeler, 2001).

Some aspects are particularly child friendly, such as the concrete language, use of imagination and respect given to children's wishes for the future (Lethem, 2002). "SFT's non-blaming attitude, together with problem free talk and exception gathering, serves to widen the perspective, reminding all concerned that there is more to the child, parents and teachers than the problem." (Lethem, 2002, p191).

Wheeler (2001) finds SFBT relevant to his practice within a UK CAMHS. It can reduce problem saturation, match parents' desire for a brief intervention and is applicable across presenting problems. It can reduce blame placed upon a child and enhance binocular vision (seeing strengths/resilience as well as difficulties encountered) (Wheeler, 2001). Wheeler (2001) posits that the consequences for
a family can differ significantly depending on whether they receive a solution or problem focused approach. He suggests that families who receive a solution focused approach can have a perception shift or adopt more useful solutions. SFBT can shift the focus from the child to other issues that can be addressed and encourages parents to work collaboratively with services. This is in contrast to the more negative consequences of using a problem focused approach (Wheeler, 2001).

Solution focused approaches are also being explored and promoted in other domains such as children’s nursing (Carter, 2006), mental health nursing (Ferraz & Wellman, 2008) intellectual disabilities services (Lloyd & Dallos, 2006, 2008), with Social Workers (Sundman, 1997; Saleebey, 1996; De Jong & Miller, 1995), Health Visitors (Iveson, 1995) and in education settings (Atkinson & Amesu, 2007; Miller, 2003).

SFBT’s stance on who should attend therapy is unique, compared to other family therapy models. In a US clinic Lee (1997) found goal attainment was not related to whether one or both parents attended sessions, suggesting SFBT does not make assumptions about attendance requirements. Lee (1997) suggests that the approach is effective with any family member who will attend if they are motivated as one change in the system leads to other changes.

**Effectiveness and outcome research**

Whilst a body of anecdotal support for SFBT has been generated, empirical evidence for SFBT lags behind (Corcoran, 2006). Despite good intentions, research around approach has been minimal (de Shazer & Berg, 1997). From the outset, interest lay in finding out what made a difference. De Shazer & Berg (1997) did not want to prove anything to the outside world and saw the model’s development as a teaching and training focused endeavour. “Ever since I (de
Shazer) began practising brief therapy in the early 1970s, my 'research' question was 'What do therapists do that is useful?' In the 1980s, we changed this to 'What do clients and therapists do together that it useful?' What is loosely called the model is the answer.” (de Shazer & Berg, 1997, p122).

De Shazer et al (1986) recognised that therapy needs to be evaluated. They positioned themselves as somewhere between research findings and clinical impressions in their investigation of SFBT. They asked clients in America if they had achieved their therapy goals or made significant progress. In the first study de Shazer (1985) asked 28 clients and found an 82% success rate. The second study, using 25% of 1600 clients seen from 1978-1983, revealed that 72% had met their therapy goals or that there was significant improvement. Brief therapy was useful even if complaints/goals were vague and one small change often led to other changes (de Shazer et al, 1986). However, this was a brief survey, limited by self reports with no clear definition of success or improvement. There was also a proportion of clients for whom SFBT was not helpful, which was not explored.

Other follow up studies have found similar positive effects, but also rely on subjective, self report outcome measures without established psychometric properties. George et al (1990) contacted 62 clients of UK CAMHS six months after treatment and found a good outcome with 66% of clients. Lee (1997) telephoned families of 59 children six months after therapy, using a 14 item questionnaire to assess goal attainment and any changes. They found a 64.9% success rate. Macdonald (1997) looked at outcomes of 36 adults who had been treated with SFBT in Scotland. Using postal questionnaires, a good outcome was found for 64% of clients.

However, “...widespread use and anecdotal reports of success do not provide an adequate basis for the ongoing use of SFBT, or any therapeutic approach. What
is needed is objective, empirical evidence of the effectiveness of SFBT – evidence that clients are better off in demonstrable and meaningful ways as a result of intervention.” (Gingerich & Eisengart, 2000, p477).

Gingerich & Eisengart (2000) felt the lack of experimental control meant these studies could not permit causal inferences to be made about the effectiveness of SFBT. This prompted their review of 15 experimentally controlled studies of SFBT. Five studies were deemed to be well controlled and showed positive outcomes of SFBT. These were Sundstrom’s (1993) randomised experimental study with depressed US college students, Zimmerman et al’s (1996) comparison of US parenting groups, Cockburn et al’s (1997) comparison of treatments for orthopaedic patients, Lindforss & Magnusson’s (1997) work with prisoners in Stockholm and Seagram’s (1997) work with adolescent offenders in America. SFBT was universally shown to be better than no treatment or standard institutional services. Four studies were defined as moderately controlled (Littrell et al, 1995; LaFountain et al, 1996; Triantafillou, 1997; Zimmerman et al, 1997) and six as poorly controlled (Polk, 1996; Eakes et al, 1997; Franklin et al, 1997; Sundman, 1997; Geil, 1998; Lambert et al, 1998). They investigated the use of SFBT with various client groups across different settings. These studies were consistent with a hypothesis of SFBT as effective. “We conclude that the 15 studies provide preliminary support for the efficacy of SFBT but do not permit a definitive conclusion.” (Gingerich & Eisengart, 2000, p477). They note that SFBT research not demonstrating effectiveness may have been withheld and that the research was conducted by advocates of the model. This research does not comment on why SFBT might be helpful for clients compared to other therapies.

Outcome can be evaluated in non-standardised ways and still provide useful information. Sundman’s (1997) exploration of using solution-focused ideas in social work, defined by Gingerich & Eisengart (2000) as poorly controlled, examined how the use of solution focused ideas might change the relationship between social workers and their clients (families in Finland). Small participant
numbers and limited training of workers made the research tentative. There were no significant differences in the relationships in those who did and did not receive solution focused ideas. However, when social workers used solution focused ideas clients seemed more satisfied, focused on their goals and more engaged in problem solving. Perhaps solution focused ideas enabled clients to feel more empowered and could have a positive impact on subsequent help seeking or engagement with services.

Corcoran (2006) investigated the proposed advantages of SFBT for American children with behaviour problems. Completers of SFBT (n=58) were compared with completers of treatment as usual (family intervention based on cognitive behavioural techniques) (n=27). All families received 4-6 sessions. Referrals were screened out for stressful events, for example bereavement, to make the sample more homogenous, although this limits the generalisability of the sample. SFBT did not exceed treatment as usual on outcome measures (Conners Parent Rating Scale and Feelings, Attitudes and Behaviors Scale for Children) but both conditions did produce positive changes. Drop out rates were high for both conditions but significantly lower for families who received SFBT.

Corcoran (2006) suggested that families in the SFBT condition may have remained engaged in treatment as strengths and resources were emphasised (thus parents felt better about themselves and more hopeful for change). Corcoran (2006) proposed that parents may expect their children to be seen alone. SFBT was more focused on the child's behaviour and may have been more congruent with parents' expectations than the treatment as usual condition. The limitations of the study include a reliance on self report measures, that the results could be due to other unknown client/therapist factors, that treatment fidelity was not examined and that there was no longer term follow up.
Brown & Dillenburger (2004) found mixed results when using parent management training with SFBT in Northern Ireland. However, numbers were small (n=10), it was the work of a single therapist and SBT was used in conjunction with parent management training.

Wheeler (2001) emphasises that SFBT is relatively young and research is at an early stage. He reminds us that even established therapeutic approaches were once young, that therapeutic approaches usually find a place in services before rigorous studies support them and that approaches are often a matter of clinician preference.

**Experiences of SBFT and family therapy**

Although research investigating the outcome of SFBT is limited, and currently does not rigorously demonstrate the effectiveness of the model, it has produced useful findings applicable to clinical practice. SFBT can enhance engagement and reduce drop out (Corcoran, 2006). It can increase positive statements, shared views between professionals and clients and enhance goal focus (Sundman, 1997). Clients' experiences of SFBT are vital to address de Shazer' & Berg's (1997) question regarding what therapists and clients do that is useful in therapy. SFBT has a unique way of viewing and approaching problems that sends an empowering message to clients which may be a vital part of its success. Understanding client perceptions may help determine the important and meaningful aspects of successful therapy (Bischoff & McBride, 1996).

Research specifically addressing clients' experiences of SFBT is limited. Lloyd & Dallos (2006) explored the initial sessions of SFBT with British families with a child with intellectual disabilities, finding that the approach highlighted parents' competencies and expertise. It enabled empowerment to be incorporated into mothers' narratives and helped them contemplate a preferred future. The miracle
question raised important issues, particularly that their child could never be “normal” Lloyd & Dallos (2000) suggest that the approach is useful for mothers who have children with intellectual disabilities.

Beyebach & Carranza (1997) highlighted the notion of fit between the therapist and client that should occur in SFBT. They summed this up as two important therapeutic practices – listen to your client and use your client’s language. They explored dropout and continuation in SFBT. Clients who dropped out from therapy - that is those who found it helpful and were deemed successful along with those who found it unhelpful and were deemed unsuccessful - were involved in more conflictive therapeutic interactions. Participants’ mean age was 27 years, nearly a third were college students and half were unmarried. There were limitations in this study, including the specific clients that participated (they had individual therapy at a private therapy practice) and that the therapy model applied was not purely solution focused but included some problem focused practices. They concluded that “Our data give some support to the idea that brief therapists (and probably family therapists in general) should see the promotion of a supportive, harmonious and non-conflictual conversation as one of their main goals…” (Beyebach & Carranza, 1997, p204).

Metcalf & Thomas (1994) interviewed six cohabitating couples and their therapists who had successfully completed SFBT in America. Clients were asked what they found most helpful in the therapy process. Therapists were asked what they did that seemed to help change occur. The data were analysed using a stages approach. Clients viewed the therapists as very active in the process and attributed success to them. They entered therapy for a variety of reasons, which were articulated differently by the therapists and their clients. Termination was explored and therapists differed in their views to those of clients. Some couples expressed disappointment as they felt therapy was not completed. This was considered by Metcalf & Thomas (1994) to be at odds with the SFBT
Major Research Project

approach to termination, where the therapist should accept clients' ideas about when to terminate according to whether they have achieved their goals. Both clients and therapists felt that reinforcement, listening and focusing were helpful aspects of therapy. Clients also found therapists pointing out things differently, highlighting what worked and noticing changes as, helpful. All clients found the change that resulted from SFBT meaningful, helpful and making a difference, lending support for the use of SFBT (Metcalf & Thomas, 1994). It would have been interesting to hear the perspectives of clients who were not defined as successful completers of SFBT to explore what was helpful and not helpful in their experience of therapy.

Jordan & Quinn (1997) explored the impact of client gender and perception of the outcome of the second session of problem versus solution focused approaches in America. Using three measures (The Working Alliance Inventory, Session Evaluation Questionnaire, The Handy Outcome of Psychotherapy and Expectancy Scale; all with good psychometric properties reported) with 37 mainly white adults and three children, they found the approach (problem or solution oriented) did not have an impact. The results revealed that women were more optimistic in their expectations of therapy and possibilities for change than men. Women also felt more positive about their sessions. However, the therapists were doctoral students, the research took place after only one session and there was some overlap in the approaches utilised (both used goal specification). Given these limitations, the results should be viewed tentatively, but the study does provide useful information about how men and women might approach SFBT differently.

Therapist views

SFBT seems to have universal appeal. In its claim to be brief and therefore incurring fewer costs, it is attractive to health management organisations (Stalker et al, 1999). Carter (1997) suggests SFBT is appealing as it infers savings in
time and money and the notion of leaving problems behind is attractive. Carter (1997) proposed it is irresistible to therapists overwhelmed with increasing caseloads.

SFBT appears to empower both clients and workers. Sundman (1997) found social workers who used the approach represented themselves rather than the agency or referrer, conveying more of a sense of person rather than acting on behalf of another. Hope was maintained by the Social Workers who used SFBT, despite situations not changing, and more positive views were enabled. This was as a result of minimal training for social workers due to the service's limited financial resources.

SFBT has also been shown to be of benefit to counsellors. LaFontain & Garner (1996) followed up the counsellors involved in Zimmerman et al's (1997) US study and found that a year later there was less exhaustion and depersonalisation in the solution focused counsellors.

"It is an approach that can instil hope in clients and therapists alike and it deserves its reputation for countering the risk of burn out in its practitioners." (Lethem, 2002, p192).

Family therapy
Research exploring client views on the process of SFBT appears scarce. Heatherington et al (2005) highlight the lack of published empirical evidence for some widely used approaches, including SFBT. They pose questions that need answering, such as what happens during and outside family therapy sessions that result in therapeutic outcomes? In beginning to explore this, it is useful to more broadly consider clients' experiences of family therapy.
Bischoff & McBride (1996) interviewed adult clients about their experiences of couples or family therapy in America. Three themes emerged; respect for the hierarchy inherent in the therapeutic relationship, therapist empathy and the perceived helpfulness of therapeutic techniques. Clients reported the power differential between them and the therapist, at times deferring to the therapist's expertise at the expense of their personal agendas. The issue of hierarchy was important in family therapy where multiple perspectives needed to be managed, and left individuals feeling frustrated at times. Clients reported finding the therapist's empathy, understanding and ability to listen at a deeper level the most helpful about their treatment. Clients wanted to feel that their therapist was invested in the treatment and in them as people. Therapists' curiosity, sincerity, responsibility, non judgemental stance and desire to learn from the client were also cited as important. The out of session tasks and experiential activities were also helpful aspects of therapy. However, clients were interviewed by their therapists, which may have impacted on the results, particularly given hierarchy was highlighted as important element in therapy.

Kuehl et al (1990) interviewed 37 mothers, fathers, adolescents and siblings from 12 families who had completed family therapy in America. They found that clients' descriptions of the phases of family therapy paralleled the therapeutic process described by Munichin and Hayley. The therapist characteristics that were most often included in discussions were seeing the therapist as caring, understanding and able to generate relevant suggestions. These were important factors in families continuing and completing therapy and in feeling satisfied with the process. Therapist flexibility was also important.

Howe (1989, 1996) interviewed 22 families about their experiences of family therapy in the UK. He found three overall themes: families needed to feel engaged in therapy, to understand and to feel understood.
Research exploring children’s and adolescents’ views of family therapy have found similar themes were important. Strickland-Clark et al’s (2000) UK study found that feeling heard was important and that not feeling heard was a difficulty. Therapy was presented as a challenge by the young people. At times it brought back painful memories and some children were concerned about family member’s reactions when they spoke. Strickland-Clark et al (2000) hypothesised that children’s reactions were influenced by their attachment style.

Lobatto (2002) interviewed children in the UK with the presence of their parent/carer. The children talked of sometimes feeling too central in the therapeutic system and sometimes feeling excluded. Negotiating when to talk and listen in an adult context was challenging. Lobatto (2002) conceptualised the children’s experience of the therapeutic encounter as a therapeutic circle, in and out of which family members and therapists manoeuvre.

**Limitations of SFBT**

SFBT has not escaped having its limitations highlighted, sometimes by the very people who practice it.

**One model fits all?**

Stalker et al (1999) expressed concerns about the indiscriminate acceptance of SFBT by social workers despite a lack of clear empirical support for the model. Whilst they welcome the departure from resistance as a concept in therapy and the move towards a more collaborative, client centred way of working, they suggest that many of the strengths of SFBT are present in other models of therapy. They highlight that, whilst there are different emphases, all therapeutic models stress forward movement and change. Stalker et al (1999) suggest that emphasis on client strengths and resources has existed in social work practice since it began in the 1930s.
Stalker et al. (1999) suggest four major limitations of SFBT. Firstly, that brief therapies have been shown to be less effective than longer term therapies with clients who have severe problems. They challenge the assumption that a therapist does not need to know how the problem developed, and that severe difficulties involving trauma and neglect can be solved quickly. Some clients may be able to move on quickly, however, others may not. The second concern is the neglect of client history and further assessment in SFBT. They posit that SFBT does not take a gender sensitive perspective or take large systems factors into account. SFBT's neglect of micro-systemic (biological/genetic) components of mental illness causes Stalker et al. (1999) to question the ethical and clinical appropriateness of it at times.

Thirdly, Stalker et al. (1999) suggest that SFBT may perpetuate an unhelpful, rigid adherence to one model, which may not suit all clients. Fourthly, they suggest that the emphasis on theory and technique detracts from the importance of the therapeutic relationship. Nylund & Corsiglia (1994) suggest this is related to SFBT's tendency to become solution forced or problem phobic. Stalker et al.'s (1999) main concern is the narrowness and rigidity of the model, but propose that therapists may be more flexible in their approaches than the literature suggests. Wettersten et al.'s (2005) US study of mainly white females suggest that the therapeutic relationship is minimised in SFBT. They found that therapeutic alliance was not associated with outcome in SFBT as it was in interpersonal therapy. The study had limitations including varying levels of therapist experience and small sample size.

Lipchik (1994) highlights how the techniques of SFBT look deceptively simple yet require a wealth of knowledge and experience to be applied appropriately. She cautions against focusing on technique at the expense of joining with the client and developing the therapeutic relationship. Lipchik (1994) gives examples of how therapists operating in managed care systems in the US felt compelled to
use SFBT in order to offer time limited interventions. Nylund & Corsiglia (1994) suggested that SFBT can be useful in the context of time and money pressures in managed care. However, they caution against therapy becoming 'solution forced' (a therapist informed by SFBT practices but who minimises clients' experiences, causing them to feel invalidated). This occurs when the therapist does not allow the problem to be discussed, focuses on exceptions that do not make a difference and/or pursues the therapist's goals (Nylund & Corsiglia, 1994). They stress the need for appropriate training to enable the consistent practice of solution focused and not 'solution failed' therapy. Coyne & Arbor (1994) caution against using SFBT in a formulaic manner.

Wheeler (2001) suggests that future studies may identify particular problems for which the approach is not suitable. He refers to advice from a workshop suggesting that SFBT should not be used with clients who have requested something different or where the clinician feels unable to trust the client. SFBT may also not suitable for people whose thinking is wildly irrational or with families who are too chaotic or conflictual (Wheeler, 2001). Caution should be used when using the model with clients with social communication disorders (Lloyd & Dallos, 2006).

**Feminist perspectives**

SFBT has come under scrutiny by feminist scholars as early literature "did not include specific reference to gender, culture, ethnicity, ability, sexuality or other differences important to clients." (Lethem, 2002, p191).

Dermer et al (1998) applied a feminist critique to SFBT. Whilst SFBT has addressed important issues in working with domestic violence and survivors of sexual abuse, it does not address them from a feminist perspective. Using Ault-Riche's categories of feminist assessment, they explored the theory, values, therapy and knowledge of SFBT. SFBT is a theory of change rather than
explanation of family structure and thus does not adequately address individual or family development or larger systems influences. By subscribing to circular causality (each member of a system contributes to maintaining cycles of behaviour) therapists may minimize power differentials. SFBT subscribes to the notion of personal responsibility, which feminists agree on. However, solution focused therapists and feminists differ on the concept of blame – feminists suggest that one type of blame (other directed anger) can be useful in identifying limitations placed on subordinate groups (Dermer et al, 1998). SFBT does not recognise social pressures to undertake complementary roles (e.g. stereotypical roles of a wife being responsible for domestic tasks, a husband for financial ones) due to unequal power. Whilst the model does value individuals and their own goals, it does not question whether relationships are worth protecting (Dermer et al, 1998).

Feminist scholars believe therapy is a political process and therapists should maintain their own beliefs. They believe that one cannot be neutral, but SFBT suggests therapists can (Dermer et al, 1998). SFBT emphasises behaviours and action and may, therefore, value a male way of doing things. Whilst the SFBT collaborative way of working and belief in people’s competence is encouraged by feminism, therapists may not recognize the inherent power imbalance in the therapeutic relationship (Dermer et al. 1998).

This raises interesting questions about the application of SFBT in CAMHS, where gender roles and stereotypes in families and society are important to address at times. Whilst this may occur in the practice of SFBT, it does not seem to be addressed in the theory.

**Diversity**

Issues of culture and diversity also do not appear to be addressed in SFBT literature. McKergow & Korman (2008) do not deny that cultural norms have an
influence on individuals, but suggest that the notion that people are controlled by such macro-level forces plays no part in SFBT. Perhaps this is an oversimplification of some very complex issues, for example clients’ experiences of racism or the status of non working parents.

**The role of emotions**

Kiser *et al* (1993) proposed that emotions are related to thoughts, behaviours and influenced by context, and suggested SFBT would be enhanced by incorporating emotions into theory and practice. Miller & de Shazer (2000) agreed with these ideas, although Piercy *et al* (2000) suggest that in doing so “...Miller and de Shazer provide a rather detached, emotionless discussion of emotions.” (Piercy *et al*, 2000, p25).

Piercy *et al* (2000) suggest that Miller and de Shazer perpetuate the notion of the therapist as playing a language game, which has the potential to make clients feel not heard. They propose that Miller and de Shazer have not taken research on affect, neuroscience and psychodrama into account. Piercy *et al* (2000) believe SFBT therapists need to join with and respond to human emotion, along with thoughts and actions. “Sometimes it is best simply to be with clients in their despair, grief or depression...we need not always find exceptions or too quickly move away from such emotions.” (Piercy *et al*, 2000, p26). They suggest that SFBT therapists who do not engage with emotions are less effective.

It would seem that some advocates of SFBT are paying increasing attention to emotions. “…the most important thing a therapist can do to promote change is to listen to clients for the purpose of understanding them. I used to ascribe too much power to my theoretical assumptions and techniques.... I had to learn that they are most valuable when used in the context of a trusting relationship that results from acceptance and understanding.” (Lipchik in Young, 2005, p67). Lipchik is also exploring the integration of neuroscientific findings with systemic
and postmodern therapies, thinking about how emotions are bodily reactions mapped onto the brain which coordinate activities (Young, 2005). Lipchik emphasises the importance of the client feeling safe, understood and able to hear new ideas in the context of a good therapeutic relationship (Young, 2005). Indeed, for some clients the first solution may be to let them express their emotions (Lipchik, 1994).

**How brief is it?**

Some research has shown that SFBT can take significantly less sessions to achieve similar outcomes. For example, high school counsellors using SFBT spent less time with students to achieve similar results compared to problem focused and task focused approaches (Littrel *et al.*, 1995). Rothwell's (2005) UK study found adults who undertook SFBT had on average fewer sessions compared with adults who received CBT. However, this was due to the higher number of clients who attended a single session of SFBT. There were limitations – the groups were not randomised and there was only one SFBT practitioner compared to several CBT therapists – which could have accounted for some of the findings. It seems that there is not enough research to unequivocally demonstrate that SFBT is more time effective than other therapies.

**Aims**

This research aims to explore mothers' experiences of SFBT using the qualitative research method of Interpretative Phenomenological Analysis (IPA). It aims to consider what the helpful and unhelpful aspects of SFBT are and how the process of change is approached and undertaken by mothers. It aims to explore why mothers sought the therapy, what it was like attending therapy sessions and the outcomes they achieved from SFBT. Understanding clients' experiences is necessary in order to understand how therapy facilitates change, but it is an area that has received little attention (Hodgetts & Wright, 2007). It is therefore an
important area to research, particularly given current NHS efforts seek the views of service users and enhance access to psychological therapies (CSIP Choice and Access Team, 2007).

METHOD

Ensuring standards of qualitative research are met

Research should be undertaken to a high standard in order for the results to have relevance and utility in the field of inquiry. Qualitative research methods are being increasingly used (Elliot et al, 1999), particularly in healthcare (Mays & Pope, 2000), which has accelerated the debate on how to assess the quality of this type of research. Guidelines are evolving to ensure that good standards of qualitative research are met (Turpin et al, 1997; Elliott et al, 1999; Yardley, 2000). The current research aims to address these criteria, to produce good quality research which appropriately utilises IPA. In line with Elliot et al’s (1999) criteria I own my perspective about SFBT by considering my personal assumptions, situate the sample (by providing information about participants whilst preserving confidentiality) and use examples from the interview transcripts to ground the results. I checked the credibility of the results, by sharing my results with my supervisor, other researchers and the mothers who took part. As advocated by Turpin et al (1997), I explain my rationale for employing IPA, along with its limitations, in the proceeding text. Procedures used are clearly stated, the themes are backed up with quotes and participants were fully informed (Turpin et al, 1997).

I also address Yardley’s (2000) criteria for assessing qualitative methodologies. I am sensitive to the context; I address the relationship between researcher and researched through reflections during supervision, my reflective diary (see appendix XII) and discussions with other qualitative researchers. I have also paid
attention to the context by providing information about mothers who participated, for example single parent status. I have demonstrated commitment and rigour by describing my method and providing detailed results. This has enabled transparency and coherence to be achieved (Yardley, 2000). I have considered the utility of the results by outlining the clinical implications and future research in the discussion. As recommended by Mays & Pope (2000), I used respondent validation to address the validity of the research. I have also attended to the exceptions - when mothers had differing experiences – and avoided presenting the data as if it represents one truth (Mays & Pope, 2000). The themes are related to relevant psychological theory. As Reicher (2000) argues, one set of principles cannot be applied to all the different qualitative methodologies. Thus the above criteria have been used to merely guide the process.

**Interpretative Phenomenological Analysis**

Interpretative phenomenological analysis (IPA) was founded by Smith (1996, 1997). The aim of the approach is to explore how people make sense of their personal and social world (Smith & Osborn, 2003). IPA draws on two main theoretical frameworks, namely phenomenology and symbolic interactionism (Smith, 1996).

Phenomenology was initiated by the philosopher Husserl, as cited by Giorgi & Giorgi (2006), at the start of the twentieth century (Willig, 2006; Giorgi & Giorgi, 2006) and is concerned with how humans acquire knowledge about the world. Phenomenology does not aim to produce an objective account of objects or events (Smith, 1996), but explores how individuals engage with their world and experience it within a particular context or time (Willig, 2006). Objects and subjects are not seen as separate entities, as how an object appears depends on a person’s perception of it which is affected by an individual’s hopes, desires and psychological state (Willig, 2006). Phenomenological research aims to remain
true to the phenomena being studied, thereby capturing lived experiences unique to individuals (Giorgi & Giorgi, 2006).

Symbolic interactionism developed in opposition to the positivist paradigm (Smith, 1996) which privileges methods of inquiry that reduce concepts into measurable dependent and independent variables and hypothesises relationships between them (Smith et al, 1995). Symbolic interactionism assumes that we act according to things that hold meaning for us, and that meanings (which can change) develop from social interactions (Denzin, 1995). It suggests that humans create their world of experience by what they bring to experiences and are shaped by self reflections and interactions; symbolic interaction is the merging of the self and social interaction (Denzin, 1995). The meanings of these experiences can be accessed only by a process of interpretation (Smith, 1996).

In line with these assumptions, IPA aims to explore individuals' accounts or perceptions of events or objects, rather than comment on the actual event or object (Smith & Osborn, 2003). The notion of the interpretative process between the researcher and the researched is emphasised; the research process is dynamic. The researcher brings their own perceptions to the process and plays an active role in interpreting the individual's experience of their world. IPA contains two stages of interpretation; the participant is making sense of their world and the researcher is then making sense of this as they strive to interpret the participant's account of the phenomena under investigation (Smith & Osborn, 2003). IPA assumes that there is a link between what people say and what they think and feel, but this is a complicated connection (Smith & Osborn, 2003). Individuals may find it hard to articulate their thoughts and feelings, or may be reluctant to disclose their experiences so the researcher may need to interpret the participants' mental and emotional states from what they say (Smith & Osborn, 2003). As social beings, we are constantly editing what we say to others. We may censor expression of our thoughts and feelings according to the
context, how we think we will be perceived by others and the perceived impact of this.

Rationale for Selection
Mothers' experiences of the process of SFBT, and how they make sense of SFBT, are under investigation. Obtaining perceptions of mothers is the central area of concern, rather than an attempt to gain access to one single truth or description about the therapy itself. “...IPA is a suitable approach when one is trying to find out how individuals are perceiving the particular situations they are facing, how they are making sense of their personal and social world. IPA is especially useful when one is concerned with complexity, process or novelty.” (Smith & Osborn, 2003, p 53). Thus, IPA appears to be a suitable method to use to explore individuals’ experiences of the process of SFBT and how they make sense of this.

SFBT is a relatively new way of working, particularly in CAMHS in the UK. There are limited services that employ this way of working and small numbers of therapists who, when applying the techniques of SFBT, practise in a pure fashion and adhere closely to the model’s assumptions. Thus there are limited numbers of mothers who have experienced SFBT. IPA is an idiographic method of inquiry: it aims to capture the experiences, and comment on, a small group of individuals (Smith & Osborn, 2003). It does not aim to make large claims or generalisations about larger populations, but to say something in detail about the perceptions of a particular group (Smith & Osborn, 2003). This makes it an appropriate method to employ as the study aims to capture the unique experiences of this small number of individuals.

IPA’s connection with symbolic interactionism (Denzin, 1995), with its emphasis on how meanings are constructed through a process of interpretation within a social and personal world (Smith, 1996; Smith & Osborn, 2003) also makes it a
suitable approach to explore experiences of SFBT. The use of language is central to SFBT. IPA fits with de Shazer's (1991) deconstructive perspective in which the meaning of reality is co-constructed between, and interpreted by, the client and therapist. These interpretations are seen as misreadings as no one can reveal an ultimate truth. SFBT involves not discovering a truth, but developing ways to “misread” clients’ troubles in change oriented ways (Miller, 1997). IPA seems well placed in attempting to see how clients perceived this joint venture and will be useful in capturing the essence of mothers’ experiences of therapy and the meanings ascribed to them.

IPA’s assumptions that the researcher can interpret the participant’s thoughts and feelings according to what they say, and that this is impacted on to some degree by context, is appropriate for use in this study. Other methods are less appropriate. For example, as Smith (1996) highlights, discourse analysis challenges the idea that what people say can be mapped onto their underlying cognitions (Potter & Wetherell, 1987). The approach does not explore the relationship between verbal reports and the possibly associated behaviours, thoughts and feelings (Smith, 1996). This is at odds with what the current study is attempting to achieve and feels a less suitable approach to employ.

Grounded theory is an alternative approach which could be have been utilised. Whilst similar to IPA regarding its links with symbolic interactionism, grounded theory aims to develop a theory to explain behaviour and processes (Charmaz, 2003). The intended aim of this study was to comment on mothers’ and carers experiences of therapy, as accessed through their verbal accounts. This commentary was felt to be adequate and developing a theory, as outlined in grounded theory, was not a pre planned intended outcome. Grounded theory also assumes a more positivist stance, by assuming that there is an objective reality. This posits that knowledge is out there and can be captured by a researcher who acts as a witness (Willig, 2006). This seems a less appropriate
approach to use when exploring SFBT which does not aim to discover an objective truth but to co-create new meanings in clients’ lives.

Limitations of IPA
As appropriate a method as IPA seems, it is important to recognise that it does have limitations. Giorgi & Giorgi (2006) highlight that each research method has strengths and limitations. They propose that the research process is enhanced through acknowledging the method’s limitations, and by putting limits on the interpretation of findings.

One potential limitation is the reliance on participants’ verbal accounts, during which they might attempt to deceive or give incorrect information. However, IPA is concerned with the subjective experience of the participant, so this is less likely to be a problem (Giorgi & Giorgi, 2006). Also, interviewers are often able to detect if a participant is deliberately deceiving and as there are no preconceived hypotheses it is doubtful that a participant would want to lie, other than to avoid embarrassment (Giorgi & Giorgi, 2006). These are problems that are not confined to the realms of qualitative methods of inquiry. The dynamic process of interpretation between the interviewer and participant is not a bias to be eliminated, but a necessary part of making sense of another’s experience in IPA (Willig, 2006).

Willig (2006) notes that IPA richly describes participants’ experiences of situations and events, but does not explain why they occur or why differences between individuals’ phenomenological representations occur. This could be seen as a limitation as it restricts understanding of phenomena under investigation. Willig (2006) argues that if we want to move beyond sharing experiences with individuals and be able to understand these experiences that we need to look at the conditions that gave rise to them, which might include the historical and social context. However, exploring mothers experiences of SFBT.
is in its infancy, so it could be argued that a rich description is adequate at this point.

**Participants**

"*There is no right answer to the question of sample size*" (Smith & Osborn, 2003, p54) and it depends on number of factors. Smith (2004) states that IPA needs a small sample size in order to undertake the detailed analysis used in IPA, and cites studies that vary in sample size from 5-10 participants.

All mothers who were eligible to participate in the research (who had attended at least two SFBT sessions and had attended their last session within the last six months) were invited to take part. Details of the SBFT clinic and approach used there can be viewed in appendix I. Only one parent declined to participate because they felt that it might make them anxious. A total of seven mothers took part. In order to situate the sample without compromising confidentiality, the characteristics of the group as a whole are presented.

The participants were all mothers. Six were White British, one was White Australian and they all resided in the south of England. Three mothers resided in privately owned homes, four resided in rented Local Authority accommodation. One mother was employed and the others were full time mothers. Four were single mothers. Five mothers had two children, one mother had one three children, one mother had six children and one mother had one child. Five mothers were in active therapy (with three nearing completion), one mother was on a break and one mother had completed therapy. The number of sessions attended ranged from two to 52, with four mothers attending 20-35, one mother attending 52, one attending six and one mother attending two sessions.
**Procedure**

**Ethical approval**

Ethical approval was sought and gained from Brighton West Research Ethics Committee (see appendix II), Sussex NHS Research Consortium (appendix III) and the University of Surrey Ethics Committee (appendix IV). The ethical issues that were considered can be viewed in these appendices.

**Recruitment**

Potential participants who had attended the SFBT clinic were identified by the clinic therapists. These clients were approached by the therapists and asked if they would like to participate in the research. If they agreed, I contacted them and sought their consent to take part in the research interview. Mothers were given the option to meet at the clinic or their home in an attempt to minimise inconvenience for them. Mothers were provided with an information sheet (appendix V), detailing the rationale, procedure and what would happen to the data generated from their interview. Once they had read and been given an opportunity to discuss this information sheet, they were invited to sign the consent form (appendix VI).

**The semi-structured interview**

Smith and Osborn (2003) recommend the semi-structured interview as the exemplary method for IPA. It enables a flexible approach whereby questions can be altered according to the information shared in the dialogue between researcher and participant. It also facilitates rapport, allows new areas to be explored and enables rich data to be produced (Smith & Osborn, 2003). This was the method that was utilised.

The interview was based on a semi-structured interview employed in a previous piece of research which explored young people's experience of the same SFBT
Major Research Project

clinic (Tilley, 2006). It was felt appropriate to use its structure as it covered the broad areas of interest specified in the aims of the current research. It was developed in conjunction with therapists at the SFBT clinic and tutors at the University of Surrey. It was also based on previous research exploring client views of the process of SFBT and family therapy (Metcalf & Thomas, 1994; Joel & Nelson, 2004; Strickland-Clark et al. 2000; Stith et al. 1996; Lobatto, 2002). The main reason for using the existing schedule was to enable potential future research to be undertaken which could look at the similarities and differences of the accounts given by the young people and mothers of different families but who attended the same SFBT clinic. The semi structured interview schedule used can be seen in appendix VII.

The interview was based on the questions devised, but followed the lead of the mother. As advocated by Smith & Osborn (2003) the mother was given adequate time to respond, probes were kept to a minimum and the effect of the interview on the mother was monitored.

All interviews were taped and transcribed (see appendix VIII for an example of a transcript). One interview took place at the clinic, all other interviews took place in the mothers' homes.

Analysis

The data were analysed using the technique suggested by Smith & Osborn (2003). Transcripts were analysed one by one, following the idiographic approach to analysis. Each transcript was read and re-read a number of times, with notes being made to highlight interesting or significant points. The transcripts were then read again and themes that emerged from the initial notes were recorded (see appendix IX). These themes remained closely connected to what the mother had said. Connections between themes were then identified to
produce clusters of themes. A table was then produced which displayed the clusters of themes (superordinate themes), which were each given a name (see appendix X). This process was repeated with all the transcripts for each mother. Each new transcript was looked at to find support for already found themes, and for new themes to emerge. Transcripts that were analysed earlier were looked at again in light of new themes that subsequently emerged. Once all transcripts were analysed the final themes were decided upon (see appendix XI). In order to remain reflexive about the process, and inform my interpretation of themes, I met with my supervisor to discuss the interviews and my results. I also attended a discussion group with other Trainees who were undertaking qualitative research. I kept a diary to record my reflections on the process (see appendix XII) and assumptions about SFBT.

**Personal Assumptions about SFBT**

Remaining reflexive about the researcher’s influence on the analysis is vital, and means “…sensitivity to the ways in which the researcher and the research process have shaped the collected data, including the role of prior assumptions and experience, which can influence even the most avowedly inductive inquiries.” (Mays & Pope, 2000, p51). As IPA relies on the dynamic flux between the interpretations of the researcher and the researched, it is important to acknowledge ones own assumptions and beliefs about the phenomena under investigation.

I held a number of beliefs about SFBT that I documented before embarking on interviewing mothers, which I will briefly outline. It is perhaps also worth noting that I had not observed the SFBT clinic before interviewing mothers, therefore I could be described in some ways as a naïve observer of mothers’ experiences of SFBT. All my assumptions were based on my own ideas, rather than from observations.
My first belief was that in using this model there was a risk that clients might not feel heard; that they would feel shut down and possibly invalidated if they were unable to tell their problem saturated story. I imagined that mothers might need to tell their story first before moving on to think about solutions. I drew on some of my own experiences of being prompted to reframe something and think about solutions before I was ready to, and how this had made me irritated. I wondered whether any mothers might feel like this.

However, I also considered the power of meeting with someone (in this case the therapist) who did hold hope and maintain an outlook which encouraged, indeed expected, positive changes to take place. I imagined that this would be enormously helpful and reassuring in the help seeking process. When considering my own clinical practice I considered the importance of positively reinforcing clients' efforts to behave or think in change oriented ways and the positive effect that this had.

I was also intrigued by the factors that are important across therapeutic approaches, such as the therapeutic relationship, feeling heard and experiencing empathy. I was interested in whether mothers would be able to identify specific techniques unique to SFBT, or whether the general ingredients of therapy would be emphasised as helpful in the change process.
RESULTS

Mothers’ accounts clustered around six master themes: readiness for change, initial challenges, therapeutic relationship, positives as central, belief in the process and the power of therapy. These master themes were comprised of superordinate themes, which can be viewed in the table 1 and are described in the following text. The themes are ordered according to the chronological phases of therapy, rather than by importance, and all identifying features have been amended.

<table>
<thead>
<tr>
<th>Master Theme</th>
<th>Superordinate Theme</th>
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<tbody>
<tr>
<td>1. Readiness for change</td>
<td>1.1 Desire for change</td>
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<tr>
<td></td>
<td>1.2 Responsibility for change</td>
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<td></td>
<td>1.3 Need to be open and honest</td>
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<td></td>
<td>1.4 Bearing the pain</td>
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<tr>
<td>2. Initial challenges</td>
<td>2.1 Fear of concealed reactions</td>
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<td></td>
<td>2.2 Fear of unknown</td>
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<td></td>
<td>2.3 Learning the approach</td>
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<tr>
<td>3. Therapeutic relationship</td>
<td>3.1 Therapist qualities (facilitating engagement)</td>
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<td></td>
<td>3.2 Outside session support</td>
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<td></td>
<td>3.3 Expert versus collaborative approach</td>
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<td>4. Positives as central</td>
<td>4.1 Positives from therapist</td>
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<td></td>
<td>4.2 Use of notes</td>
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<td></td>
<td>4.3 Tasks as a catalyst for change</td>
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<td></td>
<td>4.4 Anticipating positives</td>
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<td></td>
<td>4.5 Becoming own therapist/internalising techniques</td>
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<tr>
<td>5. Belief in the process</td>
<td>5.1 Belief in change as possible</td>
</tr>
<tr>
<td></td>
<td>5.2 Observing changes</td>
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<tr>
<td></td>
<td>5.3 Familiarity</td>
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<tr>
<td>6. Power of therapy</td>
<td>6.1 Outcomes/gains</td>
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<td>6.2 The struggle to end</td>
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<td>6.3 Valuing therapy</td>
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Table 1: Master Themes and Corresponding Superordinate Themes
1. READINESS FOR CHANGE
This master theme encompasses the superordinate themes which allude to mothers' commitment to therapy. This was indicative of commitment to initially engage in therapy and then actively work towards achieving changes for themselves and their family. Some of these issues appeared to have been thought about at the time of entering therapy, whereas others were considered whilst retrospectively reflecting upon the experience of the therapy process.

1.1 Desire for change
This theme reflects the mothers' need for change within the family, which appeared to be a crucial factor in their willingness to consider attending therapy. As Heather said:

“Well yeah, you just want to get to be resolved and better.” (Heather).

This need for change was also apparent when the mothers talked about who might benefit from the therapy. Wendy described the sort of person who she thought would find SFBT helpful:

“A person who cares about the future of their child, cares about how their behaviour may damage their child. And, um, who wants to change things, when things are tough.” (Wendy).

1.2 Responsibility for change
All mothers were aware that they had a role to play in facilitating change and that they were influential as change agents. They recognised that effort was needed, both inside and outside of the sessions, in order for the process to be effective.

“...it just made me more aware of it, I had a part in this as well and I could make the situation a lot better if I behaved better. Which I did.” (Heather)
“...some parents I think end up, almost imagine them taking their child in and expecting, you know, them to completely fix them. But you can’t expect that. You know, you’ve got to put work in for your child’s sake.” (Kate)

“...you get back what you put in.” (Kate)

British Mothers of children with intellectual disabilities, in Lloyd & Dallos’ (2008) study of experiences of the first session of SFBT, highlighted that change was brought about by their own efforts. They too recognised that they were responsible for change.

1.3 Need to be open and honest
Three mothers spontaneously talked explicitly of this, and it felt significant enough to warrant its own superordinate theme. These mothers conveyed the necessity for being open and honest in the therapy for it to be effective.

“...one thing I thought about – and you must be honest. Because if you go in there and lie and scoot and think anybody’s trying to check you out, if you are not blatantly honest, it will not work. Because you’re lying to yourself and I think some people that are caught in a situation might be tempted to do that. So I would, I would absolutely say that take the courage and be very honest. That is one of the key rules.” (Fiona)

“...just be open...and if there was anything they were thinking about, I’d just tell them to say...” (Anna)

1.4 Bearing the pain
This superordinate theme arose from mothers’ reflections on the process of therapy. There was a sense that mothers had to be committed enough to the therapy to bear the difficult times (both inside and outside the therapy session).
This was necessary in order to achieve a positive outcome. Whilst at times the process was excruciating, it was worthwhile as it lead to positive changes.

Fiona likened the process to going to the dentist; the work would be painful but necessary:

“So that’s how I would give the analogy, it’s like going to the dentist knowing you’ve got major work to be done. It’s gonna be painful, it’s gonna be awkward, it might leave a little bit of a ting for a few hours afterwards.” (Fiona).

Margaret had a briefer experience of therapy, and the process was difficult throughout. However, there was still a sense that it was justified as the outcome was good:

“I just felt it was something I had to do. I can’t say that I enjoyed the experience ‘cos that would be lying. But it was good in the fact that it helped my daughter and that was my aim ” (Margaret).

Stiles et al (1990) suggest an integrative model of an element of change in psychotherapy, which seems to fit with some mothers’ descriptions of the painful process of therapy. Stiles et al (1990) propose that in successful therapy, clients pass through a number of stages in order to process painful experiences and assimilate (incorporate) them into their schemata (a pattern of ideas, a way of thinking). These stages include the client being oblivious and warding off painful experiences, finding the experiences more focused and problematic, finding the experiences puzzling, then understanding and accepting them to finally mastering them. Mothers seemed to be explaining the commitment needed to pass through these stages. Some were able to describe the stage where the problematic experiences were perceived as more focused and problematic, which was painful.
Another useful transtheoretical theory of change which warrants attention is the stages of change model (Prochaska & DiClemente, 1982; Prochaska et al, 1994). This model suggests that people who go through a process of change move through stages in a cyclical fashion. The six stages outlined are of precontemplation (no intention to change self), contemplation (acknowledging problem, but struggling to understand it), preparation (planning to take action), action (modifying behaviour, making changes), maintenance (preventing relapse) and termination (reaching ultimate goal). Mothers talked in a way that suggested they had entered therapy in the action stage, and this contributed to their positive outcomes. They acknowledged that they were experiencing difficulties (contemplation) and considered taking action (preparation). They then entered into a phase of action through accessing SFBT with the desire to make changes. Mothers described their commitment to the action phase, which “requires the greatest commitment of time and energy.” (Prochaska et al, 1994 p44) by being honest, actively taking responsibility for making changes and tolerating the pain. Mothers were also willing to rise to the challenges of the maintenance phase by taking responsibility for change. Atkinson & Amesu (2007) highlight how solution focused questions can assist people in moving through stages of change.

2. INITIAL CHALLENGES
This master theme arose out of mothers' descriptions of initial feelings of anxiety, nervousness and sometimes fear about what lay ahead in therapy. These challenges needed to be overcome for mothers to continue to be engaged in therapy.

2.1 Fear of concealed reactions
All mothers were nervous about the camera in the room or the screen that was used. This seemed to be about concealed reactions from the hidden therapist.
As Wendy explained:

“Nerve wracking, knowing there was someone behind the screen. It was like, yeah, frightening.

I: And what, what do you think made you particularly nervous?

P: Not knowing what to expect and I say, knowing there was another person behind this screen and not being able to see them and their reaction to things that were said and um..” (Wendy).

For most mothers these fears were alleviated fairly rapidly as the sessions progressed and the process became more familiar. Interestingly, this remained a concern for Margaret who attended less sessions. Margaret perhaps did not have time to develop a stronger relationship with the therapist and overcome this challenge. She likened the screen and camera to “Big Brother watching you.”

Anna found meeting the therapist behind the screen was useful and enabled a connection to be maintained:

“...so she was involved but wasn’t there, if you know what I mean” (Anna).

Kuehl et al (1990) found “clients often conceptualized ‘the group behind the mirror’ as a ‘necessary evil.’ ” (Kuehl et al, 1990, p316). Clients valued the group for their suggestions and for keeping therapy on track, but at the same time found them intruding. Some also perceived them as a group of experts which was reassuring (Kuehl et al, 1990).

Sells et al (1994) found that clients of couple therapy reported that the reflecting team being visible, i.e. coming into the room, was important. Having both
genders represented in the reflecting team was important as clients viewed males and females as thinking differently. The team was more difficult to work with in the beginning until trust was developed. This seemed to be what mothers in this research were describing. Those mothers who felt a connection with the therapist behind the screen seemed to be less worried about the notion of it, and building trust facilitated the process.

Howe (1989, 1996) found that clients feared the camera and the unseen group of observers. He suggested that clients projected their fears onto, and had fantasies about, the unseen observers, and that the camera made the situation feel more threatening. One mother also likened the reflecting team to Big Brother, as Margaret did.

Smith et al (1995) suggest that when using reflecting teams it is necessary to set the stage in order for clients to find them useful. This includes building trust in the team and developing a sense of credibility. They found clients only found the team useful, and could make use of their multiple perspectives, when these conditions were established. Reflecting teams can enhance therapeutic alliance, but a good therapeutic relationship needs to exist before it can be subsequently improved by the reflecting team (Kleist, 1999).

2.2 Fear of unknown
This reflected four mothers’ initial fears about what might happen in the therapy. Again, these seemed to dissipate as the process unfolded.

"It, it was at first, because it's the fear of the unknown and I'd been pushed around a lot within the services." (Fiona).

“Yeah, not knowing what to expect” (Wendy).
Joan also expressed some worries about talking to someone unfamiliar:

"With a stranger it’s...you’re not quite sure what you’re getting into and if I thought, as I found out, it was beneficial.” (Joan).

For two mothers, these anxieties were heightened by the stigma associated with accessing mental health services. Anna explicated this well;

“It’s all a bit daunting, really, because you don’t know what to expect. It all sounds a bit um...dramatic, you know...mental health seems a bit scary and that’s on the headed paper... when it comes through the door you think, ‘Oh gawd!’...” (Anna).

2.3 Learning the approach
Essentially, this theme reflects how mothers took to the unique approach of SFBT. Some revelled in the approach from the beginning, for example Heather:

“I think possibly they, we talked about sort of...that we were talking about solutions to the problems. It was a nice experience you know, it wasn’t horrible or anything it was quite nice and I felt quite relieved after I’d been.

I: Mm, um, what was it like thinking that you would be talking about solutions?

P: Great! (laugh). Great, great, yes.”(Heather).

Whereas Wendy and Fiona found the approach more challenging to adapt to. They needed more time to adjust to focusing on positives rather than having an anticipated “sounding board” (Wendy) for negatives.
“At first I used to feel really angry because I’d, I’d think “Oh for goodness sake, you know, I’m coming here, I need help. Nobody wants to help. Um, I’m trying to tell you what things are going wrong I need you to give me answers. And all you want me to do is get me to talk about the good. But I need help with the bad to make it good. “And you know, all this. But in the end I could see what they were trying to do, you know” (Wendy).

Fiona and Wendy seemed to use the therapeutic relationship to assist with making the adjustment to a focus on positives and possible solutions.

Again, the mothers’ readiness for change, and commitment to it (Prochaska et al’s 1994 action phase) seemed to enable them to confront these initial challenges, with the support of the therapists.

3. THERAPEUTIC RELATIONSHIP
This master theme focuses on the relationship that was developed between the parent and therapist and the child and therapist. It incorporates how mothers perceived the words and behaviours of the therapist.

3.1 Therapist qualities (facilitating engagement)
All mothers referred to the positives qualities of the therapist, which seemed to facilitate their engagement and ultimately commitment to therapy. Building a relationship with mothers, and their children, was a vital aspect of the therapy for all mothers, although less so for Margaret.

“Sam was very easy to talk with” (Heather).

“And I just felt that Sam, perhaps more than anybody else, was able to hit buttons that other people weren’t. In the way she asked her questions” (Margaret).
The development of the therapeutic relationship was a turning point for Wendy:

"I started to feel comfortable with the two of them. I knew how to take Jo." (Wendy).

This subsequently became one of the most important factors of the therapy for her:

"They're friendly, welcoming, make you feel good about yourself and that's what I miss." (Wendy).

It was a facilitating factor in the therapy for Joan too;

"although it's in some ways it's difficult it's easy because I got to know Jo and Sam and I know that they're there to help and not to be judgemental." (Joan).

For Kate, the relationship the therapist built with her child also helped her to feel at ease and trust the therapist. Anna found talking to the therapist the most useful aspect;

"I think just sort of being able to talk to her [the therapist], really" (Anna).

Clients in Kuehl et al's (1990) study who were satisfied with the outcome of their family therapy talked of the therapist being caring and understanding. Their perception of the therapist as caring and interested made it more likely for them to share information. This enabled the therapists to generate ideas based on the information. Bischoff & McBride's (1996) found therapist empathy and understanding as most helpful for clients. Respondents in Lee's (1997) study reported feeling validated and supported as the most helpful element of SFBT.
3.2 Outside session support

Five mothers, without prompting, referred to the supportive actions that the therapists undertook outside of the therapy session. For example, speaking on the telephone and providing support or accompanying mothers to school meetings. There was a feeling of therapists going the extra mile, a sense of therapists being busy but remaining committed, and this led to mothers feeling valued.

"the same with Jo when I needed the [omitted] form, it was you know war on peace and Jo sat with me and took an hour out of her own time and I felt, you know, so grateful, that I had that help and I thought you didn’t have to do that” (Fiona).

Mothers also felt reassured that they could access support on an ad hoc basis.

“I know that they’re so kind and nice that I could phone up if I was in a real spot and they’d push me in the right direction. Um, and I would only do that if I absolutely had to, but...” (Heather).

Parish & Eagle (2003) explored how therapists can serve as an attachment figure; provide a secure base from which the client can explore their world (Bowlby, 1988). The relationship that clients formed with their therapists was similar to an attachment relationship, containing every feature associated with an attachment relationship (proximity seeking, turning to them when distressed, holding a mental representation of them) except protest on separation. Some mothers in this study seemed to similarly use the therapists as a secure base, enabling them to explore and undertake tasks outside of the therapy session. By providing support outside sessions, the therapists seemed to demonstrate themselves as available and sensitive caregivers. This facilitates the development of an emotional bond (Bowlby, 1982) and enhances the sense of
safety. Bowlby (1982) described how attachment figures are used as a safe haven, who can be turned to at times of distress. By providing support outside of sessions, the therapists were able to provide a safe haven for mothers to access if they were distressed and required comfort.

SFBT techniques do not comment on support outside of sessions, yet this was offered by therapists at the clinic and was an important aspect of therapy.

3.3 Expert versus collaborative approach

Although not explicitly stated, mothers seemed to describe the flexibility of the therapists in their ability to switch between an expert and collaborative approach depending on the mothers' needs at the time. At times, therapists were more directive and mothers relied on their advice:

“It's like when you go the dentist, he tells when you go for a filling or just a review. They're the specialists.” (Joan).

Whereas at other times the therapists were less directive, more exploratory and encouraging of mothers to be involved in decision making.

“they never said “do this do that” ever, ever, um we just talked about different ways of dealing with things and it was up to me whether I chose to take it on board.” (Heather).

Flexibility of the therapist was important to clients in Kuehl et al's (1990) study. Clients who were dissatisfied described their therapist as on “too strict a program.” (Kuehl et al, 1990, p319). The therapeutic relationship was also highlighted as important in Lloyd & Dallos’ (2008) study. Collaboration and advice was highly valued by mothers, although some were disappointed by their unfulfilled expectations of the therapist as a directive expert.
In terms of the therapists as an attachment figure, Bowlby (1977) suggested that the figure is usually seen as stronger or wiser. In the therapeutic situation, if the client does not experience the therapist as stronger or wiser, they may feel unsupported and fearful (Liotti, 2000). Mothers seemed to perceive the therapists as stronger and wiser, which further enhanced the relationship and secure base from which to operate.

A salient aspect of this theme not explicitly labelled, but important to address, is the notion of power within the therapeutic relationship. Mothers may have alluded to this in their descriptions of times when they positioned the therapist as an expert. Bischoff & McBride (1996) found that family therapy clients recognised the power differential inherent in the therapeutic relationship. Clients would defer to the expertise of the therapist and follow their lead, sometimes at the expense of their agendas.

DeVaris (1994) highlights power as a difficult concept to define in psychology, but that ideas about power in models of therapy can impact therapists’ conceptualisations of the problem and associated treatment goals. It is complex; "power in the treatment relationship is like a double-edged sword, that can either free a patient from the bondage of psychopathology, or unwittingly reduce a patient’s sense of empowerment." (DeVaris, 1994, p591).

Literature has shown that the role of the therapist is central (Blow et al, 2007, Flaskas, 1994). Relationship factors are thought to account for around 30% of client improvement (Lambert, 1992). Therapist factors are essential to outcome, for example therapist belief in the model used in therapy is more important than the type of treatment employed (Wampold, 2001). Therapist qualities of friendliness and positivity are consistently related to good outcome, and therapist hostility and criticism are related to poorer outcome (Beutler et al, 2004). Blow et
al (2007) believe that “it is in the therapeutic relationship that therapists either make or break therapy.” (Blow et al, 2007, p306).

4. POSITIVES AS CENTRAL
Fiona’s quote sums up the unique nature of SFBT and the importance of this master theme:

“And with other services, there’s never been positives. There’s been tablets, there’s been pills, there’s been wards, but there’s never been anything positive out of it.” (Heather).

4.1 Positives from therapist(s)
Mothers valued the positive commentary and feedback that they received from the therapist highly, and for some the feedback had a huge impact.

“It just buckered me up, honestly, I would come in thinking Oh I want to slit my throat and I would leave thinking thank God I have them to talk to and ..ah go out with fresh new eyes and perked up again ready to fight the good fight” (Heather).

“I think when they used to go out and come back in Sam would, er, went with the positive things that came out of the meeting. She kinda neglected the negative things which was good really – it gave Jemima something to focus on” (Margaret).

Fiona and Wendy also highlighted the benefits of having more than one therapist picking up on the positives:

“Oh yeah, somebody else to highlight something to you that you could have found but actually needed a bit of help. I ‘spose it would be like looking for a
needle in a hay stack - be really hard with one pair of eyes, but if there were four... it increases the chance of being able to find it by three.” (Fiona).

Other clients of SFBT mentioned praise as a one helpful aspect of therapy (Metcalf & Thomas, 1994).

4.2 Use of notes
For Fiona and Wendy there was a sense of the positive progress as undeniable as it was documented in their notes. This led to a feeling of safety and that the process could be relied upon.

As Fiona articulated:

“Nothing would ever be forgotten, 'cos they had notes.” (Fiona).

4.3 Tasks as a catalyst for change
Tasks acted, for three mothers, as a catalyst for change. The tasks enabled positives to be created and enabled families to move on.

“I can only liken back to the tasks. 'Cos there was always, if we was having difficulty the tasks would be set about making something positive happen within the family. So the tasks were important." (Fiona)

It also seemed to increase the sense of self efficacy, by demonstrating mothers' and children's influence over the change process.

“And she [therapist] gave her little goals to achieve by each by the telephone appointment or the next time we saw her. Which she had to achieve, which was really fantastic really because that, coupled with her antidepressants, made her move on.” (Margaret)
Anna talked of the usefulness of the tasks in producing short term changes, but also of the difficulty in generalising them beyond just competing them once.

"they are quite useful but as I say, once he's [child] done them he doesn't want to do them again" (Anna).

Anna was in the early stages of therapy, and perhaps the tasks will change in their value for her as they progress and she has the opportunity to hopefully observe more sustained changes.

Kuehl et al (1990) conceptualised a phase that involved parents putting suggestions into practice and reporting back to the therapist. After succeeding in this, parents moved into a phase of sharing successful experiences with the therapist, during which parents felt stronger and more confident. This seems to fit with what mothers experienced in the current research.

4.4 Anticipating positives

Four mothers talked of how they looked forward to the positive feedback:

"cos I used to look forward to the comments that would be coming back. You know, the nice things that would be said or the feedback that would be helpful." (Wendy).

Others also anticipated the positive feelings associated with the feedback:

"I looked forward to the sessions, I really looked forward to them. They were my little fix that could, you know, would make me feel stronger and better." (Heather).
“...so it was a bit addictive actually, because I'd think “Ooh, what good things are you gonna tell me today, and do all these things.” ...So that's how I felt it was a golden carrot, I felt I'd been good, it was a reward.” (Fiona).

The clients in Metcalf & Thomas' (1994) study reported that amplifying strengths, reinforcing, praising, noticing differences and questions highlighting what worked were helpful. These results seemed to be mirrored by mothers in this theme.

There are interesting links that could be made to neuroscientific and psychophysiological research on plasticity within the brain and the impact of therapy. Lipchik in her interview with Young (2005) raised the notion of integrating neuroscientific findings with systemic therapy. Cognitive behavioural therapy for social phobia has been shown to produce changes in the brain similar to changes brought about by medication (Furmark et al, 2002). Davidson's research, in press (see Davidson, 2000), found that mindfulness meditation-based stress reduction resulted in an increase in left sided anterior activation, which was different to the wait list control. Davidson (2000) suggests that “What is absent are data on plastic changes in the brain that might be produced by the practice of methods specifically designed to increase positive affect...” (Davidson, 2000, p662). SFBT is increasing positive affect over time according to the mothers in this research.

Davidson (2000) suggests that setting goals and working towards achieving them activates the reward circuitary in the prefrontal cortex. It could be argued that this is what SFBT does. By setting goals, working towards them and receiving rewards for achievements as described by mothers, neurobiological changes could be taking place as a result. Perhaps this is the addictive feature described by Fiona.
At a behavioural level, SFBT is operating according to principles of operant conditioning (Skinner, 1953). The positives from the therapist are positively reinforcing and therefore increase the likelihood that the desired behaviour (completing the task) will be repeated (Stallard, 2002).

4.5 Becoming own therapist/internalising techniques
All mothers alluded to continuing to use some techniques learned in SFBT independently, either in between sessions or after therapy was complete. For Margaret, whose brief experience of the process was less positive than other mothers, the scaling question that was used was a vital part of the therapy and continues to be important:

“I think that tool was the best thing that we ever had. We still use it now.” (Margaret).

Two mothers in Lloyd & Dallos’ (2008) study similarly continued to use the scaling exercise.

For other mothers, it seemed to be a subtler internalisation of the techniques. Their cognitive style changed, in that they were able to more autonomously search for positives.

“All of a sudden your mind would, rather than think “Oh God! You know this is a nightmare. OK this is a nightmare, but, it was even worse, you know, a few months ago.” So I can now, “what can I do to make this a little bit better”. So depending on the situation you try and find a positive and the sneakiness is that you would never have done that before.” (Fiona).
5. BELIEF IN THE PROCESS

5.1 Belief in change as possible
Four mothers alluded to the belief that they held in the process, which was important to hold on to.

“...there is help, but you have to believe” (Fiona)

Mothers seemed to hold onto the idea that change was possible which enabled them to stay with the process of therapy. This was facilitated by the therapists instilling confidence in and validating mothers’ hopes for change.

“...there was a lot of hope there and a lot of confidence given that you know given across to you that things will you know, won’t be like this, you know they will change. And erm, not just the parent but more for the child, you know, giving them confidence to say erm, you know, it isn’t always gonna be like this, you now, it will will get better, so..” (Kate)

Two of these mothers also used the analogy of therapy as light at the end of the tunnel;

“...reassured that there is light at the end of the tunnel, even though it could be an awfully long way to get there” (Anna).

“...there’s light in a dark world, there is light there you just gotta take time to look for it.” (Wendy).
5.2 Observing changes

All mothers talked of changes that they observed. This led to mothers feeling that the therapy was working, increased belief in the process and encouraged mothers to remain in therapy.

Kate was amazed at how quickly she observed changes (from the first night) and this immediate success rapidly built trust with the therapist:

"she did the very first time ... that automatically built a trust as in I could... I trust you for what you said, you know, it's working" (Kate).

For Margaret, the success she witnessed with her daughter seemed to be the only reason they returned to the next session:

“And because we were quite successful in what we were doing I don’t know how a parent would go that wasn’t so successful. I don’t know how they would feel.” (Margaret).

5.3 Familiarity

Four mothers talked of how the routine and knowing what to expect made going to therapy easier. The predictability of sessions seemed to foster a sense of safety and enhance belief and trust in the process.

“I think it gets easier each time, cos you’re more familiar with the room, the staff. It’s um, the sessions seem to follow the same pattern,” (Joan).

This master theme resonates with literature on hope and expectancy. Lambert (1992) suggests that 15% of client improvement is accounted for by expectancy and placebo effects; the client’s knowledge that they are receiving treatment.
Garfield (1994) supports this position, finding a relationship between expectations and improved outcome, particularly early on in therapy.

"Successful negotiation and acceptance by the therapist and client of the tasks, techniques, or rituals of therapy, as well as the therapist's communication or belief about the efficacy of these tasks, naturally lead to increased morale and hope in the client." (Asay & Lambert, 1999, p45) Thus SFBT's emphasis on the possibility of change, and rapid experience of change for some mothers, fosters hope.

Flaskas et al (2007) remind us that "Psychotherapy itself stands as an activity for hope, for the collaborative project of client's and therapist is always about the possibility of change." (Flaskas et al, 2007, p1). They highlight that the move towards strength based approaches, such as SFBT, speak to the importance of hope as a central tenet. Weingarten (2007) describes hope as a wish, or expectation of something desired, along with hope as a practice which you can do with others. McGoldrick & Moore Hines (2007) view hope as central to therapy and consider it a verb; hope enables people to see a future and mobilise the self for action. Lethem (2002) suggests that SFBT can instil hope in therapists and clients.

Clearly, the hope that mothers brought to therapy, along with the hope that was instilled by the therapist, was created together and was a helpful part of the process. It kept mothers coming back to therapy and engaging in the tasks. Seeing changes enhanced the hope that their goals could be achieved. The preferred future became a possibility and ways to achieve it emerged.
6. POWER OF THERAPY

6.1 Outcome/gains
All mothers identified a wide range of positive outcomes as a result of engaging in SFBT, for themselves and their children.

"I'm a much stronger person for coming." (Heather)

"Certainly things have got much better" (Joan)

"but now I mean they [the problems] just seem like distant memories." (Kate)

Mothers talked of changes that were both internal (changes in thinking style/improved mood) and external (observable behavioural changes).

6.2 The struggle to end

For four mothers still in active treatment, ending therapy was construed as a difficult task. It seemed indicative of the importance placed on attending SFBT and the usefulness of it.

"Gonna miss em! (laugh)...But um, I don't know, it's nice knowing they're there but not having an appointment to go to seems a bit scary (laughs). Thinking I'm on my own now, you know." (Wendy).

Loosing the support that the sessions afforded seemed to be a concern:

"they've been so supportive that it's a big crutch to throw away" (Heather).
Anna also expressed concerns about the lack of services to access when the therapy terminates:

"there doesn't seem to be a great deal outside that is going to help us from... outside, apart from just going there, really, so I don't know, really" (Anna).

Metcalf & Thomas (1994) also found therapy termination of SFBT was difficult, with some clients feeling that they had not completed therapy. Mothers in the current research felt that the time to end would be negotiated with the therapists, but that it was still difficult to consider life without it.

The ending is important from the beginning of therapy, and there is a balance to be found in not ending too early or too late (Mander, 2000). Seeing the therapeutic relationship as an attachment reinforces the notion of the therapist as important and that the termination may be experienced as a loss (Parish & Eagle, 2003). Some mothers in this study seemed to anticipate the termination of therapy as a loss, which made the notion of it hard to consider.

6.3 Valuing therapy

This theme encompasses mothers' feelings of overwhelming gratitude for being given access to the service and for the far-reaching consequences it enabled them to achieve.

"...because I felt that I would have gone under - I think I would have ended up killing myself if I hadn't had um Jo and Sam to talk with, I really do. They've been my little saviours." (Heather).

" it rescued us, is that way I looked. It helped, It was like a wing, a protection, because it helped us" (Fiona).
This was also demonstrated by the mothers’ desire for others to derive the benefits from SFBT:

“I just feel like if it helps other people it’s got to be good isn’t. I mean I’ve been helped, got to pass it down the line.” (Margaret).

“…anybody that’s got you know a child that’s got you know those kind of problems, if they get a chance to you know see somebody then you know, definitely I think it would help them. Definitely, definitely.” (Kate).

This theme supports Metcalf & Thomas’ (1994) study, which found that clients described the changes resulting from SFBT as meaningful, helpful and making a difference. Improving mothers’ quality of life enhances the whole family’s quality of life. There are social and economic benefits to this, particularly in improved mental health of mothers. It enables mothers to maintain their position as carers for their children, minimising the likelihood of children entering the care system.

**Respondent Validation**

Mothers were sent an amended version of results and an accompanying letter (appendix XIII) and asked to give feedback over the telephone. Summaries of these conversations with three mothers can be viewed in appendix XIV. Although only three mothers are represented, they were in broad agreement with the results and all felt that the themes fitted with their experiences.
DISCUSSION

Summary of findings

Mothers were able to share their experiences of embarking on, continuing with and in some cases ending SFBT. Whilst therapy was a mainly positive endeavour for mothers, their experiences of the process varied. For those who were nearing the end, or had terminated, there was a sense of the process being meaningful and leading to positive changes for them and their family. These finding broadly fit with other studies exploring clients’ experiences of SFBT (Metcalf & Thomas, 1994; Beyebach & Carranza, 1997) and family therapy (Bischoff & McBride, 1996; Kuehl et al, 1990). In line with existing literature, the therapeutic relationship and the feeling of being understood, validated and supported were important. This research demonstrated the centrality of mothers experiencing and anticipating positives from the therapists, from the tasks and from their ability to continue using what they learned. The therapeutic relationship provided a safe base from which to take risks and try new ways of doing things whilst feeling supported.

Challenges for these mothers during the process of therapy included the initial fears of what lay ahead, anxieties about what was hidden from them and, for some, learning that the approach emphasised positives. There was also acknowledgement that the process was a difficult one at times. These were, however, hurdles that were overcome - these challenges were faced and accomplished. This was partly through what the mothers brought: a desire to change and a commitment to do so, dedication to the therapy, hope and trust that the pain of the process would be worthwhile. It was partly through what the therapist brought: the ability to create a safe relationship by listening and validating mothers’ experiences, presenting themselves as credible therapists, responding flexibly to mothers’ individual needs, being supportive and available.
It was partly what the model brought in its assumptions and techniques. What has become apparent is that it is the combination of what a mother, therapist and model can offer in collaboration with one another that makes for effective therapy.

In the main, the results seem to dispel the criticisms that have been made of SFBT. The therapeutic relationship and the role of emotions (Piercy et al, 2000; Kiser et al, 1993; Stalker et al, 1999) seemed to be adequately addressed for these mothers. The process did not seem to be 'solution forced' (Nylund & Corsiglia, 1994) and mothers did not report feeling invalidated. Mothers commented on opportunities to talk about difficulties and in doing so were then able to take a different, more positive, perspective on them. SFBT seemed to produce good outcomes for mothers who presented with a wide range of difficulties, in terms of type, severity and duration. Whilst SFBT perhaps does not address the feminist perspective in its theory and assumptions, some mothers in this research did seem to become more empowered, gain an increased sense of control and power in their role as a mother and individual in society. Perhaps this might have been different if the therapists were male and a different power dynamic was apparent in the therapeutic relationship.

However, the therapist was experienced as having good clinical practice and judgement. The mothers in this research came with a variety of presenting concerns and varied in their existing support networks and levels of resilience. Some had completed parenting groups first. Some mothers talked of the timing of the intervention and, whilst this was not developed as a theme, it was important. The therapists did seem to be making careful choices about when it was appropriate to offer families SFBT and perhaps this was key to the positive nature of the accounts given by mothers.
**Common factors versus specific ingredients**

The current research findings can be thought of in relation to common factors and specific factors of therapy. Common factors are aspects of therapy that create change which are common across schools/models of therapy. This area has received much research interest (Asay & Lambert, 1999). Specific ingredients are the techniques used in interventions which are specific components of therapeutic models. There is little evidence to support the superiority of one model over another (Wampold, 2001; Asay & Lambert, 1999) and methodological limitations hamper clear conclusions being drawn (Lambert & Ogles, 2004).

Lambert (1992) concluded that 40% of improvement in psychotherapy is due to extratherapeutic factors, related to the client and the environment which facilitate change regardless of whether individuals enter into therapy. The next largest factor that he attributes change to is the therapeutic relationship (30%). Equal weighting is then attributed to techniques specific to models (15%) and expectancy or placebo effects (15%).

**Extratherapeutic factors**

Research suggests that some change can be attributed to factors outside of the therapy, such as client variables, fortuitous events, social support (Asay & Lambert, 1999). Clients come to therapy with difficulties that vary in severity and duration, with differences in personality and social support (Asay & Lambert, 1999). These impact on their capacity to develop relationships. Strupp (1980) found differences in therapy outcome could be related to the client and that preconditions of the client’s motivation and openness to therapy must be in place.

Many of the mothers in this research were single parents or did not live with a partner and talked of how friends and family could no longer provide meaningful assistance. Asay & Lambert (1999) suggest that many people improve without formal psychological treatment and highlight the role of supportive networks such
as friends, family, teachers and religious leaders. Perhaps some of the mothers in this study were more isolated and required a more formal intervention as their supportive networks alone were no longer sufficient. One parent who seemed to have by far the most support from sources outside therapy had the shortest intervention. Perhaps in this research the extratherapeutic factors have more of a bearing on treatment duration or frequency of appointments, with those with more support requiring less sessions.

**Therapeutic relationship**

This is a commonly studied aspect of therapeutic change with the central importance of this widely recognised (Asay & Lambert, 1999). The therapeutic relationship is related to outcome across approaches (Bachelor & Hovarth, 1999). A positive relationship is a necessary part of therapy and seems to be formed early on (Bachelor & Hovarth, 1999). It is how the client perceives the relationship which is relevant to outcome and both the therapist and client contribute to the relationship; the therapist creates a safe, trusting space and the clients commits to therapy and collaborating with the therapist (Bachelor & Hovarth, 1999).

In this study the therapeutic relationship was seen as important by mothers and most perceived the relationship in a very positive fashion. Clearly, mothers brought qualities to their therapeutic relationships, including the commitment to therapy and their willingness to work in collaboration with the therapists. The centrality of this relationship is also exemplified by mothers’ descriptions of their struggle to accommodate the termination of therapy and the importance of accessing support outside of sessions.

Attachment theory (Bowlby, 1977, 1982) assists in understanding the importance of the therapeutic relationship and the function that it serves. The therapeutic relationship served as a safe base from which mothers could explore and
experiment with tasks outside of the sessions. The relationship also enabled mothers to anticipate and experience the delivery of positive reinforcement. This is encompassed in Bordin’s (1979) concept of the working alliance, formed of agreement of goals (mutual aims endorsed by therapist and client), tasks (the work of therapy, viewed by both as important) and bonds (the relationship between therapist and client which needs trust, confidence and acceptance).

**Techniques specific to models**

There appears to be little literature examining the effectiveness of SFBT compared to other models, with recognition that SFBT research is in its infancy. More broad research suggests evidence which consistently supports the effectiveness of specific models is lacking (Wampold, 2001).

The mothers in this research described their experience of the positive nature of SFBT, which felt a unique aspect of the therapy. The emphasis was on searching for positives, using tasks to create positives and receiving positive feedback for achievements. Whilst positive elements are used within other therapeutic modalities, the central nature of them in SFBT does seem to provide mothers with a unique experience. Mothers were adept at identifying techniques used in SFBT and able to attribute changes to them and the way that they could apply them.

**Expectancy**

Although findings are inconsistent, expectations of clients, particularly early on in the therapeutic process, seem to be important in outcome and treatment duration (Clarkin & Levy, 2004). Therapy is an activity of hope as it creates the possibility for change, and is an integral aspect of the journey that clients make (Flaskas et al, 2007).
For mothers in this study, a desire for things to change, and a belief that change was possible, were vital. It seemed necessary to enable them to initially embark on the process and remain engaged when things became difficult during the process of assimilation (Stiles et al., 1990). The importance of timing, which was highlighted by some mothers but was not incorporated into the final themes, is also salient. Some mothers had completed a parenting group or accessed other services first. This would have had an impact on their expectations and hopes for change. Experiencing previous changes may have increased their expectations for change.

The Therapist

Whilst these factors are important to the current study, it is not possible to determine the relative weighting of each aspect. More recent thinking also suggests that not enough attention has been paid to the role of the therapist in outcome (Blow et al., 2007). Simon (2006) suggests that the bridge between common factors and model factors takes place in the therapist when congruence exists between their worldview and the therapy model principles. Blow et al. (2007) argue that the role of the therapist is key and that being a competent therapist is in itself a common factor. This fits with research that shows therapist allegiance to a model is more important to outcome than the type of treatment used (Wampold, 2001).

Another factor that does not appear to be addressed in the common factor debate is that of therapist supervision and support. As therapist belief in the process is important, good supervision may play an important role in maintaining belief when therapy progression may be slow. Flaskas (2007) highlights the challenge for therapists in times of impasse when the work becomes stuck and it is important to hold hope for the family. Supervision would be vital at times like this. Perhaps just like the therapist would temporarily hold hope for the family, the supervisor would hold hope for the therapist to enable the work to continue.
Diversity

Gender

This is an important aspect which requires exploration. It is notable that in this research endeavour a female discourse has dominated the enterprise. The participants were all female. The therapists were female. The researcher was female, and so was the research supervisor. Psychotherapy can be perceived as a feminine activity as the process of therapy fits with the stereotypical female, rather than male, experience (Brooks, 2001). Within this research it is possible that the male perspective has unwittingly been marginalised.

Research has shown that there is not a clear relationship between therapist gender and outcome of therapy (Lambert, 2004). However, there are limitations of gender effects research, including small sample sizes, lack of control for symptoms/diagnoses of clients investigated and therapist factors such as experience, and using measures which are not reliable or valid (Zlotnick et al, 1998).

Clearly, the issue of gender effects in therapy is complex. Therapists and clients both bring preconceptions about gender roles and ideas about the contributions that each other should make in the therapeutic encounter at each stage of the process. Being aware of one’s own gender identity, acknowledging beliefs and attitudes about gender roles and how they are transmitted in families is necessary for systemic therapists to reflect upon in order to effectively join with families (Jones, 1996; Brooks, 2001) and practice ethically (Avis, 1998).

Some research suggests there may be some initial effects of therapist gender which reduces as a relationship is formed (Newberry et al, 1991). Therapists and clients alike may have to overcome their own stereotypes about gender (Newberry et al, 1991). When investigating gender effects in the first phase of family therapy, Newberry et al (1991) found male and female therapists used
similar kinds of behaviours, but that the families responded differently to them. Fathers responded more positively to structuring behaviour and female therapists were responded to in a more supportive way when they offered support, compared to male therapists. Whilst this was only in the first few sessions, it did seem that clients were more comfortable with gender stereotypic behaviours from the therapist.

Whilst research investigating the impact of matching therapist and client gender is not clear cut, it is an important issue. This issue was not explicitly explored with mothers in this research. However, it does appear that mothers were satisfied with the therapists in the main, and it is possible that the gender match contributed to the formation of good therapeutic relationships. At times mothers referred to the therapists being mothers themselves, and perhaps this also contributed positively to the formation of the sound therapeutic relationship.

Gender may play a hidden role in the therapeutic relationship, with male therapists having more socially prescribed power than a female, and a more balanced power differential when therapist and client are the same gender (DeVaris, 1994). Perhaps there was less of a skewed power differential in the relationship that mothers had with their therapist(s) which assisted the process as mothers could be open, honest and freely take risks.

Fathers
Another aspect related to gender roles which requires attention is that of the involvement of fathers. In all cases, fathers were not actively involved in the treatment, in that they did not attend the therapy sessions. Fathers seem to attend therapy for children and families much less than mothers (Duhig et al, 2002; Walter et al, 2001), but research suggests that fathers’ presence can increase the effectiveness of family therapy (Carr, 1998). For some families involved in this research, fathers were not present in the family, and thus their perspective would be less relevant if they did not maintain contact. However, for
other families fathers made a choice not to attend. How and why this decision was made is important. Duhig et al (2002) in the USA and Walters et al (2001) in the UK stress that it is important for clinicians to engage and involve fathers in therapy and make recommendations for how to do so.. However, Lee (1997) found that SFBT was effective regardless of who attended the sessions and suggested that one change in the system creates bigger changes. Perhaps this is what occurred in the families of the mothers who participated in this research.

**Ethnicity**

There is a lack of research which explores therapist and client ethnicity related to outcome (Lambert & Ogles, 2004). The workforce of the NHS is not representative of the communities which it serves and inequalities exist in mental healthcare provision for Black and Minority Ethnic Communities (Department of Health, 2003). It is important to address this and make steps to create a culturally competent NHS workforce (Department of Health, 2003). In the current study, all mothers and therapists were White, although each individual's heritage would have varied. Perhaps, though, it did go some way to minimise the inherent power imbalance in the relationship and forged a good therapeutic relationship which enabled the therapy process to continue.

**Single Parent Status**

Many of the mothers in the study were single parents. This may have impacted the value that was placed on therapy and the importance afforded to talking frankly with another adult. As Parish & Eagle (2003) found, adult attachment figures are frequently a spouse or romantic partner. When mothers are without this form of relationship, therapists may adopt a more central role as an attachment figure and safe haven. It did seem that mothers who lived alone or whose partners were less emotionally available used the therapist as a primary attachment figure and that the thought of ending was harder to consider.
What constitutes brief?

The research raised an interesting question about what constitutes brief in SFBT. Some mothers had been in contact with the SFBT clinic for many years. O'Connell (2005) highlights that different approaches have different definitions for brief therapy, but suggests that brief means less than 20 sessions. He highlights that brief therapy does not mean less of the same, but that it offers something different to longer term therapy. “Brief does not mean rushed” (O’Connell, 2005, p24).

These definitions do not indicate the length of time between therapy sessions. SFBT does not dictate number of sessions. Many therapists avoid contracting according to number of sessions and the frequency of sessions is negotiated (O’Connell, 2005). Some mothers in this research had lengthy gaps of months between sessions, or may have had telephone contact in between sessions. Presumably then a client could feasibly remain in contact with a service for such a long durations and still be receiving a brief intervention if it was measured by number of sessions. Roberts (2001) defines brief therapy very broadly and includes solution focused therapy in this bracket, without being any more specific. Rothwell (2005) found in an NHS primary care setting that treatment duration with SFBT with adults was on average less than CBT. This difference seemed to be partly accounted for by the greater numbers of clients who attended only one SFBT session. Perhaps there are some clients who are able to utilise a very brief intervention, such as the mother who attended two sessions in this research. Perhaps there are other individuals/families who require longer interventions in terms of time, but still benefit greatly from the solution focused approach. They can have a larger duration between sessions enabling them to remain connected with a service for a longer time period. Indeed, O’Connell (2005) suggests that SFBT does not need to be brief and suggests that time needs to be made an ally, not an enemy.
Personal reflections

It is necessary to consider how I as a researcher influenced the process. I came to the research with a set of assumptions about how it might feel to undertake SFBT. I wondered whether there was a risk that mothers might not feel heard, wondered about the power of focusing on positives and was intrigued by the notion of common factors in therapy. Perhaps the results that were produced reflected these interests. I was more likely to pick up on instances when mothers found it challenging to remain focused on the positives, or were expecting to talk about problems and had to adjust to thinking about solutions. However, the findings suggested that perhaps some mothers needed more time to adjust to the model, as they might do with any therapeutic intervention, and that ultimately they did feel heard and valued the way of working. Focusing on the positives did appear to be a valuable aspect of the therapy, along with the factors such as therapeutic relationship and expectancy that are important across schools of therapy.

Whilst I did have some assumptions, I acknowledged them prior to completing the interviews. I also wished to remain open-minded to the process and attempted to respond flexibly to what mothers told me. I hope that I was able to go some way to achieving this.

What I also found interesting was how I was perceived and positioned by mothers in my role as a researcher. Mothers often assumed that I knew information about their difficulties for which they sought help, or information about their background or number of sessions that they had attended. I was often positioned as part of the system from which they accessed help. I wonder what impact this had on the way that mothers answered questions, and whether they felt they needed to remain positive about their experiences. It felt like mothers were genuine in their responses and able to expand their answers with prompting. This suggests that
they were being genuine, although perhaps they omitted information that they felt might be difficult for me, as a representative of the system, to hear. I considered myself as a naïve observer of the process as I had not seen the SFBT in action. This was rapidly disbanded when I realised how mothers viewed me as a person with knowledge. Mothers asked me about my stage of training, what I would do when I qualified and whether I was like their therapist in my professional background.

I also wondered about how mothers perceived me as an individual. Being White and female may have had an impact. Mothers may have been more likely to disclose personal information to me, despite having never met me before, as they knew my status as a Trainee Clinical Psychologist. They may have expected me to be supportive, in line with gender role stereotypes as female therapists are often perceived to be. Perhaps being a White female and interviewing White females there was less of a power differential, which facilitated talking. Perhaps conducting interviews in mothers' homes also facilitated mothers' descriptions of their experiences and helped them to feel more at ease, or more in control, in their familiar environment.

I also considered the impact of the way that I asked questions and the dynamic that was created between me and different mothers. Some mothers needed minimal prompting to talk, whereas others required much more. In my desire to not influence mothers' accounts of their experience too greatly I was hesitant to ask additional questions at times. At other times it is possible that I asked closed questions which hampered open responses. In retrospect I wish that I had taken more risks and probed more, and asked mothers to deconstruct some of what they said. Despite this, much of the data was rich.

Undertaking IPA was an interesting and at times anxiety provoking process for me. At times it was difficult to know what constituted a good enough
interpretation; I wanted to stay close to the data and loyal to mothers’ accounts, but I was also eager to use psychological theory and produce insightful themes. This tension also raised anxieties about not knowing and there not being a definitive answer. It was hard to make judgements about what needed to be prioritised and which concepts to reject as final themes. There were important aspects that were not included as independent themes, but that I hoped would come across throughout. One such element was mothers’ ability to name the specific techniques used in SFBT in their own language. In their own way mothers neatly described compliments, scaling questions, not needing to know the origin of the problem and an orientation to the future. Devising a word limited piece of research inevitably means that it cannot be all inclusive. I as the researcher with the support of a supervisor held the power to make those decisions and emphasise particular themes. It was also a challenge to give equal weighting to all mothers and not focus on those who articulated more compelling narratives.

The process of completing this research has also led me to contemplate my own clinical practice. The importance of developing a sound therapeutic relationship has been reinforced, along with the importance that therapists hold for some clients as an attachment figure. It has also served as a reminder of the usefulness of being flexible and the power of hope and being positive. These are aspects that I hope to advocate in my clinical practice.

**Limitations**

Through employing IPA this research has gone some way into entering the world of mothers to gain an understanding of some mothers’ experiences of SFBT. The sample has been situated whilst maintaining anonymity as far as possible. The use of IPA has been justified and its application has been described in a sufficiently transparent fashion. Quotes have been employed to exemplify
themes and relevant psychological theory has been applied. The results have been checked by others (research supervisor, other Trainee Clinical Psychologists) and read by the mothers in order to ensure that they are grounded in the data and reflective of mothers’ real world experiences. The results have some utility, in that they provide information about the helpful aspects of therapy and the challenges that needed to be overcome in order to achieve a successful outcome. Suggestions will be made for how clinical practice can be adapted to incorporate the results. However, there are inevitable limitations to the research which require acknowledgement.

IPA deals with texts and relies on language to access participants’ worlds, but can be criticised for not attending to the complexities of language; words construct and give meaning to, rather than just describe, experiences (Willig, 2006). Individuals are not always able to express their experiences in words (Willig, 2006; Baillie et al, 2000). The mothers in the current research certainly varied in their ability to articulate their experiences. Some mothers were able to provide very rich accounts, with minimal prompting, whereas others struggled to explain what they meant. In addition, much of the non-verbal communication was lost in the recording of the interview. This may have also provided valuable information about how mothers found the process of SFBT, or indeed the interview process, and may have impacted on how the interview progressed.

Whilst qualitative research does not aim to be generalisable outside of the sample which was used and caution should be exercised if attempts are made to do so (Brocki & Wearden, 2006; Flowers et al, 1997), it is notable that only White Mothers were interviewed who had experienced SFBT with female therapists. The male perspective, or that of individuals from Black and Minority Ethnic Communities, has not been represented. None of the mothers had dropped out of therapy either, and these individuals may have provided alternative views about the process.
IPA is also limited to a certain extent by the researcher's ability to reflect (Brocki & Wearden, 2006). My bias dictated how to make the difficult decision of which themes to prioritise and present, the level of interpretations made and what constituted good enough analysis (Smith, 2004). Perhaps additional opportunities to reflect may have altered these decisions. Triangulation (comparing results from two or more sources/methods of data collection) may have enabled a more comprehensive or reflective account of the results (Mays & Pope, 2000).

**Implications for service**

The service should be reassured that they have offered these mothers a good experience of therapy that has created meaningful changes. For some mothers, adapting to the solution focused element of therapy was a challenge. Perhaps this is an area that changes could be considered in the way that the therapy is delivered to assist this transition. One parent thought that being told that they would be focusing on the positives would have helped her. Perhaps explicit conversations about the model and its delivery could be had at the initial appointment and then revisited at later stages.

The presence of an invisible therapist behind the screen, and the notion of the camera, was difficult for some mothers. One mother found that meeting the therapist behind the screen, which enabled a connection to be made, was useful. Perhaps for those who find it challenging, multiple opportunities to meet the therapist behind the screen could be offered. Perhaps there might be opportunities for the reflecting team to be in the room, thus increasing their visibility and making the process more transparent to allay fears.

Indeed, sharing the results of this research with parents who are about to embark on therapy might be useful. Hearing that the process helps to create positive
changes for people who are committed to therapy and prepared to work might increase motivation and hope for change. It might normalise some of the initial anxieties experienced by mothers and help them to return to subsequent sessions. It might also provide useful information about the focus on positives and solutions and give reassurance from mothers who experienced the process that it is worthwhile. Perhaps a leaflet could be developed which shares the experiences of mothers who have been through the process and would like to encourage others to do so, as the mothers in this study did. This fits with the service user involvement ethos within the NHS.

The research also raises questions about the extent to which fathers are involved in the SFBT and indeed child and family services as a whole. Some research has shown that interventions involving fathers are more effective (Carr, 1998). Where possible, fathers should be invited to sessions and efforts made to engage them, as suggested by Duhig et al, 2002 and Walters et al (2001). Perhaps services might need to consider offering flexible appointment times, and the impact of having male therapists as the index therapist or as part of a visible reflecting team. The service might also consider exploring fathers' experiences of past relationships, particularly with their own father (Walters et al, 2001), although this may be at odds with the ethos of SFBT.

**Future research**

Further research should address the role of the therapist and what they bring to the therapy. Interviewing the therapists to gain their perspective on the therapeutic relationship, what families contribute, the techniques used and what is most helpful about the change process would be invaluable. Looking at whether the important aspects seen by mothers are the same as those identified by therapists would be interesting – is what therapists believe as helpful in therapy matched by client views? Further exploring the notion that a fit between
the worldview of the therapist and the worldview of the model creates the delivery of effective therapy would also be interesting. It would be useful to see whether aspects of therapy experienced as challenging by mothers are perceived similarly by therapists. It would also be valuable to research the role of supervision in SFBT. For example, the role of hope in supervision and how SFBT techniques might be used within the supervisory relationship.

Interviewing the parents who did not attend SFBT would be valuable. This might elicit information regarding why attendance was not possible or desirable, and whether these aspects could be addressed to encourage attendance. Hearing about the changes that the non-attending parent witnessed or experienced as a result of other family members attending would be helpful in exploring the change processes of SFBT. Interviewing fathers and parents from Black and Minority Ethnic communities would also be useful to see whether their experiences would be similar or different to the White mothers who participated.

From a resource perspective it would also be beneficial to explore the number of sessions that families had in relation to the frequency of appointments. Perhaps this way of working lends itself to having longer times between appointments, whilst still enabling changes to be made and parents to feel supported by a service. This might be a more effective use of resources within the NHS. Exploring the use of outside session support and how this fits with SFBT would be another area of interest.

Exploring how the results from this research compare with young people's views on SFBT at the same clinic (Tilley, 2006) would be useful, particularly to consider whether the aspects of therapy that were helpful for mothers were also highlighted as helpful for the young people. It would also be interesting to see if there were similar challenges faced by the young people.
Summary

The research has shown that mothers can usefully describe their experiences of the process of SFBT. It has highlighted the challenges that were faced by mothers as they embarked on therapy and the qualities they brought with them. It highlights the importance of the therapeutic relationship, the qualities of the therapist and their importance as a possible attachment figure. The importance of creating and receiving positives was central for these mothers. SFBT led to meaningful changes for these mothers and their children and is reflected in their struggle to end, gratitude for receiving the service and desire for others to have a similar experience. Links to existing psychological theory and research examining the process of therapy have been made, along with personal reflections. The limitations of the research, service implications and potential avenues for future research have been highlighted.

REFERENCES


Appendix I: The SFBT Clinic

The Solution Focused Brief Therapy Clinic (SFBT) is based in a Child and Adolescent Mental Health Service (CAMHS) in the south of England. It is run by two Clinical Psychologists who completed training in SFBT at the Brief Therapy Practice, London. The Clinical Psychologists have worked together for approximately eight years.

Families gain access to the SFBT clinic from the generic CAMHS waiting list, via a referral from a GP, school, Health Visitor, Mental Health Professional. Families can also be referred internally by a CAMHS professional if alternative therapy has been requested by the family, if SFBT is considered the most suitable approach, or if progress is not being made.

The whole family, or individual members of the family, attend the SFBT sessions, depending on the preference of the family and recommendations of the therapists. SFBT techniques and assumptions are employed. In the clinic, there is an index therapist in the room with the family/individual, whilst the second therapist remains behind the screen. At some point in the session there is a break. During this time the index therapist leaves the room and has a discussion with the other therapist behind the screen. The index therapist then returns and feeds back useful/interesting points from the discussion. This would include compliments, what to do more of and some suggestions about tasks to try outside of the sessions for the family. The index therapist also uses SFBT techniques throughout the session, such as scaling questions, searching for exceptions, orienting to the preferred future, looking for solutions rather than focusing on problems and making suggestions. Each session is viewed as potentially the last. The length of time between sessions is negotiated between the therapist and the family/individual client.
Appendix II: National Research Ethics Approval

26 September 2007

Miss Claire R Edwards
Trainee Clinical Psychologist
University of Surrey
Department of Psychology
University of Surrey
Guildford
GU2 7XH

Dear Miss Edwards

Full title of study: An exploration of parents’ experiences of solution focused brief therapy.

REC reference number: 07/H1111/59

Thank you for your letter of 04 September 2007, responding to the Committee’s request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

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<th>Document</th>
<th>Version</th>
<th>Date</th>
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<tr>
<td>Application</td>
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<td>04 September 2007</td>
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<tr>
<td>Investigator CV</td>
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<td>26 June 2007</td>
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This Research Ethics Committee is an advisory committee to South East Coast Strategic Health Authority. The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.


Statement of compliance

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

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

07/H1111/59 Please quote this number on all correspondence

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

Yours sincerely

Dr Andrew Nayagam
Chair

Enclosures: Standard approval conditions
Appendix III: NHS Trust Research Approval and Monitoring Committee Approval

Miss Claire Edwards
Trainee Clinical Psychologist
Department of Psychology
University of Surrey
Guildford
GU2 7XH

19 December 2007

Dear Miss Edwards,

RAMC ID: 1005/NOCI/2007
TITLE: An exploration of parents’ experiences of solution focused brief therapy.

Thank you for your application to the Research Approval and Monitoring Committee (RAMC) for approval for this study.

A sub-committee of the RAMC have considered this study. The documents considered were as follows:

- NHS REC form parts A and B (unsigned, dated 26/06/07, received 30/11/07: lock code AB/118926/1)
- NHS Site Specific Information form (signed and dated 22/10/07)
- Protocol (no version control undated received 30/11/07)
- Interview schedule (version 1 dated 26/06/07)
- Surrey and Borders Partnership NHS Trust employment contract to September 2008 (signed and dated 20/09/05)
- Letter from University of Surrey confirming indemnity (signed and dated August 2006)
- CV for Claire Edwards (signed and dated 22/10/07)
- Brighton West REC approval letter (signed and dated 26/09/07)
- E-mail from Claire Edwards regarding clarifications (received 17/12/07)

I am pleased to tell you that the study was approved, and so may proceed. This approval is valid in the following Organisations:

- NHS Trust

Your RAMC approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application to the committee.
2. You notify the RAMC by contacting me, should you deviate or make changes to the RAMC approved documents.
3. You alert the RAMC by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of RAMC approval.
5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should
refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

6. You ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Please contact the Consortium Office if you wish this approval to be extended to cover other Consortium Organisations; such an extension will usually be agreed on the same day. We also have reciprocal arrangements for recognition of Research Governance approval with some other NHS Organisations; such an extension can usually be arranged within ten working days.

Good luck with your work.

Yours sincerely,

Mrs Helen Vaughan
Senior Research Governance Officer
Dear Claire

Parents’ experiences of solution focused brief therapy  
EC/2007/89/FAHS Fast - Track

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

Date of confirmation of ethical opinion: 31 October 2007

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:-

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<tr>
<td>Information sheet</td>
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<td>Consent form</td>
<td>31 Oct 07</td>
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<tr>
<td>Questionnaire form</td>
<td>31 Oct 07</td>
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<td>Evidence of insurance cover</td>
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<tr>
<td>Information concerning NHS</td>
<td>Ethics Committee 31 Oct 07</td>
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This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Aimee Cox (Miss)  
Secretary, University Ethics Committee  
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Appendix V: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Research Title:

Parent/carer's experiences of attending the Solution-focused Therapy Clinic

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully.

Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you would like to take part.

What is the purpose of the study?

This study is for my PsychD qualification as I am training to be a Clinical Psychologist at the University of Surrey. As part of my training, I am carrying out this research study to find out what it is like for parents/carers who have attended the Solution Focused Clinic.

I am hoping to find out what parents/carers think about the Clinic, what it was like to attend, and what (if anything) was important.

Thank you for reading this.

Why have I been invited?

You are being asked to take part because you are a parent/carer who has attended this type of therapy at the clinic. I am hoping to talk with twelve parents/carers who are attending or have recently finished therapy.

Do I have to take part?

It is up to you whether or not to take part. If you do decide to take part you will be given this information sheet to keep. You will also be asked to sign a form which says that you give your consent to take part.

If you decide to participate you can change your mind and withdraw at any time, without giving a reason. This will not change any help you might receive from the Child and Family Service.
What will happen to me if I take part?

If you decide to take part, you will talk with me for about 45 minutes. I will ask you about your experience of coming to the Clinic. The interviews will be recorded on a tape, which only I will listen to, which will be destroyed when I qualify in September 2008.

You can choose whether you would like the interview to take place in your home or at the clinic. (Therapist name) or (therapist name) will be available if you feel you need to discuss the interview afterwards.

You do not need to prepare in any way for the interview. I am interested in hearing your views.

What are the possible disadvantages/risks?

Some people may find talking about coming to the Clinic distressing. It is unlikely that you will feel like this, but if you do:

- I am a trainee clinical psychologist, trained in supporting people who may feel distressed, and you can talk with me.
- You can talk with (therapist name) or (therapist name) afterwards. If the interview takes place in your home I can give you their contact details and advise them that you will be contacting them.
- We can stop the interview at any point and it will not affect the service you receive.
- You may feel dissatisfied with the service you received. If this is the case we can discuss how you may want your views heard (see “What if there is a problem?” below).

What are the possible benefits?

Some parents/carers enjoy having an opportunity to express their views about services they have attended. They feel respected and listened to. The information we get from the study may help us improve therapy for future families and help the team think about parent/carers' views. There will be no direct gains for you.

What if there is a problem?

It is unlikely that anything would go wrong. In the event that talking about your experiences makes you distressed you could withdraw at any time. You could also discuss your difficulty with me if you felt comfortable. However, if you do feel that something has happened that you do not like, you can contact the person you met with and they will help you to make a complaint. I can provide you with the local complaints procedure. You can also contact the Patient Advice and
Liaison Service (PALS) on ***********. PALS is a confidential service to support clients, relatives and carers and acts independently when seeking resolutions.

Will my taking part in the study be kept confidential?

The information you provide will not be shared with any of the therapists. I will type everything we say in the interview onto a computer and the tape will then be wiped. Only I will listen to the tape. The tape will be stored in a locked cabinet by Ms Mary John, Course Director of Clinical Psychology at the University of Surrey. The tape will be kept until September 2008 and will then be destroyed.

I will use a letter instead of your name, and change or take out any information that would identify you. I will not say your name when I talk with supervisors who will assist me with the research or when I write about the research. In the reports I might quote what you have said, but this will be anonymised.

All personal data (e.g. consent forms) will be stored at the Clinic. The researcher will store the written version of the interview for 5 years, as required by the University of Surrey.

What will happen to the results of the research study?

I am doing this as part of my training to be a Psychologist. It will form part of the portfolio I submit for examination. A copy of the research will be kept in the library at the University of Surrey.

I also hope that the results will be published for other professionals to read. I will share the results with other professionals so they can learn from this too. All details that are personal to you will be changed or taken out of any report or talks that I give. I will also write a summary of the research for all parents/carers who have taken part. You would be able to get a copy of this in the post or we could arrange to meet and discuss this. I will make copies of any published work available once these have been completed. These will be located in Clinic for you to access.

Who has reviewed the study?

The research has been checked by several bodies to make sure that it is ethically sound. The *********** Research Ethics Committee, The University of Surrey
Ethics Committee, and the ***** NHS Research Approval and Monitoring Committee have all reviewed and approved this study.

**What do I do now?**

If you would like to take part in the study please complete the enclosed Participant Reply Slip and send it to me in the envelope provided. I will then contact you.

**How can I find out more about this study?**

If you would like to find out more about the research please ring me on ********** or **********.

*If you agree to take part in this study you will be given a copy of this information sheet and a signed consent form to keep.*

Thank you for reading this information.

*Claire Edwards*

*Trainee Clinical Psychologist*

*Department of Psychology*

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Appendix VI: Participant Consent Sheet

Research Consent Form

Research Title:

Parent/carers’ experiences of attending solution-focused brief therapy

Name of Researcher:

Claire Edwards

1. I confirm that I have read and understand the information sheet dated for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I consent to an audio-tape being made of the research interview and to all or parts of this recording being transcribed for the purposes of research and education. I understand that all information which could identify me will be anonymised. I understand that if I withdraw my consent the audio-taped information will be erased immediately.

4. I consent to direct quotes being used in the final report. These will be anonymised in order to protect my identity.

5. I agree to take part in this study.

_________________________________  ___________________________  ______________________
Name of Participant                      Date                                      Signature

_________________________________  ___________________________  ______________________
Name of Researcher                       Date                                      Signature
Appendix VII: Interview Schedule

Interview Schedule:
Topic Guides and Example Questions

General questions (to build rapport and collect demographic information)

Can you tell me a bit about yourself?

**Topic 1: Reason for attending**

Do you remember why you came to the Clinic?

Would you like to tell me about this?

**Topic 2: Coming to solution focused therapy**

Can you remember what it was like to come to your first session?

How might other parents/carers feel about coming to their first session with **** or ****?

What were your hopes for meeting with ****/****?

Who came to the sessions?
  How was this decided?
  Was this okay?

**Topic 3: What happened during the sessions?**

What used to happen at your appointments?

If another parent/carer was coming to the Clinic for the first time what would you tell them to expect?

How might they feel after the first session?

When coming back for the next session, what should they expect?

How might they feel going into a second session, or ones after that?
**Topic 4: Change during therapy**

Did anything change or get better? Can you tell me about these changes?

If things didn’t change can you tell me why?

**Topic 5: Finishing solution focused therapy**

How was the decision to stop coming to the Clinic made? OR How do you think you will know when you are ready to finish?

Looking back on your sessions what, if anything, has happened during these sessions that you feel was important/helpful?

Is there anything that * or * could have done differently?

What sort of person would find this type of therapy helpful?

**Topic 6: Other**

Is there anything else that you would like to tell me about your visits to the Clinic?

Is there anything I haven’t asked you that’s important?

Can you tell me what it was like for you to do this interview?

**Additional prompts/probes:**

This is a semi-structured interview and therefore the questions may be asked in a different order or might be changed slightly depending upon the interviewees’ responses. The interviewer will follow up these questions with prompts, which will vary depending upon the individual’s response.

**Example prompts:**

Could you tell me more about that?
What makes you say that?
What happened then/after that?
How did that feel?
What was that like?
Appendix VIII: Excerpt of Anonymised Interview Transcript

(Kate)

(NB, l=interviewer, P=participant)

P: Erm... I think everybody would worry about it slightly, I think. Because obviously it's your child and you know you, but they put you at ease very very quickly.
I: Mm. How do they do that?

P: Erm, well Sam Sam is lovely. She you know, she makes it you know straight away, you're aware there's obviously a camera behind and you know you know, but then you forget about it because you know Sam is calm and and you know, she just makes you feel at ease, so, erm. Are you talking of the view of the parent rather than the child yeah?
I: Yeah yeah.

P: Yeah. Um, er, I think as well that it was something that I had done wrong.
I: Mm

P: Erm, and then through obviously talking and finding out that I it wasn't anything that I could control, anything I'd make mistakes with um, to hear that then was a relief.
I: That sounds good. And what were your hopes for meeting with Sam?

P: Erm...obviously, well to help Laura. Um, because I didn't know what to do. I tried you know I tried so many different things with her and erm I didn't know what to do anymore. So I really I was really at the point where I needed some outside outside help just to give me, you know, some ideas and also because I could see my child was suffering, you know, she was getting very distressed by it all, and stuff. So erm, yeah, to basically real, some help really as to what to do and and and how how to help her. Um..
I: Ok. Erm, and so you said initially it was Laura that went in on her own and that was her decision and then you joined

P: Yep

I: And it felt like it was very much her her choice that she wanted you there

P: Yeah

I: And was that ok?
P: Yeah. It was better for me being in there cos then I understood what was going on. Cos obviously the first session they spoke and I sort of you know, although we talked about it, I think Laura realised that I had to be in there as well otherwise it it I couldn't help her with the things that were gonna happen. Cos each week Sam after that would give her something to stop, to try to stop doing. Erm, and also we found out that it didn't matter how much I reassured her my reassurance wasn't good enough for Laura. It wasn't in her head to say "my mum's reassuring me," you know, erm, you know. like if I say to her now, she might say something now and it still doesn't work - my reassurance. It has to be her that comes to her decision that it's ok. So erm, which is rally strange the fact that, and it feels, it makes you feel helpless as a parent.

I: Mm

P: Cos you think you know you want to be able to help them and you can't, so , but um... it's definitely a positive outcome. I mean we still haven't finished cos we've got to get to the point of her sleeping on her own, but (laugh). But erm, that bit will come when we move so

I: Yeah. And what used to happen at your appointments?

P: Erm, we'd go in and Sam would say whether the camera was running or not, sometimes it was or wasn't. Um, then um she'd ask Laura um, how she'd done on whatever task she'd been ask, you know, to try and stop like I said, you know, the checking of things. So one week it was to stop looking under your bed and it was to stop checking, me to you know, me to checking the heart, and then it was the doors and things like that. Urm, so she's ask her, you know, whichever one that was. And then ask Laura if she wants to talk about anything else what had happened that week. Erm, how she, and she'd go through scores on how um scared she was, so it'd be you know you're at , how scared are you if something happens here, or something happens there. So she'd say, "well last week, last time you were at this score, so you've improved a little bit." And erm, ask if there was anything I wanted , you know, to say. And then we'd decide on a course of action, you know, from that. She'd normally leave the room and go and discuss it with the other lady for a couple of minutes or five minutes. And erm, then come back and go over , you know, what we'd all said and erm, then decide on the course of action for that week. So, um..

I: What was it like when Sam left the room and went and spoke to someone else?

P: It felt a little bit strange, especially cos you know that there's a camera there. And me and Laura would sit there and go, you know, have a little bit of a giggle, it's the fact that you're sat there feeling like a naughty child almost (laugh). You think "can they hear us?" (laugh). Erm, but erm, no you know she you know she's gone to speak to somebody else, but erm, yeah we'd sort of sit there and
sort of look at each other or um Laura would then, you know, probably pick up some pens and pencils and start drawing sort of thing, so. But you get used it I think after you know, 2 sessions, you sort of know the routine. So once you know the routine you just sort of relax into it. So it's ok.

I: And what was it like sort of know there was a camera there?

P: Um...I thin to start with nerve, a bit nerve wracking. Um, but again then you forget it's there once you start, you know, talking you do forget it's there. Urm,

I: So how do you think you were able to forget it was there?

P: I think you're so focused on what you're talking about that um that's more, I don't know, that's sort of probably overrides it if you like. Um, and, yeah I wasn’t you know aware that um it was going, so.

I: Yeah. Ok, If another parent was coming to the clinic what would you tell them to expect?

P: Erm... I think I'd say that all the staff were really friendly, that you'd have , you know, you don't have anything to worry about there. Um, I think I probably would say, you know, if it's the same same clinic that we attended they will tape you, just because I think that that's ... just you know to stop that being a shock that there's someone behind the glass, you know, taping and so I think I would say, you know there will be another person taping you erm, but erm you go into a nice room and you can talk about anything, it's you know completely confidential and erm. That they you know, just make you feel completely at ease. And Laura always came out of the sessions very relaxed and calm, erm, which obviously then helped helps me as a you know as a parent, so um, I think I'd probably try and get that point across. And definitely do it, you know, if you're offered or definitely do it, cos it does definitely you know help the child. I mean I tried and I couldn't get Laura to do it, so.

I: Mm, and how they might they feel after the first session?

P: The parent?

I: Mmm

P: Erm, relieved I think. Somebody's there and somebody, you know, understands um... that em, this is, you know, it is happening to your child, it is real, it's not you making it up or the child making it up but it is a real problem, and em, I think that was more the fact, the first thing that I felt was a relief is the fact that...this is a problem a real problem for her, this isn't something that she's, you know, not playing at it's the wrong word, erm, you know, do you know what I
mean making it worse in her head for herself, that it was a genuine genuine fear. So it was a relief that right ok, it's, she's, we've you know had talked about it, had it confirmed that it's a genuine fear, but they have told us that they can help and we can do something about this. So yeah, really a relief really.

I: Mm, it sounds like there were two things that made you relieved. Possibly one that you were taken seriously

P: Yeah

I: And the other one that there was a bit of hope maybe

P: Yeah

I: That things could change

P: Yeah. Definitely. Definitely that's actually a good way of putting it- there was a lot of hope there and a lot of confidence given that you know given across to you that things will you know, won't be like this, you know they will change. And erm, not just the parent but more for the child, you know, giving them confidence to say erm, you know, it isn't always gonna be like this, you, you now, it will will get better, so..

I: Erm, and if a parent was coming back for a next session, what should they expect?

P: After the first one?

I: Mmm

P: Erm, pretty much the same as the first session. But erm obviously, your last count, it has been since the first session. I think we had about four four weeks between each session. Urm, that was decided as, we had a decision in that, you know, making as well with Sam. It wasn't like, you know just come back then, it was how do you feel about coming back then, do you think that, you know, you can do those thing sin that time. So that was good, so we were given an opportunity to say "ah no maybe we'll leave it, you know, 5 weeks, or something." But um, more relaxed obviously cos you're used to the person, not used to them, but you've me them before. Um, and em...I think more confident going into it because again like I've said, they're there to help and you know that they're going, you're nearer getting another step to getting help. And and, do you see, do you understand what I mean by that?

I: Yeah
P: Its...

I: You're getting a bit nearer?

P: Yeah, you're getting nearer to to you know, solving, not solving, yeah solving problems, not all the problems but solving the problems, so. And knowing what her homework that she'd been given she'd done and managed to conquer, yeah it was the confidence of knowing this this is working, so. Um.

I: And how, how might they feel going to the sessions after, kind of subsequent sessions?

P: I don't think they'd have, I never used to even worry about them, I just used to say, "Oh, you know Laura I'll pick you up so we're going to Sam" or Laura when roughly know when she was going there. Um, like she looked forward to the sessions because obviously she knew she knew that it was somebody for her to talk to independently. And she, but she was, you know, would start to talk to her about other things as well. And also it gave me a chance to ask things, or say "have I done this right?" Or, erm, but I didn't have any worries after that about going to, erm, and erm, what they've done with us is cos we, obviously like I said stuck in this house, Sam is going to see Laura again to do the final thing of getting her back into her own bed, but not until we're in another house, so, erm. We've had a big break of seeing her but it won't worry me going back, because I know that you know, she's there to help, so. Urm, and they are so friendly and lovely. They really, they don't make you feel like it's anybody's fault at all, it's just you know, which is reassuring. You know, especially being a parent. Am I molly coddling my child by letting her sleep in my bed? That's' a big thing I used to go though. Should I make her sleep in her own bed? Whereas Sam reassured me that no, you know, if if Laura was that distressed the right thing to do is to keep her in with me, so. Erm, whereas other friends have said to me "oh it's ridiculous" you know "you should have, you shouldn't have your 13 year old in bed with you." But I just take no notice of them now, because you know, a psychiatrist has said, you know this is, you know, fine and if that's you know how she's happy at the moment leave her like that. So, I don't even ask my friends I just ignore them now.

I: Mm, mm. And I guess you mentioned this a bit, but but what was it that changed or got better?

P: Erm, her her she stopped looking at everywhere. She stopped looking under the beds, in cupboards. Erm, she'd literally, from that first, from the session she'd come home that night and she'd start. That would be her homework. So erm, from it, from the first night of each session she actually did it. So she stopped the checking under the like I said that cupboards and the the beds and stuff. Erm, she'd stopped running, she used to have to have somebody to go upstairs with
her, erm, she stopped doing that – running everywhere, like now she will go upstairs. Um, she’s stopped having em check her heart and her breathing. Um, she’s stopped checking door handles, oh all the time, every time she got up she’d check the door handles that were locked. She just does it once now, which her and Sam and I decided was sensible because if I had a partner they’d check as well, so, she’s my partner she checks that I’ve locked the doors.

I: Yeah.

P: Urm, so that’s the thing. I’m thinking if there’s anything else – I don’t think so.

I: What about for you – was there anything that changed?

P: Erm, not having her do all of that, it was stressful to watch all the time. Um, the biggest thing was when, for me, I think changed is when we get her in her own bed. Because um obviously you know that effects my sleep and I have to go bed at the same time as her.

I: Mmm.

P: She won’t go to bed on her own, which you know, I’m working at a 13 year old’s clock, not my clock. But, erm, not to see her so scared and stressed with the other things is lovely. The fact that she’ll walk upstairs on her own and now watch, if she doesn’t wanna watch something I wanna watch on telly she’ll, like last night she quite happily took a kid’s film up to her bedroom and I could hear her happily up there laughing. That’s something she wouldn’t have done 6 months ago. You know she definitely wouldn’t have gone upstairs. Um, so

I: Wow, that’s fantastic

P: Yeah that is good, yeah. Just the last hurdle we’ve got, we’ve just got one more hurdle that’s all.

I: Mm hmm. Erm, so how do you think that you’ll know when you’re ready to finish?
Appendix IX: Excerpt of Annotated Interview Transcript

I: OK, so, do you remember what it was like going to your first solution focused session?

P: I can vaguely. I spent the first few sessions, erm, feeling quite daunted because I knew that Jo was behind the mirror and, and there's a camera on you and you do feel daunted. You also have a feeling of how the bloody hell did I end up here? What's made me so, you know am I, you know, and that whole feeling of oh did it really have to get to this? A sort of embarrassment, a feeling of being unclean, a feeling of guilt. So I had all those trepidations going in and I felt sorry for Martha, cos I thought what must this feel like for her, cos we always used to go in together. And um we used to have to say how we felt on a scale of 1 to 10, and um, I found it frustrating and I'd get wound up because perhaps Martha was drawing and then I'd have to, Sam would go over me and say "don't worry about that. Just keep focused on what you've got to say, she's doing it in her own way." So I erm, I had, I, I think I had to have a lot of trust in Sam and Jo, because trust was sort of paramount, because it's not easy to go and talk about your life, I spent the most of the sessions crying my eyes out, and getting in a very disturbed state and Martha's sort of become used to that because she's seen her mum do a lot of that, so to her it's almost, whereas to some children it might shock.

I: Mmm

P: To Martha it was par for the course and her way of dealing with it - she'd almost laugh.

I: Yeah

P: And people if they were on looking would find that quite strange, but that wasn't that Martha's coping mechanism

I: Yeah, it's her way of managing

P: So, the first sessions were really hard and to be honest I found it hard to try and be steered round - there was a lot of resistance from me saying "well yes this has happened though, but I feel this." But I always used to feel a bit relieved, like a bit, like a weight had been lifted off my shoulders when I'd come out. Tired and knackered and emotionally drained, erm but relieved.
P: I just felt, well that's rubbish, this is negative, I used to think of another negative in my head, but then I would say it, cos I thought there's no, you know, if you don't say these things out loud you're lying to yourself, so I’d say it again and then Sam would say, 'well hang on a minute' and they'd go back to your notes and they'd say 'well, you know, a month ago or two months ago when we saw you, you were this and actually our target was this and you've achieved that target, and you've done that so actually you're doing really well.' It was almost as if I was being given the golden carrot. You know, at the end of the journey up and down the beach the donkey would be given the carrot — that's how I felt. I was reminded of things that I'd forgotten. Because in trauma, with medication and with depression, erm, you, you know, you can have no awareness of dates, times and memory, you know. Erm and yet flashbacks would come and go, but actually they’ve got it written there and it’s their job to steer back to exactly where you were, that’s the whole point — it’s to find the solution. So I started believing that, you know, so in the end it got a bit easier to walk in the door. You know and I'd sort of wave at the camera, that was my way of saying "oh, hi Jo" I felt at ease. But the first few were definitely really difficult, you know.

I: And so there are two things I'm really interested in what you’re saying. There’s the bit about the kind of getting the golden carrot and how you managed to get to that point

F: Well, I suppose I did do it, I've got to credit for it myself, because I wasn't just going there and it was all done, it would Sam reminding me of what I'd done and actually that I'd achieved that and actually a year ago — she would go back as far as a year — and say, 'well a year ago look where you were, and actually you'd remained out of hospital.' And even if I was in hospital, like you know and I still went for a clinic it was 'oh yes, but you've remained to do this. You know, you've seen the warning signs.' You know. So, it was a constant reminder of facts of things that had, so I, so it was a bit addictive actually, because I'd think 'Ooh, what good things are you gonna tell me today, and do all these things.' I would kind of be...um, what's the word I'm looking for, keen, eager, to know oh, well what are they gonna, I how, what are they gonna remind me about today? So that's how I felt it was a golden carrot, I felt I'd been good, it was a reward. Because it was actually something positive rather than all the rubbish that's going on and in fact, you can have a lot of bad luck, you can have a lot of things that are going wrong, but actually if someone can highlight and bring you back to something that makes a little bit of sense, or, you know, you can go out feeling a little bit relieved. It's a guidance that actually perhaps I couldn’t have, you know, at that time. And I still have difficulty, that's why I still go, you know, years down the line, but the clinic's more based to me now because Martha doesn't feel the need, she was having art therapy and she stopped that because she actually said to me 'I don't think I need that.' So, you know, and the sessions, can, it just depends on my mood as to

Honesty
Use of notes as evidence
Therapist feedback
Positives as reinforcement
Getting easier as therapy progresses
Pressure as painful
Ownership (responding for change)
Recentering to positives
Anticipation times
Benefit
Something for me
when and what's gone on, and you know I go in there sometimes and I'm giggly or I might get upset while I'm talking about things and I'll cry, but it always manages to turn around. So I'm not afraid anymore.

I: Mm hmm, and I guess that's the other thing I wanted to ask you about, was that issue of trust and about how it felt daunting with somebody behind the mirror and the camera to begin with and how I'm just wondering how you think that trust and that not feeling daunting anymore developed?

P: Because I knew it was working, like I say the addiction for the therapy. I mean sometimes at the end I'd say "Oh no I can't wait 2 months, Sam, can we please make the next appointment a month." Depending on how needy I'm feeling. If I'm feeling that actually life's OK, I'd sort of say, "Can we leave it for 2 months, but no longer." So that's, I, I don't feel that daunting anymore. If it was at first, because it's the fear of the unknown and I'd been pushed around a lot within the services. But because I trusted them, I didn't feel so bad, and then it became, like anything, you get used to it. So my way of overcoming that would be to wave at the mirror and "hello Jo." You know and um, know that sometimes other people that were there as well – students would be there, and we'd be like that, and Martha would put her thumbs up. We kind of made it a bit humorous, but not humorous, but in our way of dealing about the fear of people being and knowing our business, you know, cos it's quite, that's quite hard. But they're professionals, you know that once your in that, that that circle, you're in that service and it's the way that it goes.

I: Ok, erm, just wondering, how do you think other parents or carers might feel about going to their first sessions?

P: I should think exactly the same as me; oh, I don't like the, whose behind that camera, can't relax a little bit, nervous. Very conscious to your body movements on the, you know, is someone judging you in, you know; all those feelings of guilt and lack of trust, and the fact that you, you know, actually someone else is watching me and, you know, is this another crock of rubbish. It it it depends on how bad you feel at the time, but I think, like anybody, if you know someone's watching you behind the screen and you've got someone sitting there asking you awkward questions no one looks forward to that. That's like going to the dentist and being told "well yeah you've go to have a root canal. We're going to make you another appointment." You don't exactly skip into the dentist for that do you? You know, you're like ugh. So that's how I would give the analogy, it's like going to the dentist knowing you've got major work to be done... it's gonna be painful, it's gonna be awkward, it might leave a little bit of a ting for a few hours afterwards. I mean I'd recommend anybody that does go in to not have plans or anything to do afterwards, because sometimes you just, quite, more often than not Martha and I would come out of the session and we'd
And it is addictive in the sense it makes me understand and feel better - a little more normal if there is such a category that you could say. I don’t believe in normal but it’s about the only word I can find that would probably fit. And that’s what I’d say to anybody else. It will work as much as you want it to work and as honest as you can be.

I: And it sounds like it’s been a really integral part of your journey

P: Oh my God, yeah. I don’t think I would have, I wouldn’t have seen any positives if it hadn’t have been for that. It rescued us. is that way I looked. It helped, it was like a wing, a protection, because it helped us, it was, and it helped me with Martha as well. Cos I was being honest in front of Martha and it was a chance for Martha to be able to say how she felt about things, which you don’t get really in any services. They like to segregate you both, but when you’re a family you don’t really get a chance, and that’s what I liked about this, you could do it as a family.

I: And so it was both you and Martha that came to the sessions

P: Yeah, but that’s just stopped. A few years in. Because, you know, she’s at her teenage years. You know, she wants, she gets support from Space which are the young carers organisation. And um she’s growing into, I mean she’s older than her peers in terms of, because she’s looked after me and it’s been a very close knit relationship. And I think that Sam and Jo know that I still need this because as she veers off in that direction I think we’re a bit worried that I’ve got no support and won’t be able to function on my own. So if anybody said they were taking it away I’d kick and scream and I’d be really distraught. That’s how much I need it.

I: Ok, and how, how did it get decided in the beginning who was coming to the sessions?

P: I can’t remember. I think it was suggested by erm Sam, and I think she’d had a chat with Jo and then she proposed it to me and she explained about, way before it all happened, it wasn’t oh you’ve got to come in there and oh by the way there’s someone behind there. It was all explained to me on sessions, and I think it was when my life was a little bit more settled and we were in accommodation, it couldn’t happen when things were really rocky, because if you’re homeless it’s a bit difficult to do solution focused clinics. You know, you’ve got to be realistic, things have got to be a little bit, you know, there’s got to be a foundation I would say.

I: So there was a lot of preparation and there was a lot of thought about the timing
P: Yes, oh yeah, absolutely, and if anything it made me feel frustrated more on my part. Cos I was having to wait. But I trusted them so I knew that there were reasons.

I: Ok, so you've touched on this a bit, but can you remember what would happen at your appointments?

P: Well Martha and I would sit outside, possibly get there a bit early. Um, depending on how we were, I might be 'foot tapping, apprehensive, you know, almost like a dog in a trap, ready to get in there and spit it all out. Or I'd sort of be the other way round thinking, you know, "how's it going to go today, what's Martha gonna say, is she gonna say something that's gonna make me feel really terrible". So again a lot of guilt going on. Um... I spose a certain amount of anticipation, wondering what if, what if, you know, an awful lot if what ifs. So that time, you know, I didn't like getting to the waiting room too early. Because you had too much time to think. And that's not, again, that's not always a good thing, you, it's too relax and to, to really, cos I have a tendency to go off on a tangent, it used to be very guided by Sam, she'd be very, you know and I didn't really notice it at the time but she'd be very one single track, yeah but we asked you this. And she was very clever with Martha, cos Martha might not want to but she was very clever with the way she got the information out of Martha and creative I would say.

I: And what did that feel like being put back on track to answer the question.

P: I think I felt relieved actually and I felt comforted that I knew that Jo was there and that actually it wasn't just one person's but actually, they would, have, I felt quite important, that actually somebody was taking notice of us. They were, they would spot any good sign, they would remind me of the things that were actually positive and that I would have something to hang on 'til next time. That's how I used to feel. I felt reassured.

I: It sounds like it was quite a safe space in that you knew that you would be

P: Yes totally. When they used to have the break the funny thing was that I used to feel awkward sitting there. I know that the curtain, cos Sam used to make a point of going up and closing the curtain so that there'd be no one watching, but because there wasn't her guidance in the room I'd I used to get an OCD thing going on and I used to be cleaning up the toys in the box and making the dolls house, tidying things up and Martha used to draw. I used to tidy because I'd be nervous. So...

I: It sounds like that structure and guidance was really important

P: Yeah
I: To keep you on track and when that was gone it was hard to fill it almost

P: Yeah yeah, definitely, definitely. And like I say I'd be sort of running around like a headless chicken in the room waiting for them to come back in, thinking "oh hurry up, hurry up." Do you know what I mean? That's how I'd feel. So yeah

I: And what else used to happen. There was the kind of trepidation of going into the room, and then you've talked about the way you would wave at the camera and you know, acknowledge whoever was behind there, the screen. What else used to kind of happen that you can remember?

P: Well, if I didn't cry and burst into tears, you know, cos I'd start going "woooileer" you know and Sam would ask me a question and I'd say "Well this has happened and "you know I'd be in a right state and I'd be grabbing for the tissues and I'd be, you know I'd be fiddling and looking down and and wishing the floor would swallow me up, wishing that I wasn't having to go through this. But actually something anchoring me, I can't describe it, but something anchoring me in that very spot, and erm, again without Sam's structure to make sure I didn't veer too much off the left and off that path, I mean, it kept it unmessy if that makes sense. And she wouldn't mind if Martha was up and down like a yoyo, it would more wind me up but I'd have Sam saying to me "It's alright leave her." You know, "don't, you know, you get upset by it, don't worry about Martha, let's keep on the track here." So I would very much say it was a guidance. Very good.

I: Yeah, and do you remember the kind of...

P: Sounds like I'm their number one fan doesn't it. No it worked, I'm trying to be honest. It worked and it does work for me. In fact I think I couldn't really let go of it, erm, I'd be mortified. I think if anything at the end of the sessions now I'd sort of like "oh you're not going to let me go and they're like "no, no, it's" you know cos I think if anything I get into a panic, you know you feel like the rug's been taken from you. So...

I: Yeah, can you remember anything about the sorts of things you were asked or the way that things were done?

P: Erm, it would be, Sam would first say "I last saw you on such and such and I just want to get a hold on, perhaps you could bring me up to date on how your feeling now, the last time Ia Ia, how are you feeling now?" And that's when I'd shoot off. If I were anxious or particularly bad it would be you know very fast cos I do, I'm very manic in that respect. It would sort of be "bileblebleble" and she'd sort of like you know try and bring me down but keep me guided to where it was going. Erm, then Martha and I would have
### Appendix X: Example of Initial Table of Themes

(Joan)

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1. READINESS FOR CHANGE/COMMITMENT TO THERAPY

1.1 Desire for change

Heather  “Well yeah, you just want to get to be resolved and better” 3:32

“If, again I can only go by own experience, someone who wants more for their family, who wants improvement, who wants to help a child who seems unhelpable.” 13:25

Fiona  “Um, the want and the desire for things to seem like they could be worked out, like they were normal, like it was ok to feel crap, um, and that it wasn't the end of the world and actually I didn't want to kill myself. It was that that made me go back. Um, it was I wanted help. I wanted help. I wanted to be shown it was for me it was my need.” 14:4

Margaret  “I just wanted really my daughter to get a grasp on life and… start being a normal teenager again rather than this very depressed, moody, unpredictable child that I had.” 3:2

Joan  “I knew they hadn't got a magic wand, they couldn't give me a solution over night. I think I'd hoped, I probably talked to the doctor, and hoped they would give me some advice and pointers” 3:7

Kate  “Erm…obviously, well to help Laura. Um, because I didn't know what to do. I tried you know I tried so many different things with her and erm I didn't know what to do anymore. So I really I was really at the point where I needed some outside outside help just to give me, you know, some ideas and also because I could see my child was suffering, you know, she was getting very distressed by it all, and stuff. So erm, yeah, to basically real, some help really as to what to do and and and how how to help her.” 2:25

Wendy “So eh I wanted to um get back on track the things I'd learned at the parenting course.
I: Mm hmm
P: And, is there any solutions to his behaviour and to work out how to deal with it” 1:11

“A person who cares about the future of their child, cares about um how their behaviour may damage their child. And um, who wants to change things, when things are tough. And needs to see the good in their lives again.” 13:33

Anna  “… I'm hoping to be able to get something out of it” 9:19

“Anybody that thinks they're at the end of the road of their problem” 8:21
1.2 Responsibility for change

Heather  “it just made me more aware of it, I had a part in this as well and I could make the situation a lot better if I behaved better. Which I did.” 12:11

Fiona  “It will work as much as you want it to work and as honest as you can be” 7:4

“Well, I suppose I did do it, I've got to credit for it myself, because I wasn't just going there and it was all done” 4:24

Margaret  “yeah and reinforce them as well. Because when Dawn wouldn't do certain things I would stand there and say "no you promised you got to do this, you gotta do it.” 6:30

Joan  “Patience, but also to realise that, er, as long as it was, er, it comes from within how you follow the teaching methods. How you handle it” 7:6

Kate  “somebody that wants to help their child. Not somebody that is just expecting a psychiatrist to, or you know or a group or whatever, to come up with the magic answers.” 10:43

“I yeah, I think that um, some parents I think end up, almost imagine them taking their child in and expecting, you know, them to completely fix them. But you can't expect that. You know, you've got to put work in for your child's sake.” 12:13

“you get back what you put in.” 14:35

Wendy  “To sort of try and change myself, you know, change the way that I deal with certain behaviours – behaviours, like take a step back and think before I react to his behaviour.” 2:34

“Somebody that wants to do right by their child. Um, family focused. I don't, you get the people whose kids have got problems and they just open the door and throw them out and don't give a monkeys about them. A person who cares about the future of their child, cares about um how their behaviour may damage their child.” 13:30

Anna  “Just... um...back-up, really, on things that I'd already started...and be more...have more ideas on things...maybe just... um... show me what I sort of already know but didn't know I know, I think” 2:13
1.3 Need to be open and honest

Heather “it’s, it’s really up to them how their session goes, uh...in a way. As if you’re prepared to be open and honest and all that I think you can get a lot out if it” 7:14

“I just think you’ve got to be very brutally honest and open and...honest about your reactions” 7:25

Fiona “one thing I thought about – and you must be honest. Because if you go in there and lie and scoot and think anybody’s trying to check you out, if you are not blatantly honest, it will not work. Because you’re lying to yourself and I think some people that are caught in a situation might be tempted to do that. So I would, I would absolutely say that take the courage and be very honest. That is one of the key rules.” 6:23

Anna “just be open...and if there was anything they were thinking about, I’d just tell them to say...” 3:48

1.4 Bearing/tolerating pain – ends justify means

Heather “it is draining and it is heart breaking, I mean I’ve cried and cried and cried in some sessions, where it’s just been, you know, awful in a way. But I’ve always come out feeling yes, yes, we can get there, we can get there. We have got problems, but we can get there.” 7:26

Fiona “So, it, yes it’s painful but at the end of the day you need it to be able to function, it will help you function in the better way. So I think you’ve got to embrace it rather than fight it.” 6:17

“you know I’d be in a right state and I’d be grabbing for the tissues and I’d be, you know I’d be fiddling and looking down and and wishing the floor would swallow me up, wishing that I wasn’t having to go through this.” 9:16

“of course there was the pain and there was things that you would talk about and the tears, but again I can only liken it to that nothing gets better without it hurting a little bit.” 19:31

“So that’s how I would give the analogy, it’s like going to the dentist knowing you’ve got major work to be done. It’s gonna be painful, it’s gonna be awkward, it might leave a little bit of a ting for a few hours afterwards.” 5:41

“I’m not gonna say that it’s easy when you come out, that every session I came skipping out like Julie Andrews singing the Hills are Alive. I didn’t do that. But I always went back for next session.” 13:35
Margaret "I just felt it was something I had to do. I can't say that I enjoyed the experience cos that would be lying. But it was good in the fact that it helped my daughter and that was my aim was." 7:16

Kate "you're sat there feeling like a naughty child" 3:44

"Because you do will have to come home and be prepared for the hard, hard times" 10:45

Wendy "Well at one point I thought, you know, I'm not sure what I'm getting out of this, you know, but like I said eventually I could see the good." 8:5

Anna "A bit traumatic, I think...because you get quite a battle before you get to the actual tasting of it...we have tears...and 'I'm not doing it' and...(omitted) but I mean each thing we have actually managed to do but it's been quite hard going to get the tasks done." 6:33

2. INITIAL CHALLENGES

2.1 Fear of concealed reactions

Fiona " and the fact that you, you know, actually someone else is watching me and, you know, is this another crock of rubbish. It it depends on how bad you feel at the time, but I think, like anybody, if you know someone's watching you behind the screen and you've got someone sitting there asking you awkward questions no one looks forward to that." 5:33

"The biggest fear was not knowing what someone was saying or doing, and you know, acute bits of paranoia. You know, you find it difficult, but actually after a while you forget about that, because you know they're there." 20:42

Margaret "The only thing that was a bit off putting was someone sitting behind the window looking at you. It's not very nice." 1:31

"a bit like Big Brother watching you" 1:37

"And that my daughter really disliked cos she felt people were talking about her behind her back. And I can understand that cos I felt the same." 5:32

Joan "Cos I know a couple of times I thought are we be going to be watched – our every move, myself and my children – but it's not like that." 5:16

"I think I was a bit concerned to start with, maybe that was when I was concerned about every move being watched, and what were they looking for, I think. It was well explained beforehand. I seem to remember we relaxed." 6:1
Kate  "She you know, she makes it you know straight away, you’re aware there’s obviously a camera behind and you know you know, but then you forget about it because you know Sam is calm and and you know, she just makes you feel at ease"

"It felt a little bit strange, especially cos you know that there’s a camera there. “

3:42

Wendy "Nerve wracking, knowing there was someone behind the screen. It was like, yeah, frightening.

I: And what do you think made you particularly nervous?

P: Not knowing what to expect and I say, knowing there was another person behind this screen and not being able to see them and their reaction to things that were said and um..” 1:34

Anna  "I wasn’t bothered...it didn’t bother (inaudible) though...but Matthew wasn’t bothered at all, so it was...er...he knew who it was because he’d seen her before she went in so... um...yeah...

(child is giggling)...

I: It was alright, so that helped, having met her...

P: Yeah...meeting her... beforehand... (Child is giggling)...this could take longer than it should...get off...but yeah, it was nice for Matthew meeting her before going behind the screen thing...” 3:7

“so she was involved but wasn’t there, if you know what I mean” 3:25

2.2 Fear of unknown

Fiona  "It it was at first, because it’s the fear of the unknown and I’d been pushed around a lot within the services.” 5:15

Joan “With a stranger its...you’re not quite sure what you’re getting into and if I thought, as I found out, it was beneficial.” 2:9

“they might feel a bit anxious about what happens next, although you’re explained essentially what does happen you might feel a bit er, where do you go from now.” 6:14

Kate  “Quite nerve wracking I think” 1:20
2.3 Learning the approach

Heather “I think possibly they, we talked about sort of...that we were talking about solutions to the problems. It was a nice experience you know, it wasn't horrible or anything it was quite nice and I felt quite relieved after I'd been.

I: Mm, um, what was it like thinking that you would be talking about solutions?

P: Great! (laugh). Great, great, yes.” 3:2

Fiona “So, the first sessions were really hard and to be honest I found it hard to try and be steered round – there was a lot of resistance from me saying “well yes this has happened though, but I feel this.” But I always used to feel a bit relieved, like a bit, like a weight had been lifted off my shoulders when I’d come out. Tired and knackered and emotionally drained, erm but relieved.

I: When you said you were a bit resistant to being steered around, what did you mean by that?

P: I just felt, well that's rubbish, this is negative, I used to think of another negative in my head, but then I would say it, cos I thought there's no, you know, if you don't say these things out loud you're lying to yourself, so I'd say it again and then Sam would say, “well hang on a minute” and they'd go back to your notes and they'd say “well, you know, a month ago or two months ago when we saw you, you were this and actually our target was this and you've achieved that target, and you've done that so actually you're doing really well.” It was almost as if I was being given the golden carrot. You know, at the end of the journey up and down the beach the donkey would be given the carrot – that's how I felt. I was reminded of things that I'd forgotten.” 3:36

Margaret “I mean I’m only surmising. I'm, I I felt good, but that's because of my understanding of it. I think maybe if I hadn't understood it I would have perhaps not thought a great deal of it, I don' know. I don't know I can't say.” 6:22

Joan “And they would often ask this lovely question, which I hate, of how I rated myself or the family on a scale of 1-10
I: Mm hmm

P: It's nothing, you you can't quantify something like this, so I always found it very difficult.”

Wendy “So I kind of learned that when I went there, try and forget the bad and focus on the good. “ 6:40

“At first I used to feel really angry because I'd think “Oh for goodness sake, you know, I'm coming here, I need help. Nobody wants to help. Um, I'm trying to tell you what things are going wrong I need you to give me answers. And all you want me to do is get me to talk about the good. But I need help with the bad to make it good. “ And you know, all this. But in the end I could see what they were trying to do, you know. I mean... I do anyway, in a really bad situation, think “well there's somebody always worse off than yourself.” I'm very good at that. And trying to make the best of the of a bad day, sort of thing.” 7:8

“I'd say probably about a quarter of the way into it, sort of thing. I couldn't see at first what they were trying to do. And then after a few sessions, then I realised that yeah, I can see the point of this.” 7:27

“I: In our case – maybe I'm thick – just explained at the start, but then she said the family therapy's whatever you want it to be, so...

I: What do you think she could have explained?

P: That erm, it's best to focus on the positive rather than looking at the negative.” 11:39

3. THERAPEUTIC RELATIONSHIP

3.1 Therapist qualities (facilitating engagement)

Heather “well very, Sam was very easy to talk with” 2:43

“it's almost a release to be able to talk with somebody who understands and who is non judgemental, that's what I found it.” 6:13

“Um, they were just accepting, they were just accepting and I have a very good friend and I used to confide in her and then one day it all came blowing back in my face and I felt very, very betrayed and upset by that and now I feel that I will never confide in her again, as dear a friend as she is, I will never confide in her again, cos I'm not gonna have that situation just be blown back and blown out of all proportion back in my face. And it's just lovely to be able to talk with them because they do understand.” 6:38

Fiona “Because actually someone has listened to you and they've listened to you the
Major Research Project

last month” 11:40
“she was very clever with the way she got the information out of Martha and creative I would say.” 8:22

Margaret “And I just felt that Sam, perhaps more than anybody else, was able to hit buttons that other people weren’t. In the way she asked her questions” 4:15

Joan “although it’s in some ways it’s difficult it’s easy because I got to know Jo and Sam and I know that they’re there to help and not to be judgemental.”

“support and empathy. Compassion” 5:15

Kate “well Sam Sam is lovely” 2:6
“Sam is calm and and you know, she just makes you feel at ease” 2:8

“That they you know, just make you feel completely at ease. And Laura always came out of the sessions very relaxed and calm, erm, which obviously then helped helps me as a you know as a parent,” 4:30

“They are so friendly and lovely. They really, they don’t make you feel like it’s anybody’s fault at all, it’s just you know, which is is reassuring.” 6:29

Wendy “I started to feel comfortable with the two of them. I knew how to take Jo.” 8:28
“They’re friendly, welcoming, make you feel good about yourself and that’s what I miss.” 14:31

Anna “I think just sort of being able to talk to her [the therapist], really” 7:45

3.2 Outside session support

Heather “Just how supportive they were and when I had real problems with the school and the school in fact got in touch with them, they were just so, so supportive and came down to a meeting at the school. Um.. they were just, they’ve just been wonderful and I mean they’ve been several times when I’ve phoned them up in an absolute state and they’ve just spent the time to talk with me and again put in perspective and that it’s not that big a deal, well not that it wasn’t a big deal they never said that, but you know, worse things could happen and that I could cope with this” 5:28

“I know that they’re so kind and nice that I could phone up if I was in a real spot and they’d push me in the right direction. Um, and I would only do that if I absolutely had to, but…” 10:39

Fiona “and also they did support me in the interims of the sessions because if I got very low I’d phone Sam and be in, and I’d say look, and it got particularly near the end of school when the school terms, and either Jo or Sam would come to the phone.
you know they're very busy people,” 10:17

“the same with Jo when I needed the psychodrama form, it was you know war on peace and Jo sat with me and took an hour out of her own time and I felt, you know, so grateful, that I had that help and I thought you didn't have to do that.” 22:11

Joan “Even to know that they're on the end of the telephone” 1:45

Kate “So you, that's nice the fact that they're there and you can just you know ring” 8:12

Wendy “So I made arrangements a couple of times for Jo to accompany me to a meeting” 3:25

“I felt like I wasn't on my own.” 4:2

3.3 Expert versus collaborative approach

Heather “Um, well just some of the ideas that they came up with, how to to deal with things, you know, just taking a different ah approach.

I: Can you tell me anymore about that – the different approach?

P: Well, letting me, because its always really, ah, self awareness isn't it, it's sort of me becoming aware or them letting me become aware of ah...the dynamics” 12:4

“They never said “do this do that” ever, ever, um we just talked about different ways of dealing with things and it was up to me whether I chose to talk it on board.” 12:23

Fiona “I think Sam and Jo always had a path for me to go. They knew I needed help and the best way to do it was the solution focused clinic because there were so many negatives I needed education.” 2:41

“But they would actually both say, “no, you're both run down, keep her off.” You know, and actually be my advisers. You know, “you're shattered” you know and make me listen.” 10:23

“And that ‘ll be a decision between all of us, that we come to mutually.” 19:46

“It was given to us as a choice, it wasn’t you are going to do this. what do you think about this? It was a question. It was our choice and that’s how we, erm, decided that yeah we would like to work that way, yes that would be very helpful.” 17:9
4. POSITIVES AS CENTRAL

Fiona “And with other services, there's never been positives. There's been tablets, there's been pills, there's been wards, but there's never been anything positive out of it.” 11:23

4.1 Positives from therapist(s)

Heather “It just buckered me up, honestly, I would come in thinking Oh I want to slit my throat and I would leave thinking thank god I have them to talk to and …ah go out with fresh new eyes and perked up again ready to fight the good fight” 5:21

“They were always, always, always so encouraging, you know, when I was at the depths, and Sam wrote me a letter and she said “I wanted to write down all the positive things that have happened and don't just look at the negative, look at the positive things that have happened and that's all because of you.” And they really, they just made me more confident and…I wasn’t’ a failure as a person, you know, I was getting there and I had a difficult job and I was getting there. There were some very very positive things to look at as well, not to just concentrate on the negative, which I had been.

I: Yeah, what did it feel like getting that letter?

Joan “It's like when you go the dentist he tells when you go for a filling or just a review. They're the specialists.” 11:44

“I never felt they were being dictatorial, or…always polite and always very gentle” 4:8

Kate “because you know, a psychiatrist has said, you know this is, you know, fine and if that's you know how she's happy at the moment leave her like that” 6:38

“And then we'd decide on a course of action, you know, from that.” 3:33

“that was decided as, we had a decision in that, you know, making as well with Sam. It wasn't like, you know just come back then, it was how do you feel about coming back then, do you think that, you know, you can do those things in that time. So that was good, so we were given an opportunity to say “ah no maybe we'll leave it, you know, 5 weeks, or something.” “ 5:36

Anna “you know she's [the therapist] got an answer” 7:30

“and obviously, they've got that background knowledge and possibly people that have been through it before, whereas I don't know anybody” 7:36
P: Well, I think it made me cry, yeah, yeah, it was very touching. Very touching.”
12:38

Fiona “I think I felt relieved actually and I felt comforted that I knew that Jo was there and that actually it wasn’t just one person’s but actually, they would, have, I felt quite important, that actually somebody was taking notice of us. They were, they would spot any good sign, they would remind me of the things that were actually positive and that I would have something to hang on til next time.” 8:27

“Oh yeah, somebody else to highlight something to you that you could have found but actually needed a bit of help. I spose it would be like looking for a needle in a hay stack - be really hard with one pair of eyes, but if there were four, it it it lesses, it increases the chance of being able to find it by three.” 13:23

“I: And how do you think you got to have that?

P: Well, from really going to the sessions. From having feedback and someone to tell me the good things that I’d done, rather than all the rubbish. Having someone concentrate on your life and asking questions and reminding you of good things and things that you have achieved.” 16:9

Margaret “I think when they used to go out and come back in Sam would, er, went with the positive things that came out of the meeting. She kinda neglected the negative things which was good really – it gave Jemima something to focus on”
5:23

Joan “encourage her if it was going well or encouraging her if it wasn’t going so well”
5:7

“helped me see how well I’d done in that situation, you know even things that weren’t related ()that were obviously helping erm as a person. I think they were very good at picking up on the positives.” 8:42

Kate “she did it with Laura by just, you know, telling how fantastically she’d done and how wonderfully she’d done. And stuff like, you know, erm, which she she she had done so well, so you know, it made you feel very child that, you know, your child had done that and stuff. And erm
I: And did you get their kind of encouragement and praise for doing well?
P: Yeah. Yeah.
I: And what was that like?
P: Um...it makes you feel good that, you know, you’re doing the right thing as a parent for your child.” 13:29

Wendy “Sam would have been listening in, making points that maybe Jo hadn’t picked up, and she’d send some feedback through Jo, of positives that we were doing well and sort of thing.” 4:20
"Well, seeing the good, in, of what's gone on in our lives. Seeing the good in each other, seeing the good in yourself. And the positive feedback coming up from both Jo and Sam. So it's not just one person saying it, you get the other person's opinion as well" 11:12

4.2 Use of notes

Fiona  "Nothing would ever be forgotten, cos they had notes." 21:36

"And if I didn't agree I'd say "yeah, but" but then she'd go back into the notes and say, "well, actually yeah" and you'd go "oh yeah" Cos you tend to forget or you lock it off in your brain what's good." 13:16

Joan  "but also they would refer back to their notes and ask me how I was getting on with something or how my daughter was getting on" 5:5

4.3 Tasks as a catalyst

Fiona  "I can only liken back to the tasks. Cos there was always, if we was having difficulty the tasks would be set about making something positive happen within the family. So the tasks were important." 21:18

Margaret  "Maybe about giving her goals as well because, because where she'd been very low she hadn't been doing things like cleaning her teeth and washing and getting ready for school on time. And she gave her little goals to achieve by each by the telephone appointment or the next time we saw her. Which she had to achieve, which was really fantastic really because that, coupled with her antidepressants, made her move on." 4:33

"That gave her the lift cos she realised she was doing it." 10:17

Kate  "Um, then um she'd ask Laura um, how she'd done on whatever task she'd been ask, you know, to try and stop like I said, you know, the checking of things." 3:21

"So she'd say, "well last week, last time you were at this score, so you've improved a little bit," 3:30

Anna  "they are quite useful but as I say, once he's done them he doesn't want to do them again, which is...you know... you set them once and then he doesn't want to do it again, so it's just trying to get him into a flow" 8:17
4.4 Anticipating positives

Heather “I looked forward to the sessions, I really looked forward to them. They were my little fix that could, you know, would make me feel stronger and better.” 7:43

Fiona “so it was a bit addictive actually, because I'd think “Ooh, what good things are you gonna tell me today, and do all these things.” I would kind of be…um, what’s the word I'm looking for, keen, eager, to know oh, well what are they gonna, how, what are they gonna remind me about today? So that's how I felt it was a golden carrot, I felt I'd been good, it was a reward.” 4:31

Joan “I know I always come back feeling better off, er, try and focus on the positives and to look forward. Remind me of something I've done.” 3:12

Wendy "cos I used to look forward to the comments that would be coming back. You know, the nice things that would be said or the feedback that would be helpful.” 4:37

4.5 Becoming own therapist/internalising techniques

Heather “whereas I didn't feel in control of myself, ah, before and I think that I sort of know enough…to sort of advise my husband a bit” 6:32

Fiona “All of a sudden your mind would, rather than think “oh God! You know this is a nightmare. OK this is a nightmare, but, it was even worse, you know, as few months ago.” So I can now, “what can I do to make this a little bit better”. So depending on the situation you try and find a positive and the sneakiness is that you would never have done that before.” 12:31

Margaret “I think that tool was the best thing that we ever had. We still use it now.” 8:12

“That gave her the lift cos she realised she was doing it. And she was beginning to set her own goals then. BY saying I will get to school 5 minutes beforehand so I can catch up and it was I will bring my homework home which she hadn't done for ages. She was setting her own, so yeah that was definitely a big part of it.” 10:17

Joan “I try to but I know I don't do it enough. I praise the children a lot, or other people – I try to be encouraging. Erm , I'm not very good at saying it to myself (laugh).” 9:8

Wendy “Thinking I'm on my own now, you know. And er, I've got to look for the good myself, I won't have the coaching.” 13:45

“Yeah, I started to focus on the good. The fact that when I, when I um, I'd see that Joseph was argumentative and had no respect for me and my friends and,
um ah, like his little sister and all this, and when I'd come out of there I'd have looked at the fact that when I walk the dogs round the back of th house I've come back and he's hoovered the lounge, and um... how loving he is and and although he's rude to my friends and and sometimes his behaviours a bit inappropriate, he's also very loving to them and and compliments them a lot as well. So I could see all that, you know. Good.” 9:1

5. BELIEF IN THE PROCESS

5.1 Belief in change

Heather “you know we would get there, we would get there.” 8:24

Fiona “there is help, but you have to believe” 14:22

“I think if you have that realistically in your mind and that you’re not waiting for a miracle to happen and that you work with it, it’s er a saying isn’t it all good things come to those who wait. And that’s a saying that, you know, we’ve become practised in the art of believing.” 19:34

Kate “there was a lot of hope there and a lot of confidence given that you know given across to you that things will you know, won’t be like this, you know they will change. And erm, not just the parent but more for the child, you know, giving them confidence to say erm, you know, it isn’t always gonna be like this, you , you now, it will will get better, so..” 5:21

“but they have told us that they can help and we can do something about this. So yeah, really a relief really.” 5:6

“that everything's going to be ok and that something that you know, is all going to be ok, is you know sortable, it's not it's not a problem that, she's not gonna be in your bedroom at 18 years old, you know. Um, you know that was real reassurance, it was really really helpful to have.” 13:45

Wendy “there’s light in a dark world, there is light there you just gotta take time to look for it.” 6:27

Anna “ Um...reassured, I think...a bit bewildered...but reassured that there is light at the end of the tunnel, even though it could be an awfully long way to get there...” 4:9

“but coming out is sort of a bit of light eventually” 4:16
5.2 Observing changes

Heather “I think I’ve changed as much as anybody. My attitude changed, um, my way of dealing with things changed.”

Fiona “Because I knew it was working.” 5:10
“because it shows us actually we are doing we are gaining you know, back on track, we are gaining experience, we are understanding, we’re gaining knowledge that we, you know, we didn’t know how to think before but now it’s working.” 15:1

Margaret “And because we were quite successful in what we were doing I don’t know how a parent would go that wasn’t so successful. I don’t know how they would feel.” 7:37

“but then I thought things were a lot better the second time we went and she said she was a 4. So, you know. But the next time we went she was an 8, so that was great. “ 8:10

Kate “Erm, she’d literally, from that first, from the session she’d come home that night and she’d start. That would be her homework. So erm, from it, from the first night of each session she actually did it.” 7:2

“she did the very first time and she and she managed it without any you know problem at all, I was like, that automatically built a trust as in I could, I you know, I I , I trust you for what you said, you know, it’s working, um., And you know the way they talk to you and explain things, that you, they’ve got your feelings um and you know the child’s feelings at the, you know what I mean, at the, they’re the most important thing. And you can tell that, um. But it was the fact that it did work – the things that we tried, were working.” 9:28

“Yeah, you’re getting nearer to to you know, solving, not solving, yeah solving problems, not all the problems but solving the problems, so. And knowing what her homework that she’d been given she’d done and managed to conquer, yeah it was the confidence of knowing this this is working, so.” 6:8

Wendy “Yeah, I started to focus on the good. “ 9:1

Anna “I mean, for me, definitely, feeling that I can achieve these things, even though I’d sort of lost all hope really... now I think I can do these things even though I’d sort of decided this was a ‘no hope’ sort of thing...” 5:24
5.3 Familiarity/predictability

Fiona  "Well at least I know I felt a direction in the clinic. I knew what the score was, the pattern never changed. So I had a belief in it."  12:31

Joan  "I think it gets easier each time, cos you’re more familiar with the room, the staff. It's um, the sessions seem to follow the same pattern,"  6:25

Kate  "But you get used it I think after you know, 2 sessions, you sort of know the routine. So once you know the routine you just sort of relax into it. So it's ok.”  4:3

Wendy "Cos I knew what to expect, I was used to it.”  4:46

6. POWER OF THERAPY

6.1 Outcome/gains

Heather “but I can deal with his behaviour a lot better. I feel more in control of myself, in fact I feel very in control of myself, whereas I didn’t feel in control of myself, ah, before”  8:30

“It really has, cos I've felt very desperate on many occasions that some oc I mean I've felt suicidal on one occasion and just, I'd come to the end of the line with it and you know they just... I do believe they've saved my life.”  8:40

“I'm a much stronger person for coming.”  11:11

Fiona “Yeah from thinking bad, guilty thoughts. It was almost like a brainwash. In a nice way, to find that part of the brain that encouraged rational thinking, which might sound simple to someone else, but for someone whose had depression or really difficult times, it's a truly different way of thinking. To think, actually no, it's not my fault that's happened, it's a circumstance beyond my control. It helps you do that, rather than so, parallel and so, it helps with that. It gives you another way of thinking and direction.”  16:1

Margaret “Obviously her mood getting better. Erm, she started to think about other people as well, so, which hadn't happened”  8:45

Joan “Certainly things have got much better”  7:32

Kate “not to see her so scared and stressed with the other things is lovely. The fact that she'll walk upstairs on her own and now now watch, if she doesn't wanna watch something I wanna watch on telly she'll, like last night she quite happily took a kid’s film up to her bedroom and I could hear her happily up there
laughing. That's something she wouldn't have done 6 months ago.” 7:30

“but now I mean they [the problems] just seem like distant memories.” 10:6

Wendy “Well, seeing the good, in, of what’s gone on in our lives. Seeing the good in each other, seeing the good in yourself.” 11:12

“Joseph improved quite a bit” 13:43

Anna “I don’t get bothered about it any more, whereas before I was getting quite frustrated about it, I just don’t bother any more. I think... ‘You know, I’m not going to worry (Child banging)... any more,’ so I think I’ve just become level-minded about it, really.”

6.2 Struggle to end

Heather “they’ve been so supportive that it’s a big crutch to throw away” 10:41

Fiona “So if anybody said they were taking it away I’d I’d kick and scream and I’d be really distraught, I’d be really distraught. That’s how much I need it.” 7:27

Joan “, but I felt I needed that, that as a safety net” 1:42

Wendy “Gonna miss em! (laugh)” 13:41 “But um, I don’t know, it’s nice knowing they’re there but not having an appointment to go to seems a bit scary (laughs). Thinking I’m on my own now, you know.” 13:43

Anna “there doesn’t seem to be a great deal outside that is going to help us from... outside, apart from just going there, really, so I don’t know, really...I don’t know the answer” 7:20

6.3 Valuing therapy

Heather “because I felt that I would have gone under - I think I would have ended up killing myself if I hadn’t had um Jo and Sam to talk with, I really do. They’ve been my little saviours.” 8:34

“Mm, it is, it was and it is powerful. And that’s why I would I would say to anybody, “if you’re lucky enough to be offered it, just grab it and don’t look back.”” 13:19

“I’d just tell them that um they’re very lucky to be able to access this sort of thing” 6:11

Fiona “It, it rescued us, is that way I looked. It helped, It was like a wing, a protection,
because it helped us” 7:10

“But that, you know, that is like the Holy Grail, that positive, when you’re actually in depression and you’re in difficulties and you’re in the capital d of dysfunctional. That positive is, it is like the Holy Grail, it’s like someone’s, it’s like the quest for the Holy Grail is over.” 19:7

“No I just wish there was more availability for therapy. I know that they’re quite under funded, and erm that thought does sadden me. Because I do think if we all, for problematic families and problematic people, if they had the chance of this therapy it’s a slight re education to your brain. Everybody needs that now and then” 23:13

Margaret “Oh no, yeah, she wouldn’t be where she is now without without those sessions, absolutely not”. 9:43

“I’m just delighted that it had such positive effect on my daughter and of course that goes right across the family then.” 11:44

“I just feel like if it helps other people it’s got to be good isn’t. I mean I’ve been helped, got to pass it down the line.” 13:42

Kate “And definitely do it, you know, if you’re offered it definitely do it, cos it does definitely you know help the child.” 4:33

“I think, well, the fact that they’ve changed, obviously, such a big part of our you know our daily routine and our our night time routine is lovely, you know, fantastic. Erm, and I wouldn’t have been able to do, do it without them. Erm, no ‘m I’m relived that they’re there.” 13:9

“And looking at us now, you know, its, you know, it has completely it has changed our lives and it has made me, you know, think “Oh gosh yeah it was like that.” So me talking about it a little bit later, but um, anybody that’s got you know a child that’s got you know those kind of problems, if they get a chance to you know see somebody then you know, definitely I think it would help them. Definitely, definitely.” 14:28

Wendy “You know, they’ve become like a family” 14:28

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Appendix XII: Extracts From Reflective Diary

11/02/08
...I’m about to embark on completing my first interview. Feeling anxious about the process as I’m not sure what to expect having never seen the clinic in action. I’m hoping that this will enable me to take quite an open position and have a fresh perspective on the process. However, I am very intrigued to see whether the mother who went felt invalidated at any point of she was unable to spend much time talking about the problems and is encouraged to focus on the positives/solutions. I’m completing this interview at the clinic, so I’m not sure what impact that might have on the interview. Perhaps it might feel a bit more formal. I’m not sure how I’ll feel about having to listen back to my own voice! I’m also wondering how much the mothers will be able to talk freely and whether I’ll need to do much prompting. I guess I need to get used to managing lots of uncertainty as this is what qualitative research is all about!...

15/02/08
...Completed my first interview. This mother thought I knew all about her background. I think she may have even thought I worked at the CAMHS where the clinic is based. Fortunately she was very chatty and was able to articulate her thoughts and feelings really well. She was highly complimentary of the service and the therapists and it was a really nice interview to be a part of....

11/03/08
...Just completed another interview. This parent was really hard to talk to and seemed to find it difficult to think about the process. As I had interviewed other parents before I was able to make a few suggestions which she accepted or rejected, but it was so hard to prompt her but not put words in her mouth. This is a big dilemma for me when I’m sat opposite someone who seems to find it hard to express them self. It’s hard to know to what extent to prompt and influence the interview, or whether to just have a really short interview which ends up not being rich and not really giving a sense of the person’s experience. I tried to strike a balance. This interview may be a bit more of a challenge to analyse than the others...

14/04/08
...Just met with some other Trainees who are also completing qualitative projects. People do seem to be anxious about managing the uncertainty of analysis which is not concrete and clear cut like quantitative methods. We discussed some of the tensions that we are all facing. Talked about how to conduct interviews in a way that gets the most amount of information from people whilst trying not to bias them. Also, about whether to offer up things that other participants have said to see whether the experiences/reflections fit with them. Seems to be about judgement and personal style. Also had a really interesting discussion about levels of interpretation. What constitutes a good level of
interpretation for the analysis? Is there a good enough standard that we should be aiming for? I talked of how some of my themes that are beginning to emerge are just common sense. The tutor asked what is wrong with common sense?! It feels like there is a pressure to make the themes insightful and unique and linked in with lots of psychological theory. It seems to be a case of sticking with the data and continuing to work with it. I have to hold on to the notion that I will be able to produce some meaningful themes in the end!...

06/05/08

...had a meeting with another Trainee who is also using IPA and looking at the process of therapy. We were talking about how hard it is to pay equal attention to all of our participants. There are two parents who I interviewed who gave really articulate and compelling narratives about their experiences. It's really hard not to base my whole analysis around them. The other trainee is also finding this a challenge. It seems to be a common tension. It makes sense that you could use IPA to write an in depth case study as you can get so much data from one interview. I need to remain engaged with all of the participants so that I can develop themes that are common across most of them, or can at least be identified as exceptions. We also talked about how it’s so hard to make decisions about what to leave out. It feels like quite a powerful position to be able to make decisions about what stays and what goes. It all feels important, but there just aren’t enough words to be able to include it all! The word count is becoming a real challenge....

...completed another interview. I’m really intrigued about how positive the parents are being. I wonder whether they feel the need to be positive with me as they think I know the therapists or that I’m connected to the service in a way that I’m actually not. I do tell them that I’m interviewing them in a purely research capacity and that their answers will be anonymous. They also have a preconception that I know lots of information about them already. The parents have all positioned me in a way that I had not intended. I thought I could remain a lot more neutral, but I don’t seem to be able to....

02/06/08

...just had a really useful meeting with my research supervisor to discuss final themes. I feel reassured that we have met and talked about the emerging themes previously. I was beginning to worry that it might seem as if I had made the themes up and that they were not grounded in the data. They made sense to me but would they make sense to anyone else? It’s such a subjective process that the whole thing could have just been a mystery to another reader. Fortunately I was able to show where I got the themes from and how the process developed. My supervisor thought that they did make sense and that they did reflect the experiences of the participants. She also gave some ideas to think about. Will see if I can incorporate them into the final clustering of themes...
Dear

Research interview: Parents’ experiences of Solution Focused Brief Therapy

Thank you for taking part in my research exploring parents’ experiences of Solution Focused Brief Therapy. I have met with seven parents in total who have talked about their experiences of going to meet (therapist name) or (therapist name) at ************. I have typed up the interviews and changed all names so that you cannot be identified. I have also changed (therapist name) and (therapist name) names to Jo and Sam so that the service cannot be identified. I have looked at all of these interviews and identified themes that summarise important points.

As we discussed when we met for the interview, I would like to hear your views on what I have found. I have enclosed a copy of the results and would be interested to know whether they fit with your experiences. I would also be interested to know your thoughts about taking part, and whether there was anything important that you wish you had said.

When we met, you agreed for me to phone you to find out your views about these results. I would really appreciate it if you could look at the results and then I will phone you within the next 2 weeks. It is fine if you decide you do not wish to give your views and I will respect your decision to do so. If you do not wish to give
your views you can let me know on ************. If I do not hear from you I will assume that it is fine to phone you.

Many thanks for your help and I look forward to hearing your views.

Yours sincerely,

Claire Edwards
Trainee Clinical Psychologist
RESULTS

Parents’ accounts were arranged into six master themes: readiness for change, initial challenges, therapeutic relationship, positives as central, belief in the process and the power of therapy. These master themes were comprised of smaller themes (called superordinate themes), which can be seen in the table below and are then described below. All names have been changed to keep the parents anonymous.

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1. READINESS FOR CHANGE
This theme is about parents' commitment to therapy. This was commitment to first go to therapy and then to work to make changes happen. Some of these things were thought about at the time. Others were thought about afterwards.

1.1 Desire for change
This theme is about all of the parents needing and wanting things within the family to change. This seemed to be important in how much parents wanted to go to therapy. As Heather expressed:

"Well yeah, you just want to get to be resolved and better."

This sense of parents need for change as important was also seen when parents talked about who might find the therapy helpful. Wendy described who she felt might find solution focused brief therapy (SFBT) helpful:

"A person who cares about the future of their child, cares about how their behaviour may damage their child. And, um, who wants to change things, when things are tough."

1.2 Responsibility for change
All parents felt they had a role to play in making change happen. They saw that they needed to put in effort to make changes, both inside and outside of the sessions.

"it just made me more aware of it, I had a part in this as well and I could make the situation a lot better if I behaved better. Which I did." (Heather)

"I yeah, I think that um, some parents I think end up, almost imagine them taking their child in and expecting, you know, them to completely fix them. But you can't expect that. You know, you've got to put work in for your child's sake." (Kate)

"you get back what you put in." (Kate)

1.3 Need to be open and honest
Three parents talked of this and it felt important to include. These parents talked about the need to be open and honest to make therapy work.

"one thing I thought about – and you must be honest. Because if you go in there and lie and scoot and think anybody's trying to check you out, if you are not blatantly honest, it will not work. Because you're lying to yourself and I think some people that are caught in a situation might be tempted to do that. So I would, I would absolutely say that take the courage and be very honest. That is one of the key rules." (Fiona)
"just be open...and if there was anything they were thinking about, I'd just tell them to say..." (Anna)

1.4 Bearing the pain
This theme came from parents' thoughts on the process of therapy. There was a sense that therapy was painful, but worth it in the end.

Fiona saw it like going to the dentist; the work would be painful but needed to happen:

"So that's how I would give the analogy, it's like going to the dentist knowing you've got major work to be done. It's gonna be painful, it's gonna be awkward, it might leave a little bit of a ting for a few hours afterwards."

Margaret had a shorter experience of therapy, and the process was difficult throughout. However, there was still a sense that it was worth it as it made positive changes.

"I just felt it was something I had to do. I can't say that I enjoyed the experience cos that would be lying. But it was good in the fact that it helped my daughter and that was my aim " Margaret

2. INITIAL CHALLENGES
This theme came from parents' descriptions of feeling anxious and nervous. These worries had to be overcome in order to keep going back to therapy.

2.1 Fear of concealed reactions
All parents were nervous about the camera in the room or the screen that was used. This seemed to be about hidden reactions from the therapist who could not be seen. As Wendy explained:

"Nerve wracking, knowing there was someone behind the screen. It was like, yeah, frightening.

I: And what do you think made you particularly nervous?

P: Not knowing what to expect and I say, knowing there was another person behind this screen and not being able to see them and their reaction to things that were said and um..."

For most parents, their fears were reduced as they went to more sessions. This did remain a worry for Margaret who went to less sessions and maybe did not have a strong relationship with the therapist to help this. She felt the screen and camera were like "Big Brother watching you."
Anna found meeting the therapist behind the screen was useful and helped her to feel a connection:

“so she was involved but wasn’t there, if you know what I mean”

2.2 Fear of unknown
This was about four parents’ fears about what might happen in the therapy. Again, these seemed to get better as the therapy went on.

“It it was at first, because it’s the fear of the unknown and I’d been pushed around a lot within the services.” (Fiona).

“Yeah, not knowing what to expect” (Wendy)

Joan also talked of some worries about talking to someone she did not know:

“With a stranger its…you’re not quite sure what you’re getting into and if I thought, as I found out, it was beneficial.”

For two parents, these anxieties were made worse by the idea of going to mental health services. Anna explained this well;

“It’s all a bit daunting, really, because you don’t know what to expect. It all sounds a bit …um…dramatic, you know…mental health seems a bit scary and that’s on the headed paper… when it comes through the door you think, ‘Oh gawd!’…” (Anna)

2.3 Learning the approach
This is about how parents learned this positive way of working. Some liked the approach from the beginning:

“I think possibly they, we talked about sort of…that we were talking about solutions to the problems. It was a nice experience you know, it wasn’t horrible or anything it was quite nice and I felt quite relieved after I’d been.

I: Mm, um, what was it like thinking that you would be talking about solutions?

P: Great! (laugh). Great, great, yes.” (Heather)

But Wendy and Fiona found the way of working more difficult to adjust to and needed more time to switch to looking at positives rather than having a “sounding board” (Wendy) for negatives.

“At first I used to feel really angry because I’d I’d think “Oh for goodness sake, you know, I’m coming here, I need help. Nobody wants to help. Um, I’m trying to
tell you what things are going wrong. I need you to give me answers. And all you want me to do is get me to talk about the good. But I need help with the bad to make it good. “And you know, all this. But in the end I could see what they were trying to do, you know” (Wendy)

Fiona and Wendy seemed to use the relationship with the therapist to help with this.

3. THERAPEUTIC RELATIONSHIP
This theme is about the relationship that developed between the parent and the therapist and the young person and the therapist

3.1 Therapist qualities (facilitating engagement)
Parents talked about the positive qualities of the therapist. This seemed to help parents to go back to the sessions and be committed to therapy. Building this relationship with parents and children was really important, but less important for Margaret.

“Sam was very easy to talk with” (Heather)

“And I just felt that Sam, perhaps more than anybody else, was able to hit buttons that other people weren’t. In the way she asked her questions” (Margaret)

Building this relationship was a really important point for Wendy:

“I started to feel comfortable with the two of them. I knew how to take Jo.”

Which then became one of the most important parts of the therapy for her: “They're friendly, welcoming, make you feel good about yourself and that's what I miss.”

It was helpful for Joan too; “although it's in some ways it's difficult it's easy because I got to know Jo and Sam and I know that they're there to help and not to be judgemental.”

For Kate, the relationship between the therapist and her child helped her trust the therapist.

Anna found talking to the therapist the most useful part;

“I think just sort of being able to talk to her [the therapist], really”
3.2 Outside session support
Five parents talked about the things that the therapists did outside of the sessions. For example speaking on the telephone, going to school meetings. There was a feeling of therapists going the extra mile. This led to parents feeling valued.

"the same with Jo when I needed the (omitted) form, it was you know war on peace and Jo sat with me and took an hour out of her own time and I felt, you know, so grateful, that I had that help and I thought you didn't have to do that” Fiona

Participants also felt reassured that they could get support if they needed it:

"I know that they’re so kind and nice that I could phone up if I was in a real spot and they’d push me in the right direction. Um, and I would only do that if I absolutely had to, but...” (Heather).

3.3 Expert versus collaborative approach
Parents seemed to talk about the way that the therapist could move between being an expert and working more in partnership. At times, therapists were more directive and parents relied on their advice,

"It's like when you go the dentist he tells when you go for a filling or just a review. They're the specialists.” (Joan)

At other times the therapist helped parents to explore and be more involved in making decisions:

Heather “they never said “do this do that” ever, ever, um we just talked about different ways of dealing with things and it was up to me whether I chose to take it on board.”

4. POSITIVES AS CENTRAL
Fiona’s quote sums up why this theme is important:

“And with other services, there's never been positives. There's been tablets, there's been pills, there's been wards, but there's never been anything positive out of it. “

4.1 Positives from therapist(s)
Parents valued the positive comments that they got from the therapist, and for some the feedback had a huge impact.
“It just buckered me up, honestly, I would come in thinking Oh I want to slit my throat and I would leave thinking thank god I have them to talk to and ...ah go out with fresh new eyes and perked up again ready to fight the good fight.” Heather

“I think when they used to go out and come back in Sam would, er, went with the positive things that came out of the meeting. She kinda neglected the negative things which was good really – it gave Jemima something to focus on” Margaret

Fiona and Wendy also talked about how good it was having more than one therapist to find the positives:

“Oh yeah, somebody else to highlight something to you that you could have found but actually needed a bit of help. I spose it would be like looking for a needle in a hay stack - be really hard with one pair of eyes, but if there were four, it it it lesses, it increases the chance of being able to find it by three.” Fiona

4.2 Use of notes
For Fiona and Wendy the use of notes was important. It made it feel like the positives could not be ignored as changes were written down. This made the process feel safe and reliable.

As Fiona said:

“Nothing would ever be forgotten, cos they had notes.”

4.3 Tasks as a catalyst for change
Tasks acted, for three parents, as a huge help for making change. The tasks helped to make positives and make changes.

“I can only liken back to the tasks. Cos there was always, if we was having difficulty the tasks would be set about making something positive happen within the family. So the tasks were important.” (Fiona)

It also seemed to help parents realise that they and their family could make change happen for themselves.

“And she gave her little goals to achieve by each by the telephone appointment or the next time we saw her. Which she had to achieve, which was really fantastic really because that, coupled with her antidepressants, made her move on.” (Margaret)

Anna talked about how the tasks were useful but only for a short time.

“They are quite useful but as I say, once he’s done them he doesn’t want to do them again”
Anna was in the early stages of therapy, and perhaps the tasks will change in their value for her as she sees more changes.

4.4 Anticipating positives
Four parents talked of how they looked forward to the positive feedback.

"cos I used to look forward to the comments that would be coming back. You know, the nice things that would be said or the feedback that would be helpful.” (Wendy)

Others looked forward to the positive feelings they got from the feedback

“I looked forward to the sessions, I really looked forward to them. They were my little fix that could, you know, would make me feel stronger and better.” (Heather)

"so it was a bit addictive actually, because I'd think “Ooh, what good things are you gonna tell me today, and do all these things.” I would kind of be...um, what's the word I'm looking for, keen, eager, to know oh, well what are they gonna, how, what are they gonna remind me about today? So that's how I felt it was a golden carrot, I felt I'd been good, it was a reward.” (Fiona)

4.5 Becoming own therapist/internalising techniques
All parents described using what they had learned at home. For Margaret, who had a less positive experience, the scaling question she learned was important in therapy and still is:

"I think that tool was the best thing that we ever had. We still use it now.”

For other parents, the changes were about changing the way they thought about things. They were more able to look for positives on their own.

"All of a sudden your mind would, rather than think “oh God! You know this is a nightmare. OK this is a nightmare, but, it was even worse, you know, as few months ago.” So I can now, “what can I do to make this a little bit better”. So depending on the situation you try and find a positive and the sneakiness is that you would never have done that before.” (Fiona)

5. BELIEF IN THE PROCESS

5.1 Belief in change as possible
Four parents talked about the belief that they had in the process, which was important to hold on to.

“there is help, but you have to believe” (Fiona)
Parents seemed to hold onto the idea that change was possible which helped them to stay with the process of therapy.

“there was a lot of hope there and a lot of confidence given that you know given across to you that things will you know, won't be like this, you know they will change. And erm, not just the parent but more for the child, you know, giving them confidence to say erm, you know, it isn't always gonna be like this, you, you now, it will will get better, so..” (Kate)

Two of these parents also talked about light at the end of the tunnel;

“reassured that there is light at the end of the tunnel, even though it could be an awfully long way to get there” (Anna)

“there's light in a dark world, there is light there you just gotta take time to look for it.” (Wendy)

5.2 Observing changes
All parents talked of changes that they saw. This helped parents to feel that the therapy was working. This increased their belief in the process and helped parents to stay in therapy.

Kate was amazed at how quickly she saw changes (from the first night) and this quick success built trust with the therapist.

For Margaret, the success she saw with her daughter seemed to be the only reason they returned to the next session:

“And because we were quite successful in what we were doing I don't know how a parent would go that wasn't so successful. I don't know how they would feel.”

5.3 Familiarity
Four parents talked of how the routine and knowing what to expect made going to therapy easier. The pattern of sessions seemed to make a sense of safety and belief in the therapy.

“I think it gets easier each time, cos you're more familiar with the room, the staff. It’s um, the sessions seem to follow the same pattern,” (Joan)

6. POWER OF THERAPY

6.1 Outcome/gains
All parents talked of positive things that came out of going to therapy, for themselves and their children.
"I'm a much stronger person for coming." (Heather)

"Certainly things have got much better" (Joan)

"but now I mean they [the problems] just seem like distant memories." (Kate)

6.3 The struggle to end

For four parents still in therapy, ending therapy was seen as a difficult task. This seemed to show how important and useful the therapy is to them.

"Gonna miss em! (laugh)" "But um, I don't know, it's nice knowing they're there but not having an appointment to go to seems a bit scary (laughs). Thinking I'm on my own now, you know." (Wendy).

Loosing the support that the sessions gave Heather worried her:

"they've been so supportive that it's a big crutch to throw away"

Anna also had concerns that there might be no other service to help her:

"there doesn't seem to be a great deal outside that is going to help us from... outside, apart from just going there, really, so I don't know, really"

6.3 Valuing therapy

This theme is about parents feeling glad that they have been able to use the service. They felt pleased and grateful for the changes that had happened.

"because I felt that I would have gone under - I think I would have ended up killing myself if I hadn't had um Jo and Sam to talk with, I really do. They've been my little saviours." Heather

"It, it rescued us, is that way I looked. It helped, It was like a wing, a protection, because it helped us" Fiona

This was also shown in how parents talked about wanting other people to have it too:

"I just feel like if it helps other people it's got to be good isn't. I mean I've been helped, got to pass it down the line." Margaret

"anybody that's got you know a child that's got you know those kind of problems, if they get a chance to you know see see somebody then you know, definitely I think it would help them. Definitely, definitely." Kate
Appendix XIV: Mothers' Views on the Results

All mothers were offered multiple opportunities to give their views on whether the results fitted with their experiences. Mothers were also asked whether there was anything else they would have added during the interview, or had considered since the time of the interview. The following is a summary of what mothers who responded thought.

Fiona
Fiona felt that the results covered everything in terms of what it means for a parent to go through the experience of solution focused therapy. She was keen to know what her pseudonym was so that she could identify her own quotes. She said that she felt I had done a good job representing mothers' views and that she felt passionate about passing on her own positive experiences of SFBT.

Fiona reported a sense of sadness when she read that some mothers were bothered by the mirror and camera. She felt that she overcame this very quickly by acknowledging the other therapist by waving at them. Fiona felt that, for her, she was so desperate for help that she would have done anything to get that help, and that the mirror/camera was not too bad. She also felt that her personality helped her overcome this, in that she can be "quite assertive" but also "learn to be hidden" if she needs to.

Fiona felt that the theme about belief in the process was very pertinent to her. She felt that you have to believe in the therapy because it takes time to work, and that people can be very impatient. She felt that the theme definitely fitted her experiences. She said that solution focused is a perfect title for the therapy as nothing is a problem and there is the belief that everything is "sortable". Fiona also felt that the theme 'positives as central' was key to her experience.

Fiona agreed with Wendy's quote about missing the therapists but it being nice not to have an appointment to go to. Fiona felt that she does fear ending therapy but that she will discuss it and work towards it with the therapists. Fiona felt that acceptance from her and belief in herself were central to being able to end therapy. In terms of the theme 'power of therapy' Fiona said she "loved that bit." She felt that SFBT has enabled her to carry on, and has benefited her child too.

Fiona thought that there was one area missing, which was how the children experienced the therapy. She felt that it is scary for children to attend and that it was an area that needed consideration. Fiona also wanted the referral process to be thought about. She found waiting after she had been referred very difficult and would like more availability. Fiona was very passionate about the topic and felt that more funding should be available so that more families can quickly access the service.
Fiona reflected on the interview. She reported feeling at ease with me, that I was easy to talk to and that she did not hold anything back. At times, she felt saddened by hearing herself say things, but in the main she found it fine. A big motivator for Fiona was the thought that she would be helping other people by sharing her experiences. Fiona said she “just wished there was more funding for it.”

**Heather**
The first thing that Heather told me was that she had worked out who her pseudonym was. Her overall impression was that the results “came out quite well for the therapy” and that the results did fit her experiences of SFBT.

She felt that the ‘readiness to change’ theme reflected her need to for things to be “all healed” and to be better. Heather described feeling like a “lost soul” wishing “please let this be a miracle.” Heather felt that the responsibility for change and owning change was not immediately apparent for her. She thought that the therapy would help her son more and that “it wasn’t an immediate thing when you first went – it builds up to a ‘yeah, I can make a difference.’” Heather described slowly having the realisation that making a difference to yourself can lead to a difference in others.

In terms of learning the approach Heather felt that the approach was not overt, but that it was delicately done in such a way that she did not notice it. Heather felt that she was aware of the mirror to begin with but that she got to know both therapists and was not put off someone behind the mirror. These initial challenges seemed easier for Heather to overcome.

Heather described the therapists as “wonderful and non judgemental” and felt that they were a big part of the therapy for her. She felt that the outside session support, particularly the telephone conversations were “hugely important.” When asked why, Heather told me that “sometimes things got so bad and you needed support and they were so available…they would always phone you back…just to know they’re there is helpful.”

Heather also felt that the positives were central. She explained that the longer she had been the more able she was to hang on to the positive feedback at home. The positives made it easier to come back to therapy, and when given the choice of when to have the next session, Heather would want to return the following day. Heather felt that the therapists and the positives helped her take on responsibility for her situation and kept her going.

Heather felt that belief in the process and that things could change was very important. She feels that now she has a whole new way of looking at things and can drag herself out of negative times and think about the positives. Heather also found that the therapy “very powerful for me.” She did have concerns about
ending, but this was facilitated by making decisions about length of time between appointments, which was gradually increased. She described fears of “being lost at sea without a lifeboat” and “cast to the wolves” but that this has not happened and she felt it was the right time to finish. Heather felt that SFBT was a life saver for her and she told me that she “can’t speak highly enough of it.” Heather said that anyone who was offered it should grab it with both hands. Heather felt that there was not anything that she would have added to her interview.

**Wendy**

Wendy felt that the master themes definitely fitted with her experiences of the therapy. What stood out for Wendy was the ‘fear of concealed reactions’ and reading about the challenging aspects of therapy.

Wendy said that ‘readiness for change’ made sense to her as the reason that you go to therapy is for change. She felt that the ‘initial challenges’ theme described some of her experiences. Wendy felt that the beginning stages of therapy were difficult and that the reason she went back to each session was that she wanted to do the best for her children. She also said that “things don’t get better overnight.”

The therapeutic relationship was important to Wendy. Wendy had met the therapist that was behind the mirror at a parenting course. Whilst she found the experience of someone behind the mirror uncomfortable, it was made less so as she had an existing relationship with the concealed therapist. With the index therapist, Wendy was not about her at first, but she developed a good relationship with her and described her as “lovely.” Wendy was also reminded of how important outside session support was to her. Wendy said that she had not talked about this during the interview, but that she had been reminded of it when reading the results. Wendy had phoned the therapists on many occasions for ad hoc support, which had been extremely helpful for her.

Wendy ultimately found the positives useful, but had mixed feeling about them in the beginning. She described wanting to “sound off” and talk about what was wrong and found it frustrating that she was asked to talk about what was going well. Wendy said that “In the end it [the solution focused approach] worked out for the best.” Wendy said that due to her early experiences of being criticised and put down she found praise uncomfortable. It made her feel good but initially she did not know how to respond to being praised.

Wendy found that, whilst not at first, she did eventually develop belief in the process. This was at the point when she described seeing the point of it. Wendy would go into her sessions feeling the whole world was against her, and come out feeling the whole world was with her. About half way through Wendy was more able to think of the positives. She described thinking about the good things in preparation for her session, and that this ability has remained with her. Wendy
gave a recent example of where things had gone wrong but she was still able to hold on to the positives.

Wendy agreed with the theme 'power of therapy.' She and her family have experienced positive changes as a result of SFBT. With regards to finishing, Wendy is still daunted by this with the loss of “back up” but feels that she will get on with things when she does finish SFBT. Wendy said that the results definitely fitted with her experiences and described them as “a good read.”