Family members’ perceptions of therapy at a specialist older adult family therapy service

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INTRODUCTION TO THE PORTFOLIO: VOLUME 1

This portfolio contains a selection of the work submitted during completion of the PsychD in Clinical Psychology training course. Volume 1 comprises (i) the academic dossier which consists of two essays, three problem based learning reflective accounts and two summaries of case discussion group process accounts; (ii) the clinical dossier which contains summaries of the six placements and five case reports completed over the course of the three years; and (iii) the research dossier which contains the research logbook, an abstract of a qualitative project completed in year two; the service related research project completed in year one and the major research project completed in years two and three.

Volume two of the portfolio comprises the clinical dossier which contains the full five case reports, the placement contracts, and logbooks and placement evaluation forms. As the clinical material kept within volume two is of a confidential nature it will be kept within the Clinical Psychology department of the University of Surrey.

The work presented in this portfolio represents the range of client groups, presenting problems, and psychological approaches covered across the three years of training. Within each dossier the work is presented in the order that it was completed to illustrate the development of academic, clinical and research skills during training.

All identifying details have been removed or changed in order to preserve confidentiality and anonymity.
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OVERVIEW OF THE ACADEMIC DOSSIER

This dossier consists of two academic essays written in years one and two of the PsychD training course. They are presented in the order of which they were written. The first essay presented is the adult mental health essay completed in year one and the second essay is the professional issues essay completed in year two.

Three problem-based learning reflective accounts are presented in order of completion in addition to two summaries of the completed case discussion group process accounts.
Can the experience of hearing voices (‘auditory hallucinations’) be considered as an ordinary part of human experience? What implications might such a conceptualisation have for the ways that Clinical Psychologists respond to service users who hear voices?

March, 2006

Year 1.
Can the experience of hearing voices ("auditory hallucinations") be considered an ordinary part of human experience? What implications might such a conceptualisation have for the ways that Clinical Psychologists respond to service users who hear voices?

Introduction:
"Truth" is a process that develops over time through the interactions between people. As Goldberg (1980) explained:

"I assume that truth is paradoxical, that each article of wisdom contains within its own contradictions, that truths stand side by side".

(pp.296-296)

Thus there can be no statement which is indicative of an absolute truth (Linehan, 1993). Thus in order to discuss if the experience of hearing voices can be considered an "ordinary" human experience we have to contemplate that what is "ordinary" will hold a different meaning for each individual.

The Oxford English Dictionary Online (2006) offers varying definitions for the word "ordinary" including:

"Belonging to the regular or usual order or course of things; occurring in the course of regular custom or practice; normal; customary; usual".

(pp.2)

This suggests "ordinary" might refer to the occurrence of events or experiences which conform to an expected order such as developmental stages. However, who dictates what is ordinary and what is not? Or, what is customary and regular? I will argue in
this essay that one cannot make assumptions about how individuals interpret their experiences or positions in society. In addition, I suggest that there is no such thing as an “ordinary human experience”. I will posit that we all interpret our lives in terms of “frames of reference” which might include the population within which we reside, our life histories, our society or culture.

As clinical psychologists, we need to reflect upon our own context and personal and professional norms in order that we do not impose them upon others. Universalism makes the incorrect assumption that psychology can be used upon all people from all cultures. However, medical anthropologists have noted that how symptoms are expressed is socially determined and is reliant upon local knowledge, feedback from others and social institutions. Therefore it is important that we acknowledge that our methods for diagnosing mental illness and determining how psychotherapy should be conducted are in themselves social constructions and, as such, may not be applicable to cultures that are not our own (James & Prilleltensky, 2002). Knight (2005) suggests then, that as clinical psychologists we are challenged to accept individuals’ differences and assist them in living with their reality, their version of what is “ordinary” and within a wider society that may or may not share their beliefs.

**Identifying psychopathology: the difference between service-users and non service-users**

*Hearing voices: a non-psychiatric condition*

It is important to acknowledge that hearing voices can indicate a non-psychiatric medical condition. For example, seizures or lesions in the left temporal lobe can produce auditory hallucinations (Tanabe et al. 1986) and more recent research has focussed on attentional deficits and speech processing consistent with left temporal pathology. Stein & Richardson (1999) found that hallucinators can misperceive their own inner speech or subvocalisations as external. However, there are many explanations for auditory hallucinations including poor source monitoring (Morrison & Haddock, 1997), poor metacognition (Baker & Morrison, 1998) and impaired discrimination of local targets (Carter et al. 1996). In addition auditory hallucinations have been caused by taking psychoactive substances such as LSD (Miller & Gold,
1994). Unfortunately, due to the vast extent of causal theories for auditory hallucinations they cannot all be discussed here. However, it is important to consider that such biological factors may cause auditory hallucinations in the absence of other symptoms. This leaves the symptoms open to the interpretation of the voice hearer, professionals and individuals around them to make various causal and meaning attributions which may have a variety of impacts upon the individual. These in turn may effect how he or she comes to accept their experiences and the stigma with which it may be associated (Ritsher et al. 2004).

Prevalence of hearing voices:
Between 1-2% of the population have been found to experience auditory hallucinations at some point in their lives (Thomas & Leudar, 1996). However, within subgroups of the population the incident rate may be higher. For example, Posey & Losch (1983) discovered that over 70% of a sample of American students experienced occasional, short auditory hallucinations. Barret & Etheridge (1992) found that 30-40% out of 500 psychology students experienced auditory hallucinations. They also attempted to ascertain if a relationship existed between hearing voices and psychopathology. They were unable to find any difference between hallucinating and non-hallucinating participants.

In 1987 Romme & Escher decided to broadcast a television programme about hearing voices and asked voice hearers to contact them. They met voice hearers who had never needed medication or accessed psychiatric services. According to Romme & Escher (1996) these individuals led “normal” lives and did not wish to get rid of their voices. They were described as accepting their voices and being able to cope with them. This led Romme & Escher to question if auditory hallucinations are a symptom of psychiatric illness.

They decided to conduct a study comparing both patients and non-patients. Participants included 18 patients diagnosed with schizophrenia who heard voices, 15 patients diagnosed with dissociative disorders and 15 non-patients who were hearing voices but had not sought profession help or received a referral for psychiatric help.
Psychiatric definitions:

According to psychiatric definitions an individual with schizophrenia can hear voices via their ears but cannot talk to them. In contrast dissociative disorders produce pseudo-hallucinations which are voices heard inside the head to whom the individual can talk. However, in dissociative disorders, the listener does not believe that the voices are actually “not me” but only feels as if they are “not me”. Romme & Escher’s (1996) results did not conform to these definitions. In all of the groups participants could hear voices through their ears in addition to in their heads. In all of the groups most of the participants heard voices as “not me” coming from someone else. Two-thirds of dissociative patients were not able to talk to their voices in contrast to the other two groups where two-thirds could talk to their voices. Therefore, the findings of Romme & Escher (1996) are the opposite of what psychiatry would predict.

According to Schneider’s (1959) “symptoms of the first order”, voices that remark upon the hearer’s behaviour, and talk to each other about the hearer in the third-person, are sufficient, but not necessary, evidence of schizophrenia. Romme & Escher (1996) found no clear differences between the groups regarding whether or not the voices spoke in the second or third person. However, talking in the third person was more common in the schizophrenia group. Further, voices that remarked about the hearer were common in both the patient groups to approximately the same extent, and less in the non-patient group. Therefore, the psychiatric definitions failed to highlight the difference between patient and non-patient.

Conceptualising the experience:

The importance of context:

It is important to understand human experience in context. This can include social, cultural, historical and political frameworks. Thomas & Bracken (2004) argue that cognitivism:

“...accounts for human experience and behaviour in terms of mental processes that represent external social reality. This divorces human experience and action from these contexts and
renders it meaningless”

Thus, explaining to an individual that they are hearing voices due to difficulties with their mental processing suggests a deficit on their behalf and tells them about a process which may seem alien to them and divorced from their own experiences.

Clinical implications:
Thomas & Bracken (2004) argue that cognitive models describe the cause of auditory hallucinations but are able to tell us nothing about the contexts in which auditory hallucinations occur and, instead, frames them solely as disordered mental processes. Leudar & Thomas (2000) argue that it is important to explore the context of auditory hallucinations in order to enable a greater understanding of the meaning of hearing voices for the individual voice hearer.

Personal narratives:
It is important to acknowledge that each individual may subscribe to a different explanation for their experiences and find differing theories helpful. For example, in a study conducted by Thornhill et al. (2004) they found that the narratives of individuals who had experienced psychosis varied and identified three themes: escape, enlightenment and endurance.

Individuals who had “enlightenment” narratives correspond with the assertion of Romme & Escher (1996) that psychosis is a “socio-emotional problem”. The experience of psychosis is viewed as having positive and negative aspects and the narratives query a narrow view of “mental illness” or a biological view of their problems. Individuals within enlightenment narratives understood psychosis as a response to previously experienced physical or psychological trauma in childhood. For example, Donald found it helpful coming to an understanding that the voices he heard were meaningful in the context of his life experiences:
"...that he heard the voice of the catholic priest who sexually abused him as a boy, of his dead father, and of his girlfriend who committed suicide. He was then able to grapple with the issues that they raised... and thus demystify and disempower the voices”.

This suggests that for individuals who are ready to explore their past history it may be helpful to understand the meaning of their voices in the context of their life experiences.

In contrast for participants whose narratives were framed within the thematic structure of “endurance narratives”, psychosis was acknowledged as a “potential obstacle to progress”. Thus participants within this narrative were aware that they continually have to be aware of potential difficulties. Thornhill et al. (2004) view such narratives as similar to medical discourses of schizophrenia emphasising the continual management of a chronic condition. However, Thornhill et al. (2004) caution that although the endurance narratives share many similarities with the medical model of symptom management and living with chronic illness, resignation and stoicism is paired with angry protest. This includes a desire to be treated positively by professionals without such prevalent problems of stigmatisation and exclusion.

Miriam’s narrative was one of “escape”. She wanted to escape the confines of a perceived obligatory belief system and the identity of a “chronic patient”. She explained that an important route to her escape was rejecting the imposed medical/biological model which she viewed as deterministic and hopeless. Forcing upon her stigma and a belief system that she did not identify with and giving her an identity that she could not choose. Thornhill et al. (2004) argue that those who had escape narratives needed to escape from a:

“false and limiting notion of “mental illness” in order to recover meaningful lives”.

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Thornhill et al. (2004) highlight how social labelling can impact upon how an individual copes with their diagnosis. In particular they observed that participants with escape narratives had been diagnosed with either schizophrenia or schizoaffective disorder which are particularly stigmatising and escaping this identity was crucial in their recovery narratives.

Clinical implications: 
Thornhill et al. (2004) suggest that if the difficulties of clients are conceptualised as "problems in living" reflecting a type of human problem instead of "mental illness" this might reduce stigma and alter the positioning of the psychiatrist or clinical psychologist as "expert" (Thornhill et al. 2004). In addition, the narratives identified here suggest that each individual may develop their own unique understanding of their illness and route to recovery. Individuals working with clients who experience auditory hallucinations should collaboratively explore how the individual conceptualises the experience without imposing their own assumptions.

Socio-cultural context:

The impact of stigma: 
Goffman (1963) defined attributes that are stigmatised as those which are intensely discrediting in certain contexts, and which often become the overriding identity by which an individual is perceived (as cited in Camp et al., 2002). In particular he highlighted that stigma should be viewed in the light of relationships as it is a process of social devaluation, rejection or discrimination. Further, symbolic interactionism suggests that by taking the viewpoint of significant others we come to regard ourselves as others do (Blumer, 1969). However, Finlay & Lyons (2000) for example, have proposed that the relationship between stigma and self-esteem is not inevitable and that individuals may critically engage with the view that others take of them.
Camp et al. (2002) investigated if low self-esteem is an inevitable consequence of stigma and interviewed 10 women who attended a day centre for adults with mental health difficulties. Participant’s acceptance of their mental health diagnoses and labels was critical and pragmatic. Many of the participant’s reported feeling different and outside from many social groups. No evidence was found for self blame instead, Camp et al. (2002) found that the women accepted being different and avoided interacting with groups with whom they felt excluded. In contrast the day centre itself enabled participants to maintain positive self identities by providing an understanding, accepting and normalising network which they did not experience outside of that environment.

The women experienced exclusion from social roles. They acknowledged the negative consequences that can result from having a mental illness including those of not following gender or developmental norms such as having a career, marriage and motherhood. However, they did not necessarily see themselves as being to blame. This indicates the significance of distinguishing between self-perceptions and the awareness of others’ perceptions of self in stigma. Thus accepting and developing one’s own understanding of mental health difficulties, instead of uncritically accepting lay or professional explanations can be important in coping with the negative attitudes of others and the practical problems associated with possible relapse.

It is perhaps assumed that those who occupy a minority social status adopt the perspective of the majority. As a consequence they may be expected to feel if not self-loathing then at least some ambivalence towards the self. Camp et al. (2002) argue that individuals are assumed to have engaged in some kind of coping strategy to deal with social reality if they are not experiencing problems with self-esteem when in a minority social position. However, they posit that such a perspective does not account for individuals who perceive the majority perspective as spurious, based on a lack of knowledge or to maintain an imbalance of power. In addition, such a perspective does not allow for occasions when the way in which an observer constructs the identity of another (i.e. positioning the stigmatised trait as the dominant
identity) is different from subjective identity (where the individual may not regard the trait as essential to the self).

Clinical implications:
It is therefore the acceptance or rejection of the socially constructed nature of social categories that is significant. Explicitly, it is the possibility that there are a multitude of competing meanings in societies. This highlights the importance of a clinical psychologist enabling a client to explore their own understanding of their social category or label and the affects on self-concept instead of assuming that one will find a reaction to assumed definitions. Suggesting that there is no "ordinary" or "typical" way of interpreting the position you may have in society. In addition, the effect of the day centre providing an understanding, accepting and normalising network has significant implications for the importance of such places which are being reduced due to NHS monetary deficits.

Cultural attributions:
The culture within which an individual is embedded or subscribes to can effect how an individual copes with and perceives their voices. An individual's culture will thus effect their perceived self-efficacy in relation to control over the experience and affective reactions. It is therefore stipulated that those who are in the position of supporting and/or working with individuals who hear/have heard voices should reflect upon the meaning of hallucinations and functional significance as well as the social context and stimuli associated with them (al-Issa, 1995; cited in Lakeman, 2001).

Pote & Orrell (2002) studied the diversity of lay beliefs about mental health problems (particularly schizophrenia) among different ethnic populations in Britain. Participants comprised 190 individuals from five broad ethnic groups (Bangladeshi, Sub-Saharan African, Afro-Caribbean, Indian and White British).

Participants reported their beliefs about schizophrenia using the Perceptions of Mental Health Problems Questionnaire. The five ethnic groups showed significant differences in how they perceived symptoms of schizophrenia including suspiciousness, hallucinatory behaviour, unusual though content and alogia.
The findings of Pote & Orrell (2002) reveal that where significant differences in symptom perception were found the strongest predictor of these differences was ethnic background. In addition, a significantly lower proportion of Bangladeshi participants identified hallucinatory behaviour and suspiciousness as indicative of schizophrenia. The authors argue that because ethnicity most strongly predicted how symptoms would be perceived questions are raised about the lack of diversity in mental health services offered in Britain. In particular they note that through examining ethnic differences in the conceptualisation of mental health we might develop a greater understanding of why some ethnic groups under use mental health services. It is important to be aware of the importance of a lack of correspondence between an individual's conceptualisation of their experience and that of service providers. This can lead to services being viewed as inappropriate or irrelevant. Indeed it is hoped that highlighting particular variations in conceptualisations of mental health problems will challenge the ethnocentric foundation of current theoretical models allowing for a discussion of a diversity of values and beliefs.

Clinical implications:
It is therefore important to understand how individuals use their culture and belief systems to understand their experiences and ultimately move forward with them. This then allows clinical psychologists to have a greater understanding of how to enable individuals to live with hearing voices and define their own future or state of recovery. Pote & Orrell (2002) emphasise that lay perceptions of mental health symptoms cannot be studied in isolation. Instead in addition to diagnostic issues one must consider the setting, race and cultural background of the mental health professional in addition to the way in which he or she conceptualises mental health problems. It will be important to take an interactional stance exploring both the beliefs of the client and clinician and the impact of one each individuals culture, society, education and the setting upon their relationship (Rogler, 1993).
Beliefs about voices:

*Hearing voices: an adaptive experience?*

Some psychologists and psychiatrists (beginning with William James, 1902) argue that hallucinations can be adaptive experiences and non-pathological (see Fulford, 1989; Jackson & Fulford, 1997: cited in Davies et al. 2001). Identifying and understanding the diversity of beliefs that voice hearers have about their voices should therefore be of paramount importance to both researchers and clinicians.

*Theoretical and practical inconsistencies:*

Jones et al. (2003) conducted research utilising a Q-sort methodology with the primary aim of exploring how voice hearers conceptualise the experience. Eleven were currently utilising mental health services; 4 had never utilised such services and 5 had accessed mental health services for a short time period but not necessarily in relation to their voice hearing. Factor analysis was conducted on 20 completed Q-sorts and six factors were discovered. These included: positive spiritual perspective, personal relevance perspective, resigned pessimist perspective, pragmatic response perspective, passivity to forces perspective, and generic mental illness perspective. All 6 factors revealed an array of varied beliefs about hearing voices. The findings support the work of Romme & Escher (1993) that asserts that the explanations that voice hearers espouse for their experiences scarcely correspond wholly with any existing theory. Further participants on all 6 factors agreed that pejorative media stereotypes about individuals who hear voices are spurious.

*“Adaptive” beliefs:*

Of significance this study found that individuals who were accessing mental health services found voices to be negative experiences and more frightening than non service-users. This is in contrast to participants who understood that hearing voices was a normal part of their spiritual development. Significantly, none of these individuals had found their voices distressing enough to seek psychiatric help. The authors suggest that it could be their positive method of framing the experience and optimistic beliefs that protect them from seeking help.
Coping strategies:
Voice hearers who attended non-conformist and spiritualist churches shared their techniques of dealing with their voices and at times this could include a technique referred to as “closing off” from voices. This is similar to cognitive therapy techniques wherein clients are taught skills of setting boundaries on their voices and how to turn their voices on and off (Chadwick & Birchwood, 1996). Jones et al. (2003) suggest that it is therefore of paramount importance that future research continues to explore how voice hearers who do not access mental health services frame their experiences and what coping strategies they utilise. This would then lead to potential interventions that could be commensurate with different belief systems enabling the health service to be diverse in their models and interventions.

Clinical implications:
The evidence suggests that the way in which an individual conceptualises the experience of hearing voices can mediate distress if it offers a positive explanation of the experience. The findings of Jones et al. (2003) are supported by Davies et al. (2001) who found that the amount of distress experienced by hearing voices was on a continuum with psychotic participants being most distressed, followed by “normal” participants and then Evangelical Christians. Clinical psychologists are well positioned to explore with their clients if what their voices are saying have spiritual connotations which they might be able to understand within their culture or belief system. This may lead to a reduction in distress and to clients being able to seek solace or advice from an appropriate members of their community such as a priest or spiritual guide. Clinical psychologists work as integral members of multidisciplinary teams. Therefore they have a responsibility to share (when appropriate) their knowledge regarding the meaning that individual’s attribute to their voices in order to avoid conflicting dialogues with various professionals.

Relationships: an “ordinary” part of human experience

The relationship between voice hearer and the voice(s):
The study by Jones et al. (2003) highlights that it is of paramount importance to understand how a voice hearer understands their experience and that how they relate
to the voice (such as setting boundaries and "closing off") which can have important implications for how an individual manages the experience and the distress that might result.

Perceived malevolent or benevolent intent:
Chadwick & Birchwood (1994) and Birchwood & Chadwick (1997) found that emotional and behavioural responses of an individual to their voice(s) were mediated by the beliefs an individual held about the voice(s). However, when what the voice saying was perceived as particularly significant or distressing the influence beliefs had about voices had less of an effect upon responses than the content (Beck-Sander et al. 1997). Close & Garety (1998) in their research found a direct relationship between behavioural and emotional responses to voices and the content of the voices. They found that this association remained true without any influence from the beliefs held by an individual (which contrasts with the earlier findings of Chadwick & Birchwood, 1994). For example, negative voices produced negative emotion in the voice hearer and resistance. Close & Garety (1998) suggest that exploring the beliefs an individual has about the self may be important when exploring emotional responses to voices. Some of their participants were ambivalent in their feelings about their voice with certain participants viewing their voices as neither malevolent nor benevolent, and others felt that their voices could demonstrate both compassion and destructiveness towards them.

Birchell’s (1996, 2002) theory of relating:
Birchell’s (1996, 2002) theory of relating led to the development of questionnaires measuring maladaptive patterns of relating between couples based on the dimensions of power and proximity. When a relationship style is perceived as maladaptive is often can be seen that one partner is in a position of uppmess (superiority) to another and has more power to influence. The uppmess scale measures bullying, tyrannical control, criticism, and humiliation. In contrast the lowmess scale measures helplessness and seeking frequent guidance. Distancing is typified by suspiciousness, withdrawal, shutting oneself off from others and extreme self-reliance. Finally, closeness involves discouraging other close relationships, intrusiveness, and demanding time and attention.
**Level of distress and relationship with the voice:**

Vaughn & Fowler (2004) conducted a study assessing the relationship between distress and the perceptions that voice hearers have of their relationship with their voice(s). Vaughn & Fowler (2004) found that when the individual perceives the style of the voice as domineering, rather than beliefs about the voices malevolence, there is a greater association with distress. This is similar to the findings of Romme et al (1992) and Birchwood et al. (2000) who found that power structures between the voice and voice hearer are significant. The present study found that it is the way in which the voice utilises its power rather than if the hearer perceives the voice as powerful, per se, that is important. This differs from the findings of Birchwood & Chadwick (1997) who highlight the importance of perceived voice omnipotence for voice hearers.

Vaughn & Fowler (2004) also found that the more distressing an individual perceived the voice hearing experience the less likely they were to relate to the voice from a position of lowemess. Vaughn & Fowler (2004) suggest that relating from a position of lowemess may reduce distress which is consistent with Birtchnell’s (1994) finding that women in good marriages rate themselves as relating to their partner from a more passive position. However, as Vaughn & Fowler (2004) comment the degree to which this strategy is adaptive may depend on the degree to which being submissive affects an individuals self-esteem and to what extent assuming this position requires accepting abuse or carrying out aversive demands. However, the authors observe that although hearer lowemess and distress are negatively correlated, hearer lowemess and benevolence is strongly positively correlated. They posit that this may indicate that an individual responds to a voice from a position of lowemess when they trust that voice. This is commensurate with the findings of Close & Garety (1998) regarding voice hearers beliefs about the self. It can be seen therefore, that there is a similarity between the relationship an individual has with their voice and with individuals in their social world will help to normalise the experience and bring discussions to topics which the individual may feel he or she has experience of.
Clinical Implications:

Detailed assessment of relationship between hearer and voice:
When working with an individual utilising cognitive therapy it is necessary for an individual case formulation to be developed collaboratively by both the therapist and client. It is imperative that when working with individuals that the level of distress is assessed and the impact that this has upon the individuals functioning. In addition the clinician will need to assess the content and identity of the voice(s), the beliefs held about the voice(s) and the self and the client’s perception of control and coping strategies used. Vaughn & Fowler (2004) propose that this should include a detailed assessment regarding the existing relationship between the voice and voice hearer. Ritscher et al. (2004) argue that the assessment process may be an intervention in itself because it enables clients to reflect upon their experiences and can help to establish the therapeutic relationship, and implicitly shows that there are other people who have had similar experiences. Carter et al. (1996) suggest going over a list of coping strategies with a client that others have found useful may help both client and clinician develop new ideas in addition to highlighting that they are far from having explored all alternative strategies.

Relating therapy:
Birtchnell (2002) developed the notion of “relating therapy” wherein the therapist would work collaboratively with his or her client in order to raise the client’s awareness of how he or she relates to the voice. Identifying the voice may enable the hearer to relate from a more proximal location. Enabling the voice hearer to integrate this new information may enable him or her to form new narratives regarding sources of distress that had previously not been explored. This reflects the work of Romme & Escher (2000) who emphasised the importance of developing a “construct” enabling the hearer to make sense of his or her voices connected present and past experiences and hence normalising the experience in the light of events past or present.

Conclusion:
In this essay I have discussed the idea that there are multiple realities and thus what is ordinary, truth or reality is unique to each individual. Psychiatric descriptions of
symptoms have not proved efficacious in differentiating between service-users and non service-users. Romme & Escher (1996) have argued that hearing voices is not the result of a disease but a result of a socio-emotional problem. Utilising personal narratives Thornhill et al. (2004) have highlighted the importance of exploring how an individual may formulate his or her experience instead of imposing our own professional assumptions. This is supported by the work of Camp et al. (2002) who suggest that there is no ordinary or typical way of conceptualising the position or experiences you have in society. In addition they highlight the importance of an understanding, accepting and normalising networks such as might be found in day centres or support groups. What is offered by such groups may be seen as more appropriate to some individuals who may conceive that the services provided by the health service are inappropriate or irrelevant because there is a lack of correspondence between the service provider's model of mental health and their own (Pote & Orrell, 2002). It is therefore important that clinical psychologists reflect upon their own socio-cultural background and conceptualisations and that they are open to discussing alternative beliefs. This is especially important in the light of research that has shown that spiritual beliefs can positively frame the experience of hearing voices resulting in a reduction in distress and adaptive strategies for coping (Jones et al. 2003). Looking at the relationship that an individual has with their voice, their coping strategies and beliefs about the self in light of past experiences may enable the client to make sense of his or her voices and hence integrate the experience within the context of his or her life.
References


Discuss with reference to literature and using examples some of the ethical issues supervisors face when working in multicultural societies.

Year 2

April, 2007
Discuss with reference to literature and using examples some of the ethical issues supervisors face when working in multicultural societies.

Introduction:
I am writing this essay from my position as a Trainee Clinical Psychologist (who has thus far only received supervision) in addition to my other social and cultural positions which vary contextually from professional to daughter and granddaughter, to friend and Catholic. The variety of social and cultural groups with which I subscribe reflects the fluid nature of modern society wherein there exists multiple cultural and social identities within communities and families. As the values to which individuals, communities and organisations subscribe are manifold it will be necessary for me to be selective in the ethical issues that I discuss in this essay. I have chosen to focus on the ethical issues that supervisors face when working with the elderly with dementia and people with learning disabilities in multicultural societies. I have selected these two groups because they are both marginalised in society and the access they have to social and cultural roles frequently resides in the hands of others. This produces multiple ethical issues due to the conflicting values that may exist between the client, their family members, professionals, organisations, therapists and supervisors. In particular both individuals with dementia and the learning disabled have both received labels which can prevent professionals, community and family members from seeing the diverse social and cultural identities they belong to. In this essay I shall endeavour to explore definitions and processes of supervision and the complexities involved in defining “multicultural societies” in addition to defining “ethical issues”. I will explore the ethical issues that supervisors face when working with older adults with dementia and with individuals with learning disabilities in multicultural societies utilising the framework offered by Hawkins & Shohet’s (2005) “seven eyed model of supervision” in addition to using Proctor’s (1988) recommendations regarding the processes of supervision.

The role of supervisors:
Fleming & Steen (2004) observe that the Division of Clinical Psychology of the British Psychological Society does not provide a definition of supervision, although it
does recognise the need for supervision throughout the career of a clinical psychologist. In addition the DCP does not promote a particular model for use within supervision. However, there are a variety of definitions of clinical supervision. Bernard & Goodyear (1992: p.4) observe that supervision is usually given by a senior member of a profession to a junior member and the relationship is evaluative. In particular Bernard & Goodyear (1992: p.4) regard supervisors as gatekeepers to the profession and as such have an ethical responsibility to keep their training, knowledge and skills up to date. However, although this is a comprehensive definition it fails to address the significance of supervision post-qualification where there would be an increased pressure on the individual clinician to be self-evaluative and to participate in peer and cross-professional supervision (Fleming & Steen, 2004). In contrast the definition of supervision offered by Butterworth (2001: p.319) focuses on the supervisors accountability for the clinical work of the supervisee and the overseeing of both safe and accountable practice. Butterworth's (2001: p.319) definition states what the content of supervision involves including not just the clinical work of the supervisee but also his or her professional development; educational support; addressing both interpersonal and management and organisational issues. Although this is a comprehensive definition it fails to explore the important issue of the process of supervision or the supervisory relationship.

One very extensive model of supervision which takes the different processes, contexts and responsibilities of supervision into account is the "seven eyed model of supervision" (please see figure 1 below). Hawkins & Shohet (2005) observe that at any point in supervision there are at least four elements in operation. These four elements include: a supervisor, a therapist, a client, and a work context. There are seven elements that they suggest that the supervisor focuses on in supervision but the order is not dogmatic (please see figure 1 below). The first element described is "session content" focusing on the client and the issues that are brought to therapy. Secondly Hawkins & Shohet (2005) refer to "the therapists strategies and interventions" comprising the actions taken by and the thoughts of the therapist. This element might include suggestions or advise for the next stages of therapy from the supervisor. The third element is described as "the process/relationship between the therapist and the client. This normally involves the supervisor giving the therapist
space or helping them to stand outside the relationship in order to identify client’s transferences or identify any patterns that may be developing in the relationship. The fourth element is focusing on the internal experience of the therapist identifying and exploring the counter-transference in order that it does not obstruct the therapeutic work. Another element identified by Hawkins & Shohet (2005) is the here and now process between the supervisor and supervisee. This has been termed “parallel processes” whereby complexities in the therapeutic relationship may reveal themselves in the supervisor-supervisee relationship. The sixth element identified by Hawkins & Shohet (2005) is the supervisor attending to his or her own internal experiences and reactions and considering how this might inform the therapeutic work. The final element is the broader context including political, social, cultural and organisational elements which will impact upon the therapeutic work. This will include professional codes and ethics. In addition Proctor (1988) identifies three main processes of supervision: formative, restorative and normative. The formative process is about the supervisor understanding the abilities of the supervisee and helping them to develop. This may be facilitated through enabling the supervisee to reflect and explore their clinical work. The restorative function involves supervisors supporting supervisees to be aware of how their clinical work may be affecting them emotionally and how to deal with these reactions. Hawkins & Shohet (2005) suggest that ignoring these emotions can lead to ineffective work whereby clinicians either over identify with clients or defend against being further affected by them. The normative aspect of supervision includes the responsibilities that supervisors have for the clinicians work and to ensure that the standards of their organisation are upheld and that supervisees are working within ethical standards. This is a necessary function as all clinicians have blind spots to their own prejudices and vulnerabilities and need to support to reflect on their own assumptions and beliefs.
Multicultural societies:

All supervisors and clinicians work within multicultural societies within which diversity may or may not be visible. Sue & Sue (1990) specifically attempt to pin down different factors which contribute to defining a culture. These include unique experiences, class values and communication style. Further factors are beliefs about individuality, self-disclosure, behavioural/emotional/verbal expressiveness, beliefs about cause and effect, and how the culture deals with ambiguity/structure/flexibility. Furthermore, society has been defined as a group of people which are distinguishable from other groups due to a common culture, shared institutions, characteristic relationships and mutual interests (Wilkipedia.org/wiki/society). Patel et al. (2000) assert that it is an individual’s culture that shapes their worldview. This in turn has been defined as the way an individual perceives his or her relationship to the world, for example, other people, animals, nature, institutions, the universe, objects and God.
Patel et al. (2000) recommend that by exploring the development of one's world view it is possible to understand the development of one's values, norms, beliefs, morals and prejudices. Indeed they suggest that our world views affect how we, think, make decisions and define events.

In modern day families there is a vast amount of cultural diversity (O'Hara, 2003). Spouses may belong to and identify with different religious, racial or ethnic groups and amongst children and parents different cultures may be represented (Falicov, 1995). Thus relying on cultural stereotypes could be very misguided. For example, Iliffe & Manthorpe (2004) argue that “ethnicity” (defined as “a common culture”) is a vague, unspecific and unhelpful concept because its affects are surpassed by effects of both education and socio-economic status. This is in addition to the fact that migration leads to acculturation. Thus actions and beliefs that may have been thought to be representative of an established ethnic identity may be cohort effects which were truly representative of one or two generations only (Iliffe & Manthorpe, 2004). Recent research suggests that both culture and ethnicity should be regarded as constructs which show extensive variation between families and individuals, communities and countries. Further, the cultures and ethnicities which one identifies with are diverse, subject to temporal change and situational (Hinton, Fox & Levkoff, 1999). O'Hara (2003) suggests that it needs to be acknowledged that what is frequently referred to as the “majority” culture is not a homogenous population. Instead, it comprises a diverse number of social and cultural communities which have their own desires and ambitions. Indeed, Hinton (2002) found that the perception that “culture” is a collective set of ideas and beliefs shared equally by all members of particular ethnic groups is a fallacy. Individuals show great variability in the extent to which they subscribe to cultural or religious traditions and the degree of acculturation may differ between both men and women and generations (O'Hara, 2003). Iliffe & Manthorpe (2004) suggest that instead of seeking cultural facts we should explore “cultural possibilities”. This includes both our own and the clients with whom we work. Thus in order to explore the cultures and societies of our clients we need to do this in partnership with them instead of making assumptions or trying to apply our definitions or stereotypes.
Ethical issues:
Multicultural societies contain individuals who may subscribe to different values or “ethics”. Rawson (2006) has described ethics as a standpoint where one decides what is right and wrong and what one ought or ought not to do. However, how we decide what is right and wrong and which course of action to take is also affected by the law, social convention, professional codes of conduct, experience, our religious faiths, politics, artistic taste and practicality. In order to make a decision we will utilise our ethics in addition to one or more of these other lenses through which we view the world. This essay is utilising the definition that ethical issues arise when there are at least two or more competing values (Golden & Sonneborn, 1998).

Clinical psychologists working in the National Health Service are required to provide their services to all members of the society within which they work. Therefore as a professional body they need to share a minimal set of ethical views and values with their colleagues which should be available to clients in order that they are aware of the fundamental objectives and values of the profession and be able to trust that psychologists are aware and work by these values (Rawson, 2006). Thus as practitioners clinical psychologists cannot adopt whatever ideas, values or principles that that wish. Neither can they give endless tolerance to the ethical views of others. Although as a profession we are provided with guidelines regarding our code of conduct and particular ethical issues that arise with certain client groups these are just guidelines. By this I mean that such guidelines do not remove the moral responsibility and autonomy of us as professionals who still have to consider how best to apply guidelines in the particular situation under discussion (Rawson, 2006). Thus rather than obediently following rules we need to reflect upon both the ethical guidelines in addition to our own ethical values with the support of our supervisors and colleagues.

Working with older adults with dementia:
The way we view different members of society will be influenced by our world views. This applies to our view of older adults which are culturally bound. Golden & Sonneborn (1998) observe that everyone, either consciously or unconsciously has a
variety of views regarding the aged. Therefore they advise supervisors to be aware of their own beliefs regarding aging and to support clinicians to reflect on their views about aging and older adults, what their fears might be about growing old and what they might look forward to. This may include the beliefs and rules they have learned through their own experiences of aging within their social group and family. This will include exploring the values of the organisation to ensure they are not discriminatory in addition to facilitating discussion with clients (and when appropriate family members) about their beliefs regarding their own mortality. This is essential in order that they can be aware of whose values are being heard and impacting upon decision making and therapeutic interventions. I will discuss working with the elderly particularly in relation to dementia as this diagnosis has implications for the autonomy of the diagnosed individual and how others view his or her identity.

**Working with dementia:**

Frequently professionals and family members of individuals with dementia view the individual as vulnerable and in need of protection. This value judgment can result in an ethical conflict between the views of the involved parties including the diagnosed individual, family members, professionals and the organisation. However, it has been found that the level of “awareness” and abilities of people with dementia can change depending on context. Clare (2004) suggests that awareness should be comprehended in the context of an interaction of individual psychological responses, cognitive functioning and the influence of social context. Each of these factors can significantly affect the amount of awareness an individual with dementia is assumed to, or interpreted, to have. Yet dementia assessments are frequently conducted in a clinical setting utilising neuropsychogical tests. In relation to therapist strategies and interventions (Hawkins & Shohet, 2005) and the formative processes of supervision (Proctor, 1988) supervisors can highlight the importance of clinicians assessing the client in their cultural and social environments. This will not only promote learning regarding how different cultures and societies understand dementia (Butterworth’s, 2001; educational element of supervision) but this should also impact upon the way in which the diagnosed individual is viewed in relation to his or her social and cultural abilities and identities. However, supervisors and clinicians may need to be flexible in their thinking regarding how they will gain access to and discuss beliefs regarding
dementia within their local communities. This can be especially complex if dementia is regarded with stigma and accessing help externally is regarded with shame (e.g. Patel et al. 1998; Dilworth-Anderson & Gibson, 2002). This may involve meeting with community members and exploring their experiences, fears and expectations of services.

The way in which dementia is conceptualised and understood will have implications for interventions or lack thereof. Woods & Pratt (2005) suggest that professionals should be mindful of three specific ethical principles when working with dementia and issues of insight and awareness. These include “beneficence” (to do good and act in the clients best interests)’ “non-malefience” (to do no harm) and respect for autonomy rather than paternalism (Hughes, 2002, pp. 865). As Clinical Psychologists we do not have our professional identities alone we also have personal beliefs and cultures which we subscribe to which will impact upon how we view the world and our clinical work. Keightley & Mitchell (2004) conducted a qualitative study through interviewing two clinical psychologists and 5 community psychiatric nurses about their work with individuals and families with dementia. The authors observed that professionals preferred not to tell people with dementia their diagnosis. Not disclosing this information contravenes the principle of a patient’s right to know (Heal & Husband, 1998) and it represents a tension between non-malefence (not causing distress) and autonomy (giving the client control through giving them full and clear information) (Woods & Pratt, 2005). Professionals were influenced by their own personal cultural values and feelings of uncertainty regarding whether they would want to know if they were in the same situation. They also found it difficult to engage with the client with dementia and consequently were unclear as to who was the client – the individual with dementia or the carer. This is a significant issue as the individual diagnosed with dementia may have different values and beliefs than his or her family members and the professionals working with them. What was found to influence the professionals overall experience of dementia was the personal impact that it had on them in addition to their past experiences of working with dementia. This included a sense of hopelessness and a perception of dementia as “worse than death”.

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What is described by Keightley & Mitchell (2004) is a strong countertransference wherein the clinicians' own reactions and beliefs about aging and dementia significantly impact upon their clinical work. Of significance during the interviews for this study the clinicians commented that they had not recently reflected upon their own work or discussed with colleagues how they deal with similar ethical issues. This lack of time for reflection may mirror clinicians' reluctance to discuss diagnosis with clients. Reflecting upon the countertransference within supervision is essential in order for supervision to function restoratively whereby clinicians are supported to identify their emotional reactions to their work in order that they do not overidentify with clients or defend against being further affected by them. Not bringing ethical issues (such as the dilemma of whether or not to disclose a diagnosis of dementia to a client) is irresponsible as the supervisor will not be fully informed of the work for which they are responsible for. Supervisors should outline what clinicians should bring to supervision in a supervisory contract at the beginning of their work together. Thus this may work to ensure that clinicians are working within ethical standards or supervisors may need to take disciplinary action (the normative element of supervision; Proctor, 1988).

Discussing ethical issues in addition to personal values and beliefs regarding aging and dementia will need to be handled with care within supervision. The development of staff support groups, and/or reflective practice groups, peer or cross-professional supervision might facilitate reflection on beliefs and practices in addition to learning and discussing with colleagues how they work with similar ethical issues. This may allow both the supervisor and clinician to reflect on their own internal processes and feelings about the elderly and dementia and how their beliefs may be impacting upon their clinical work.

If the person with dementia is not even allowed to know their diagnosis their values, beliefs and identities are excluded from their treatment from the very beginning. Sabat (2005) explains that we all have different identities that are socially facilitated. For example: loving daughter, loyal granddaughter, caring friend, dedicated professional. Each identity requires unique behaviour patterns and it is not possible to develop a specific social identity without an interaction with at least one other person.
If others do not help the individual diagnosed with dementia to construct a more positive social identity then their identity can become one dimensional and be viewed solely as a “dysfunctional patient”. This loss of self then has its origins in the social world and NOT in the brain of the diagnosed individual. Supervisors therefore need to draw clinicians attention to their therapeutic strategies such as using their skills of formulation and reformulation (the formative function of supervision) in order to bring in different perspectives to how individuals with dementia are viewed and cared for. The encouragement to formulate and not just to diagnose will impact upon the professionals involved and the families. Viewing the individual with dementia as part of a system with multiple cultural and social identities is a positive step away from locating the difficulties within the individual which is pathologising and contributes to hiding the identity of the individual behind a label or diagnosis. Iliffe & Manthorpe (2004) emphasise that shared understandings of meanings and cultural differences are important in relation to how dementia care is organised and experienced. They suggest finding out what information the individual with dementia needs, what language is most suitable, what food they like, and how their religious beliefs (if they have any) affect their experience and understanding of illness. In addition they suggest that staff should be supported to understand and respond to the models of distress, illness and health that are presented.

**Individuals with learning disabilities:**

“Learning disabilities” is not a construct, concept, culture or identity that individuals who have been given the label have been allowed to be proud of. No other demographic of individuals have been subject to such frequent name changes with each new label trying to afford recipients of the label more dignity (Sinason, 1992). Sinason (1992) writes about the fact that when someone is born with a disability it invades our senses such that it challenges our perceptions of biological autonomy and control. When we are faced with disabilities that cannot be cured or “repaired” we come face to face with our own mortality and weaknesses as human beings. Sinason (1992) suggests that this can lead to impassioned research in order to prevent further disabilities or indeed individuals who passionately work with those who are disabled in order to help them to live successfully within the community. In contrast being faced with one’s own mortality can also result in condemnation, blaming,
scapegoating and rejection. Indeed, Wolfensberger (1987) labelled the ultimate reaction to learning disabilities as a “death-making culture”. This occurs when the learning disabled child is dismissed as pre-human and his or her life is written off as insignificant.

Supervisors need to be aware of the prejudices that exist in the societies within which they work. This is in addition to having an awareness of their own prejudices and supporting the clinicians they supervise to reflect on their beliefs and feelings about this client group. It will be important for supervisors to work with individual clinicians, training courses, care homes and day centres to explore assumptions about the lives and abilities of individuals with learning disabilities. This can be difficult when people perceive that they are being evaluated (such as by their employer, placement supervisor or by their training institution). This could be facilitated through group exercises for professionals and care staff to explore their beliefs and prejudices facilitated by a professional outside of the course or work environment in consultation with supervisors. This is important as a lack of emphasis on the countertransference and restorative function of supervision (facilitating an awareness of the emotional impact of their work; Proctor, 1988) can result in clinicians defensively protecting themselves from working with clients appropriately. For example, O'Hara & Martin (2003) found that that out of the ninety-one pregnancies documented in their service ten did not reach full term either due to assisted or spontaneous terminations. They found that abortions were rarely documented and specialist emotional support was not offered. Further, for the fathers included within their study (of the parenting experiences of people with learning disabilities) it was found that unless their partner also had learning disabilities they were not offered professional support. Therefore, these men were given no help to understand the psychosocial implications of fatherhood. The lack of access to services for emotional support may reflect professionals defences against acknowledging the pain of the internal worlds of individuals with learning disabilities. This is in addition to gendered assumptions regarding parenting and support. It is equally important for supervisors to support clinicians to discuss with their clients how they feel about having a learning disability in addition to considering how clients may view their non-disabled clinician (transference issues). If disability is not discussed openly in
therapy it may convey that it is too disgusting or painful to talk about to the client, and a parallel process may occur within supervision where this issue may also be actively avoided.

The values and beliefs of others regarding what it means to be learning disabled have a huge impact on the lives of individuals with learning disabilities as so much of their lives are in the hands of professional services. For example, the personal decision to have children often significantly affected by the value judgments of others. However, at the heart of the Valuing People White Paper is the rights of people with learning disabilities to marry and have a family. Indeed, Finlay & Lyons (2005) found that the learning disabled participants in their research found that one way to detach themselves from the “label” was to detach from services. Indeed, many services promote this including moving to other systems of support that may be less clearly defined or visible when compared with specific services for adults with learning disabilities. Detaching from services was gained through moving to other systems of support such as employment, marriage or having children.

Work that requires clinicians to face the ethical issues of parenting and marriage which enables clients to distance themselves from the label of learning disabilities and gain socially and culturally valued roles may be viewed as intrusive and judgmental by some communities. Summers & Jones (2004) documented the work of clinical psychologists with three cases of families who had a family member with a learning disability from ethnic minority backgrounds. In working with two clients regarding arranged marriages there were clear differences between social and cultural perceptions of being learning disabled and getting married and perceptions of the service. For example in one of the cases the family felt that marriage would facilitate an appropriate outlet for their son’s sexual desires in addition to providing him with a carer. In conflict with the families wishes were the services fear that an arranged marriage could cause mental health difficulties for the client. Particular ethical issues discussed concerned capacity to consent and conflicts between the guidelines and values of services and professionals compared to family members. Having assessed one of the clients and the extent of the client’s learning disability, beliefs about marriage and suggestibility the professionals concluded that due to his moderate
learning disability, his basic understanding of marriage and his suggestibility it would make it very difficult for him to make an informed choice about the contract of marriage. Summers & Jones (2004) acknowledge that this finding potentially could have alienated the family due to the degree of conflict between the professional’s viewpoint and that of the family. However, they openly shared with the family their concerns and rational and the family agreed to delay the marriage while further educational work was carried out with their son. Summers & Jones (2004) advise that professionals should be supported through supervision to explore if the lack of support for the marriage of an individual with learning disabilities comes from a genuine concern about the effects of marriage on that person or if it is a general reflection of the discomfort that is felt about people with learning disabilities having intimate relationships.

Such conflicts between the values of services and the communities of whom they serve may result in fewer ethnic minority community members choosing to access services. Begum (1995) highlights that the uptake of services by people with learning disabilities from minority ethnic backgrounds is lower. Barriers have been found to include a lack of accessible information, language, a lack of cultural and religious knowledge, racism within the services themselves and negative past experiences of services (Baum et al. 2000). Summers & Jones (2004) suggest that multidisciplinary health teams should try and work with support groups in the community such as voluntary groups and local community organisations. Further they suggest working with professionals who may have a better knowledge of minority ethnic communities and who may be better positioned to represent their interests. Hawkins & Shohet (2005) encompass this within the seventh eye of their model wherein supervisors endeavour to discuss with supervisees the broader context of their work including political, social, cultural and organisational elements.

Conclusion:
There are many complex ethical issues that supervisors have to work with in multicultural societies. The Hawkins & Shohet (2005) model of supervision offers a comprehensive framework for supervisors to take into account the different elements and values that may impact the work of their supervisees. This includes focusing on
the session content; therapist strategies and interventions; the relationship between the therapist and the client; exploring the countertransference; being aware of the here and now process between supervisor and supervisee; and being mindful of the broader context including social, cultural, political and organisational elements. Further, Proctor's (1988) identified three main processes of supervision which: formative (understanding the abilities of the supervisee and helping them to develop), restorative (supervisors supporting supervisees to be aware how their clinical work may be affecting them emotionally) and normative (the responsibilities the supervisor has for the clinical work). Utilising these two frameworks enables supervisors to thoroughly explore with supervisees all the different elements impacting upon the therapeutic endeavour. This relies upon a good relationship between the supervisor and supervisee which will also be affected by social, cultural and organisational factors. Not all factors can be explored in every supervision session and not all supervisors choose to work using this model. It can be seen that it is possible for supervisees to edit what they tell supervisors due to fear of negative evaluations which also has ethical implications regarding the supervisors accountability for the work. In order to protect the interests of clients supervisors should form supervisory contracts with their supervisees. As there will be a power dynamic in the supervisory relationship (which may mirror the therapeutic relationship between the therapist and client) supervisors should facilitate opportunities for supervisees to reflect upon their views of the supervision they receive. As this is reliant on the supervisor, professional bodies, organisations and training institutions need to support clinicians in ensuring they receive appropriate supervision. This is vital as it is through the process of supervision that clinicians aim to develop as practitioners. Supervisors need to support clinicians in being flexible and dynamic in the way in which services are delivered to diverse communities and work to combat stigma and discrimination. Future research is necessary in order to explore the evidence base for supervisory models when used in working with ethical issues in multicultural societies. This is in addition to research exploring how service users perceive their values and beliefs are incorporated into the services that they receive.
References


Problem -Based Learning

Reflective Account

March, 2005

Year one
Problem based learning: Reflective account

In the beginning....
On 20th September, 2005 twenty-eight individuals arrived at the University of Surrey to commence three years of training on the PsychD Clinical Psychology course. On the first day a “getting-to-know-you” exercise was carried out and each individual disclosed their educational, employment and sometimes personal journeys that led them to apply for clinical training. Every story was unique and many individuals shared the shock and high expectations of finally acquiring a place on a highly competitive training course. I was both excited and nervous. There were new people to meet, places to navigate, names to remember, role plays to participate in! This was the beginning of a vast change, a new beginning. It was against this background the cohort was asked to embark upon a problem-based learning exercise. We were going to be in groups of 6 and discuss the concept of “change”, making theoretical and practical links, incorporating and reflecting upon personal experiences and then, finally develop a presentation to share with the year group, course tutors and external visitors.

My group:
Due to the allocation of Case discussion groups on the second day of the course I felt that this would be a good opportunity to meet individuals in a smaller, perhaps more containing setting (due to the large number of people in our cohort). We by-passed initial introductions and discussions about previous experiences due to the fact this had been done quite extensively on the first day within the whole year group. In hindsight this may have been a mistake but I think we were all aware that we had to produce a final presentation within 6 weeks and so, due to time pressures became quite task focussed.

Allocation of roles:
Initially, we decided to allocate roles and it was agreed that we needed to decide upon who would be the “chair” and who would be the scribe. Two members of the group stated that they had previously assumed the role of “chair” in their previous jobs and so would value the opportunity to function within a different role on this occasion.
Several members also said that they would prefer not to yet, but may feel more confident to do so later on. Finally, one member of the group volunteered to assume the role of "chair". However, as a group we did not discuss what the role of "chair" might include. Thus, on reflection, each member of the group may have viewed the role of "chair" differently. I personally did not want to assume this role yet as I did not feel equipped to lead or direct discussions at this stage of training.

The role of scribe was also assigned in this initial meeting and it was agreed that this would include taking notes and distributing them to the group. On reflection the group did not discuss how we would ensure that the scribes voice would also be heard when she would be focusing on note taking. However, perhaps my anxieties about the lack of role definition reflected my own need for containment and a need for structure when everything was so new and almost alien to me.

The group facilitator (a course member) explained the role she would occupy. This role would depend upon the group's needs but would probably develop as the group took shape. It was explained that the facilitator would be more directive to start with but this would gradually decrease enabling the group to become more self-directive. This explanation of the facilitator's role is quite similar to that of a cognitive behavioural therapist. I felt that this explanation was helpful in that it helped me feel contained in that the facilitator was an "enabler" in that she would help us with the direction of our discussions but would allow us autonomy and independence. This may reflect how clients feel when they come to therapy - a new environment, speaking with someone they do not know, wondering what their role is and the role of the therapist. Thus in therapy it is good practice for the therapist to ascertain the client's expectations of therapy - what they think their role will include and that of the therapist. In this way any initial differences in expectations can be discussed and roles clarified. However, despite initial role clarifications at the onset of therapy roles occupied will be very much individually dependent and will evolve throughout therapy. It can be difficult to understand that roles are not static at the beginning of therapy. I think within the group I looked for role clarification too early on and now have a better appreciation of the fact that roles are not static and evolve over time.
Group process:

Diversity:
Levine & Moreland (2004) note that the diverse characteristics of group members (including personality traits, status in the group, opinions, demographic characteristics and functional background) can be both a blessing and a hindrance. Although diversity can increase the amount of knowledge, skills and experience within a group it can produce conflict and negative emotional reactions. Thus diversity can both inhibit and facilitate creativity within a group.

Farrell (2001) found that it is important that group members are similar in life stage, status, values and interaction style as these elements are vital when forming a collaborative group. We were all experiencing a similar transition of starting the course and perhaps, therefore, could be seen to share a common life stage (in addition to all being in our mid to late twenties) and status. However, I personally felt that I still felt insecure about my status on the course at this time, still not believing that I was meant to be there due to feelings of inadequacy. I later discovered that others also felt this way. This may have been a factor that impacted upon our interactional style as a group. Such that we would come to each meeting completely task-focused without checking how each individual was that week or if they were feeling comfortable on the course or in the group setting. I have tried to apply what I learnt from this to my clinical practice such that I try to be mindful not to prioritise the contents of sessions over the process and the developing therapeutic relationship.

Choosing a theoretical model of change:
Initially 3 members of the group had models of change with which they were acquainted and so they each sought information which they then shared with the group. Group members then had to be prepared to constructively discuss and criticise the work shared. Levine & Moreland's (2004) description of this process closely maps onto the process of our group. Initially, members of a group need to be prepared to share their ideas and they are only likely to do this if they evaluate that their ideas may be of use and how likely they are to be accepted by the group. The second step focuses on group members communicating their ideas and the third involves ideas being carefully thought over and discussed by group members. This
must then be followed by a consensus about which idea will be utilised. Finally, the idea has to be implemented.

The process of choosing the model was conducted by deciding which one was an accurate reflection of the experiences and frustrations we had applying for clinical training. We decided to choose the model out of the three that most closely matched with our experiences. The model we chose was Hopson & Adams (1976) transition cycle. The different aspects of the cycle (which do not have to be followed sequentially) include: first shock, provisional adjustment, inner contradictions, inner crisis, re-construction and recovery. The model highlights that change is normative, continual and through re-construction there can be recovery.

Our presentation was both dramatic and based on our personal experiences of applying for clinical training and grounded in the theory of the Hopson & Adams (1976) model.

Clinical applications of our theoretical model:
I conducted a joint initial assessment with the Consultant Psychiatrist of a medical student diagnosed with bulimia nervosa. She had recently failed a basic life support exam which shocked her, negatively affecting her self-esteem and exacerbating her binge-purging behaviours (first shock and provisional adjustment). She began to question her ability to be a good doctor (inner contradictions) and contemplated dropping out of university altogether and pondered the futility of her existence (inner crisis). The client felt that she did not have a problem that she wanted to change as regarded her vomiting: “its only once a week”. She did not want an intervention such as cognitive behavioural therapy but preferred to continue taking her medication and seeing her supportive student counsellor.

Thus, although useful for the presentation the Hopson & Adams (1976) model does not incorporate the individual’s motivation or stage of change which aids an understanding of what interventions (if any) may be appropriate and at what time. The stages of change model (Prochaska & DiClemente, 1992) allows the practitioner to evaluate if the client is not contemplating changing their current situation
(precontemplation) or if they are thinking about making a change but are not ready (contemplation). In addition, the preparation stage of the model suggests that the individual is ready to make the change(s) and is making the necessary adjustments. The next stage is "action" whereby the individual is taking the necessary steps to elucidate the desired change(s) and the final stage is maintenance wherein an individual strives to uphold the changes they have brought about. When a clinician has elucidated the stage at which their client is they maybe able to collaboratively discuss the appropriate next steps. However, in practice it is frequently only individuals already in the contemplation or even preparation stage that are considered to be suitable for treatment which has clear ethical implications. The stages of change model may encourage service-providers to give limited or no interventions to "pre contemplators" (West, 2005).

This reveals that when working therapeutically it is important to fit the model to the client rather than the other way round. In addition, it is often more than one model that can lend itself to a greater understanding and formulation of the client's experiences and difficulties.

What I have learnt from the problem-based learning exercise:

When I think of the exercise itself I remember an extreme feeling of frustration that there was no clarity of roles and that it was a strange thing for the course to do to us – put us under more pressure at the beginning of an already stressful period in our lives. However, I have now fostered a better understanding of the purpose of this exercise and with the benefit of clinical experience I am aware of the centrality of the notion of change to the practice of clinical psychology.

The exercise itself enabled the group itself to evolve. Various dyads within the group had discussed their experience of running therapeutic groups and that establishing ground rules and highlighting confidentiality helped develop a sense of ownership of the group for its members and something of a safe haven. Thus in the first case discussion group held after the presentation confidentiality was emphasised and we agreed that at the beginning of each meeting we would check with each group member how they are feeling and coping with the course and their clinical work.
Initially sharing ideas in a group can be daunting and it takes time for each group
member to increases the degree to which they feel comfortable disclosing about
themselves. This will evolve as members come to feel mutually dependent and as
ideas about the desired end result correspond (Berscheid & Reis, 1998; Rusbult &
References


Problem based learning reflective account

Year 2

March, 2007
Problem-based learning reflective account

The original problem:
The second year cohort was given a clinical vignette detailing the difficulties faced by
the Stride family pertaining to the fact that the family’s twin daughters had been
placed in short-term foster care due to child protection recommendations. Within our
case discussion groups we were to review the problem as it was detailed in the
vignette, discussing the presented background information, the family tree and
professional network involved. We learnt that the children were at risk from their
parents and that this risk involved emotional abuse and neglect and they had both
been placed on the child protection register. The local authority wished for the
children to be adopted as soon as possible due to the belief that Mr. and Mrs. Stride
would never be able to adequately care for their children. Of significance Mrs. Stride
had mild learning disabilities and Mr. Stride had attended school for children with
special educational needs. Further Mr. Stride had physically assaulted his wife during
arguments.

Additional support received included Mrs. Stride’s access to a local adult mental
health service to help her cope with feelings of despair and depression. She was
seeing a CPN for counselling and taking anti-depressant medication. Regarding
social support all the vignette stated was that Mr. Stride’s parents were very
supportive buying clothes and toys for the children. However, they were unable to
look after the children due to the grandmother’s health. Mrs. Stride had no family
that she was in contact with and was raised in the Looked After Children system.

The group process:
As a group, we were struck by how the Stride family were almost silenced by their
inability to work with the services offered and that it was framed as being almost their
fault. For example, the fact that they did not regularly attend parenting sessions
which could have been due to transport difficulties, or indeed funding transportation
costs. Further the fact that the services they were accessing were not provided by
professionals trained to work with individuals with learning disabilities also left them
disadvantaged. A situation which perpetuated their very real social disability of both
not being able to read or understand what their solicitor read to them and how socially disabled they were due to living in extreme poverty. However, hope was present in our discussion in that the children’s Guardian felt that the parents could learn to be “good enough” parents. Of note we were struck by the fact that it was Mrs. Stride who was taught by services “how to keep house”. This may have mirrored the fact that Mr. Stride perhaps felt that it is women who should run the family household as although he could operate home appliances he was “not prepared to use them”. In addition, this is the second time that Mrs. Stride has had her children taken away from her and the second time of which she has been involved in an abusive relationship. Perhaps it is in her narrative that she does not believe she could raise the children alone or does not have the strength or inclination to leave her current husband. Indeed, perhaps she blames herself which may add to her current depression.

*Task focussed?*

The vignette posed the question: “whose problem is it? Why?” We decided that our presentation would explore this question through making a video wherein some of the main people featuring in the vignette would be interviewed and, in addition, we would hold a “studio debate” in the form of “Question Time as presented by Jeremy Paxman.

One member of the group asked if she could be our version of Jeremy Paxman in the first pbl meeting and then was absent in the following meeting when the script was being written. As a result another group member took the role and on a future occasion the same group member also lost the role of foster mother in the video to the same member who got to play Jeremy Paxman. This felt slightly tense and it felt like the member who had been absent and lost both roles was in some way being overruled. This could have been because both group members were quite confident at performing and this perhaps necessarily put them in competition with one another (whether conscious or unconscious). However, this was not openly discussed within the group almost as if this went unnoticed. Perhaps this situation was reflective of the fact that the majority of group members were focussed on getting the presentation produced, thus engaging academically with the project but negating our emotional intelligence and empathy for one another in the group. However, in practice being
task focussed and conducting work within a limited time frame is difficult within the field of learning disabilities. Particularly when clients have complex needs and may have complex attachment histories. Therefore, paying attention to the therapeutic relationship is vital and on my current learning disabilities placement where I am working psychodynamically with clients I have been encouraged not to commence work until the therapeutic alliance has been established (which has sometimes taken nearly three months). This is somewhat of a luxury within the service where I am working and in many NHS settings this may not be possible due to resources and waiting lists. A lack of good working relationships with services is evident for the Stride's where the work regarding who their children should be placed with is under stringent time pressures and thus may not be taking into account the pace at which Mr. and Mrs. Stride may need to work in order for their understanding and potential learning to be facilitated. The notion of time and resources has ethical implications both for clients and the services provided.

**Labelling:**
Goodley (2000) and Gordon & Rosenblum (2001) illustrate social models of disability allow us to be mindful that disability should be understood in connection with both cultural and social structures. Indeed, the label “learning disabilities” and other labels which have been used are so powerful in determining perceptions that “it prevents people seeing the individual” (Finlay & Lyons, 2005). Murphy (cited by Bogdan & Taylor, 1994) stated in his autobiography that he rejected the label “mental retardation” because when people hear the term that make negative assumptions and this is frequently followed by social rejection. Indeed Murphy rejected the stereotypes he felt were in the minds of the general public and which he felt were reflected in the restrictive and prejudiced practices he had experienced in the service system. However, for some members of our society, in whose lives services play a great part, they may not be able to remove the presence of such agencies from their lives.

Finlay & Lyons (2005) in their found that their participants who had learning disabilities themselves used two broad categories in order to understand “learning disabilities”: service use and the characteristics of individuals. The authors note that
many services promote independence from services such as moving to other systems of support that may be less clearly defined or visible as particular services for individuals with learning disabilities. They observe that if use of specialised services or of particular social spaces is an indicator of the label "learning disabilities" then detachment from services can be viewed of as detachment from the label. As Finlay & Lyons (2005) state:

"When people get jobs, have children, or get married, they often move to other systems of support that are less clearly defined or visible as services for people with learning difficulties".

(Finlay & Lyons, 2005:p. 15)

Mr & Mrs Stride appear to have moved away from learning disability services since finishing school. However, due to having children and mental health needs they have been in contact with many services which although they may give them distance from the label "learning disabled" may not be appropriate. Mr. Stride was stated as having attended a "special needs school" and this may have affected his self-concept and esteem. Mrs. Stride, in addition to having mild learning disabilities and perhaps feeling rejected by society as a result of this, may have also had to deal with the rejection of being placed in care. Further both Mr. and Mrs. Stride may have had to deal with societies projections regarding what it means to have learning disabilities and its prejudices regarding living on state benefits.

**Parallel processes:**

Perhaps within our group there were some processes occurring that were mirroring some elements of the Stride family situation. These included communication difficulties and blame. Within our group perhaps some members feared what was okay and not okay to say about their own feelings and fears about working with individuals with learning disabilities. Further, within the group process some members of the group experienced what it was like to have individual choice removed, and a sense of disempowerment. Perhaps some of us also feared our own ability of being able to work with this client group (as we had not yet started our
placement with this client group) but felt disabled in voicing this difficulty. This may reflect anxiety that is provoked when facing working with the unknown which may be similar to the Stride family’s experience of not understanding what is happening with their family, feeling out of control and not contained. Feelings of anticipation or anxiety may arise from our previous experience in this area of work or the supervisors we have worked with and whether or not we have felt supported. In turn Mrs. Stride could use her previous experience about services and feel anxious that yet again her children would be removed from her care. Further, poor communication between us about our roles may have reflected the poor communication between the huge numbers of professionals working with the Stride family (13 in total). Perhaps Mr. Stride felt he could blame his wife for the situation as, after all, it was not the first time she had her children taken from her. Perhaps Mrs. Stride blamed her husband for his violence and/or blamed herself and her disabilities. Perhaps the professionals involved with the Strides felt uncomfortable with their learning disability reflecting the “death making” culture that surrounds the Strides and the fact that many professionals do not want to work with individuals with learning disabilities as it forces them to face some very sad issues within our society such as marginalisation whilst at the same time perpetuating this situation. Wolfensberger (1987) referred to this as the “death-making” culture, which surrounds individuals with a learning disability from the moment they are born. The child is “written off” as something pre-human and therefore his or life is de-valued and under threat and as such beliefs are present within our society at large there is no reason to think that they are not present within the minds and discourses of professionals working in services.

The presentation:
The majority of the presentation consisted of our video. Through utilising the video all members of the group commented that they felt less anxious. This is also reflective of the social nature of disabilities and that it is the tasks we attempt and our social and physical environments that can disable us, it is not fundamentally us as people that are disabled.
Conclusion:
As regarding communication and learning disabilities it is vital to consider whose voice is being heard - usually that of the articulate and well educated. Who advocates the needs of those with learning disabilities or of those who do not shout the loudest. For example within our group no one sought to help empower the group member who lost her role because she was off sick. Through this exercise and through working with individuals with learning disabilities I have realised the importance of advocacy and utilising different means of communication when working with individuals with learning disabilities and the importance of reflecting on your own thoughts and beliefs about the individuals with whom you are working and feeling able to voice these views within clinical supervision.
References


Problem Based Learning

Reflective Account

Year 3

March, 2008
The task:

Each third year case discussion group was given a vignette detailing a referral to social services to. Additional information included a genogram of the family. The vignette described the Khan family and concern was expressed in relation to the current functioning of Mr. Khan who had recently experienced the loss of his wife from cancer. He had been experiencing short-term memory problems including leaving the kettle on and leaving items to boil over. In addition he appeared unable to attend to his personal care including cooking for himself. However, it was not clear if these were roles that his wife had previously assumed when she was alive. Mr. Khan had two daughters one of whom lived in Pakistan with her husband (through an arranged marriage) and their family. Mr. Khan’s other daughter, who lived in England with her European husband, had previously been disowned by Mr. Khan and had no contact with her father until her mother passed away 9 months ago. This daughter and her husband were both journalists which required them both to travel a lot. Their careers, in addition to their estranged relationship to Mr. Khan, meant that they found it difficult to care for him. As a result a referral had been made to social services. Mr Khan and his wife were both religious and were well connected within the Muslim community. However, this stopped when Mr. Khan felt unhappy about the way the mosque had responded to his wife’s death. As a result he stopped attending but continued to pray at home.

Discussion topics:

As a group we initially discussed the vignette and made particular use of the family genogram in order to try and discuss and develop our understanding of the family dynamics. Various ideas were initially discussed. These included: depression; grief and loss; the dangers of assuming that Mr. Khan had dementia in contrast to the prevalence of dementia blindness within the Asian community, care giving, family roles, and psychodynamic theories of aging and culture. We agreed which area we would each like to go and do some further research on based on our own preferences.

Some reflections:

I reflected on my experience of working with older adults and of my Grandfather having Parkinson’s disease. Taff (my Grandfather) lived with this disease for at least
twenty years but when I think of the disease and of dementia I fill with anxiety and the memories of the end stage of the illness. This included him losing the ability to recognise family members, being entirely dependent on care staff and family members and the sense of Taff being physically present but mentally absent in the final stages of the illness. My Grandmother recalls feeling relieved when she was told that Taff (my Grandfather) had Parkinson’s because it meant that he did not have Alzheimer’s. She only found out that Taff did in fact have a dementia when she rang to speak to the doctor about his medication and the doctor said “oh yes, the gentleman with dementia”. That is how she found out Taff’s prognosis. This experience and the deterioration and eventual death of my Grandfather has made me consider my position in relation to working with individuals with possible dementia. Especially at the assessment stage – where the individual and his or her family members may not know what the assessment might find and the importance of letting them know what this might include and what this might mean before starting an assessment. This is in addition to the supporting the individual and his or her relatives to decide if he or she would like to be told his or her possible diagnosis and what treatment, support and future planning he or she might like to be involved in. A difficult element of this would be working with someone who may prefer not to know their diagnosis. Woods & Pratt (2005) argue that pre-diagnostic counselling, which is considered good practice in other areas of assessment, is often ignored in dementia care.

I can recall infrequently visiting Taff and feeling afraid of the different noises and smells on the ward in addition to witnessing challenging behaviour. Frequently, when working on acute psychiatric wards it is possible for professionals to forget how frightening such places are. In addition, when we wonder why family members are not visiting, the setting itself and the history of family relationships, as contributing factors, can be forgotten. My own experiences have contributed to my thinking about different perspectives when training staff about working with families on acute wards and when working directly with family members. Some research has found that relatives of older adults on an inpatient ward can experience a sense of unlimited responsibility and feel inadequate at coping with this (Lindhart, Bolmsjo & Hallberg, 2006). This in turn was found to lead to a feeling of powerlessness, insufficiency and guilt. It was perceived by relatives in the study that the elder family member
experienced misery which came from living alone and being excluded from life in
general in addition to family life. This implied suffering and this was difficult for
family members to accept to the extent that they would sometimes need to avoid
contact for a while. Lindhart et al. (2006) suggest that not being able to respond as
well as they would like to the responsibility may cause relatives to experience pain
and guilt and result in the need to flee. It is therefore necessary to consider why
relatives stay away from visiting and to think about how we might feel and act in
similar circumstances.

I did not share my personal experiences with my group and we did not talk about our
fears of working with older adults until later in our case discussion groups when we
each experienced difficulties with discussing death and related issues with our clients
on placement. Perhaps we initially did not want to think about how difficult our older
adult placement might be in addition to the other stresses which are encompassed in
being in our final year of clinical training. However, when we were able to discuss
some of these issues we realised the importance of exploring our own personal values
and biases and how they might affect our decision making when working clinically.
For example, research by Levkoff & Wetle (1993) found that healthcare providers
who work with older adults to assess their needs frequently make decisions based on
their own preferences, attitudes, beliefs and other elements of which they may not be
aware. This highlights the importance of self-reflection and good supervision.
Golden & Sonnebom (1998) emphasise the importance of clinicians, working with
older adults, being supported to explore how they view older adults, their own fears
about aging and what they might look forward to, in addition to considering what they
have learnt about aging and older adults from their own families. This is something
that I have been trying to do in my own practice and that I have taken to supervision.
In addition, we are supporting one another to do this within our case discussion group.

**Constructing the presentation:**
As a group we recognised the importance of privileging the wishes of Mr. Khan and
his family. In addition, through our discussions and our own experiences we were
aware of the diversity of perspectives that may be present within one family. We
thought that the best way to illustrate this in would be through the use of a sculpt. We
also decided that we would like to include systems outside the family in the sculpt including social services, a Clinical Psychologist and the Imam. As a group we identified the client as the family and decided that it would be Mr. Khan who would position the sculpt and then invite family members to comment on where they had been positioned, how this made them feel and where they would like to be positioned.

It was important for us to keep the voice of Mr. Khan at the forefront of the sculpt as we were aware that frequently with older adults the voice of the older adult can be lost. This can lead to ethical questions about who is the client. In rehearsing constructing the sculpt we realised that we based our positioning on many of our own assumptions and felt that perhaps we should acknowledge this within the sculpt. We decided to do this by introducing ourselves as an MDT who had worked with the Khan family who would be making the sculpt as if they were the Khan family drawing on their own experiences of working with the family.

As a result of our reflections on our own identities, families and cultures we decided to include a task requiring the audience to reflect on what they would want a therapist they were starting to see, from a different culture to their own, to know about their culture, family and beliefs. We wanted to encourage a thinking of culture and diversity as a broad and individual concept and felt that this could best be understood through self-reflection. The group felt that this interactive task would be good to do at the beginning of our presentation not only to increase audience participation but to encourage the audience and ourselves to reflect on our own culture. Therefore we decided on discussing the meaning of culture after the audience reflective task, and then a group member who lived in Australia would talk about how she found it difficult to reflect on how her culture was different to that of the Australian one when she moved there for a brief period. This was then followed by the sculpt.

**A retrospective reflection on the presentation:**

Perhaps as a reflection of the fact that we did not discuss our own experiences of loss and the difficulties we experienced working with older adults at the time of the presentation we neglected to consider the Khan families previous experiences of loss (that of Mrs. Khan) and their previous experiences of services and dementia. Although we thought about this in relation to Mr. Khan we did not fully explore the
fears, thoughts and feelings that may have been engendered by Mr. Khan’s illness. This may have been due to our focus on cultural, gender and generational issues at the expense of thinking about individual experiences in relation to health help seeking and loss. Our omission of this may have been due to the fact that some of the group were just starting their older adult placement (and may not have had as much experience as we now have to draw on), personal defences regarding these difficult issues may have been in place, in addition to the fact that as a group we had experienced a loss ourselves — that of one of our group members.

As a group we had not been able to talk about this loss amongst ourselves or with the member that had chosen to leave the group. Recently we have re-visited the topic of our losing one group member and gaining a member from another case discussion group. It was interesting how our group facilitator felt that we had continued to work on the issue of this transition and that she felt that this was reflected in our discussions about our clinical work. However, some group members felt that we had avoided talking about the loss of our group member directly. Perhaps this highlights the importance of alternate perceptions and the importance of meta-communication (Watzlawick et al., 1974) — “talking about talking”. For example, although as a group we have discussed the importance of giving and receiving feedback within the CDG, in order to improve how we work together, we have not discussed how we would be able to hear feedback from one another either verbally or through our actions. This has been an important learning point for me both as a group member and also when working clinically.
References


Summary of CDG process account

September, 2006

Year one
Summary of CDG Process Account Year One

In the first year of training seven strangers formed a case discussion group initially to work upon a PBL exercise and then to remain together for three years as case discussion group members. The initial focus of the group on the PBL resulted in the group becoming very task focussed. During this task group tensions were evident and this may have been compounded by anxiety about avoiding conflict in addition to having to make a presentation to both the year group and course team. At this time the group felt quite unsafe. This may have related to group parameters such as confidentiality and expectations not being discussed. In addition by focussing on the task we did not focus on one another such that we did not check-in to see how one another was feeling and this may have been due to wishing to avoid discussing difficult issues such as group members going through an intense period of change associated with starting training.

Once the “task” was completed we then worked together in a different format. I felt quite relieved that we would now be able to work in a less time intensive and pressured manner. As a group we discussed how we would like the CDG to function. We negotiated that this would include at the beginning of each group “checking-in” with each other to see how each member was feeling with the proviso that what was discussed would be confidential and remain within the confines of the group. We also decided that the format of each CDG would include group members bringing a case or professional issue to discuss. Who would present a case would be decided at the beginning of each group. I reflected that as a group we had not discussed our personal expectations about being cdg members or what we hoped to gain from the group. It was also evident that some group members had started to disengage from the group and that this was not addressed. I considered that as the group re-configured at the beginning of year two we could perhaps review and reflect upon our work as a group together discussing what we had each found difficult and how we could positively change our interactions.
Summary of CDG Process account

September, 2007

Year 2
Summary of CDG Process Account Year Two

Our second year as a case discussion group started with a new member – that of our new facilitator. The group and the facilitator negotiated what we would like her role to be. It was decided that this would include using her psychodynamic orientation to help us reflect upon our clinical work in addition to group dynamics. It was hoped by some group members that the facilitator might help create a secure base within the group. Although this can be an important function of a facilitator group members also have a responsibility to contribute towards the security of other group members through respecting confidentiality and respecting the work done both inside and outside of the group. On occasion it was difficult for group members to facilitate one another to feel safe and as a result it was difficult for group dynamics to be discussed within the group itself which could result in frustration and increasing tensions.

Avoiding conflict became a core coping mechanism for the group. However, over time this “solution” became more of a problem culminating in a peak of group tension which resulted in what felt like a useful discussion about how group members were feeling. After this it felt like cdg discussions were more lively with all group members actively engaged which contrasted with the coping mechanism in the first year wherein some group members disengaged from the group. As a group it was agreed that we would try to keep the momentum going of giving and receiving feedback amongst group members whilst negotiating the arrival of a new facilitator in the final year of our life as a case discussion group.
OVERVIEW OF THE CLINICAL DOSSIER

This dossier consists of summaries of each of the six placements completed over the course of the three years training and a summary of the five case reports which are presented in full in volume two of the portfolio. These documents are presented in the order that placements were undertaken.
### Placement summary: Adult Mental Health, Year 1

<table>
<thead>
<tr>
<th>Dates</th>
<th>2/11/05-22/9/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Placement</td>
<td>12 Month Adult Mental Health (core)</td>
</tr>
<tr>
<td>Settings</td>
<td>Community Mental Health Team; inpatient psychiatric ward; forensic unit; family therapy service.</td>
</tr>
<tr>
<td>Theoretical Models</td>
<td>CBT, Systemic.</td>
</tr>
<tr>
<td>Presenting Difficulties</td>
<td>Depression; schizophrenia; anxiety; PTSD; intrusive thoughts; dementia, hoarding.</td>
</tr>
<tr>
<td>Range of Experience</td>
<td>The age range of the clients I worked with was from 19-70 years old. The placement was varied and included conducting assessments primarily for the psychology speciality and for the multidisciplinary team. I contributed to fifteen assessments in total. Individual work was conducted in addition to group work which consisted of a psycho-educational “looking after yourself” group on an acute adult psychiatric ward. In addition I was a reflecting team member at an adult family therapy clinic. I also conducted a service related research project on an acute inpatient psychiatric ward exploring patients experiences of being discharged back into the community which I presented to the multidisciplinary team. I conducted a number of psychometric and neuropsychological assessments one of which was based on a forensic unit.</td>
</tr>
</tbody>
</table>
Case report summary one

Presenting problem:
Mr. Micheal Gregor, a Black British male with a diagnosis of schizophrenia in his early forties was referred to psychology. The referral related to his CPN’s concerns about his vulnerability within the community which included allowing strangers into his flat which resulted in violence and damage to his property.

Formulation:
A cognitive behavioural formulation was used to understand Micheal’s difficulties. His primary difficulties appeared to concern assertiveness and maintaining his own safety. Predisposing factors were collaboratively assessed as including a fear of being re-admitted to hospital (making him “passive”); previously living with his parents and being somewhat dependent upon their advice; having limited support networks and moving into independent accommodation. Precipitating factors included feeling lonely, Micheal’s trusting nature, having difficulties assertively telling people they could not come into his flat, and experiencing violence and verbal abuse from people he allowed into his flat. Maintaining factors included feeling lonely, not attending college (therefore having unstructured days), alcohol consumption and letting potentially dangerous individuals into his flat. Protective factors included Micheal’s spirituality, motivation and his ability to develop positive relationships with mental health professionals.

Intervention/outcome:
Nice (2006) suggest that psychological and psychosocial interventions with an individual diagnosed with schizophrenia should aim to reduce the impact of stressful events, decrease the individuals vulnerability, increase treatment adherence, reduce risks and symptoms whilst enhancing coping skills and communication. A problem-solving approach was utilised with Micheal in order to help him be able to identify his difficulties and recognise the resources he had to tackle them. In addition it was planned that this work would include helping him to develop skills to address both current and future difficulties. Problem-solving, role-play and activity scheduling were initially used with Micheal in addition to building a collaborative therapeutic
relationship. However, it became evident that Micheal’s use of alcohol was making it difficult for him to use the sessions and so a review was conducted. Sessions were reviewed and it was collaboratively decided that work might focus on Micheal’s experience of being diagnosed with Schizophrenia, his understanding and experience of this. This work drew upon some of the principles of narrative therapy particularly using deconstruction and externalisation.

Re-formulation:
Micheal’s difficulties were re-formulated particularly in light of him expressing that he felt low in confidence and self-esteem. The BDI-II was administered and Micheal obtained a score of 30 indicative of severe depression. He identified the trigger for his low self-esteem as being related to being diagnosed as “paranoid schizophrenic”, perceiving that he was no longer “normal”, feeling that his family viewed him as “mentally deficient” and that he had to pretend to be “normal”. It was hypothesised that as long as Micheal’s dysfunctional assumptions were maintained (e.g. “if I attend college I have not wasted my life”) he could maintain his self esteem. However, when a critical incident occurred (such as his course being terminated due to poor attendance) his bottom line was activated “I am wasting my life, I am schizophrenic, my life is over”. As a result he believed that he would not achieve anything he wanted to in life and his anxiety and maladaptive behaviours increased. The latter included alcohol abuse, feeling lonely because he has not attended college/had no structured activities and thus allowed individuals into his flat who might exploit him. Such behaviours had also been identified as resulting in Michele disengaging from services. Further such experiences were identified as confirming his “bottom line” that he is a failure and is wasting his life. This in turn seemed to result in more self-critical thinking, thus lowering his self-esteem and resulting in depression.

Intervention:
In collaboration with Micheal I referred him to the teams occupational therapist. This was in relation to him finding it difficult to incorporate structured activities in to his day. In addition he was facilitated to engage with services where he could meet other people with a similar diagnosis which he had wanted to do. Micheal was facilitated to visually represent salient aspects of his identity. He reported that this was helpful as it
helped him to see that there were aspects of his life that could positively contribute to his self-esteem. A very salient feature of his identity was his spirituality and his contacts with his local spiritual community. Micheal commented that this aspect of the work, looking at the resources he had, allowed him to see that his life was multifaceted and that he had more support and coping strategies that he had not been conscious of before. In addition work with Micheal included collaboratively developing a shared view about the nature of his illness and discussing the effects of both social exclusion and stigma. This was successfully incorporated into the work with Micheal who was shocked to see that I accepted his beliefs that the voices were saying nice things to him and that he missed his voices when they stopped.

A difficulty identified in the work with Micheal was his low attendance. He attended a total of 7 out of 13 sessions at the time of submission of the case report. It was hypothesised that he may have been using an avoidance coping strategy and that this may have been related to a fear of becoming dependent on the therapist that she would ultimately abandon him as his parents had when they moved to Jamaica. However, it was considered that through acknowledging this the therapeutic relationship might provide a context wherein if it did not result in the anticipated rejection in could be an intervention that was corrective in itself.

At the time of submission of this case report the work with Micheal was ongoing. It was anticipated that the BDI-II would be repeated in order to evaluate any reduction in his depression in addition to continuing to regular review the aims and outcomes of the work.
Case report summary two

Presenting problem:
Ms. Florence Kidd, a 42 year old Black British woman was referred to the psychology speciality in relation to her severe depression and suicidal ideation.

Formulation:
Florence completed the BDI-II and obtained a score of 61 indicative of severe depression. Her difficulties were initially formulated using Beck et al.'s (1979) model of emotional disorder. Predisposing factors relating to her depression included her childhood experiences, previous depression and her dependent-style relationships. Precipitating factors included the death of her mother and brother, splitting up with her partner and the difficulties she experienced raising her five children as a single mother. Maintaining factors were thought to include her maladaptive coping strategies including that of shopping and hoarding, negative self-beliefs, perceived lack of support with her children, cramped housing, financial difficulties, and a lack of pleasure and achievement in her life. Protective factors appeared to include being psychologically minded, assertive, intelligent, and having a support network in her local church.

It was hypothesised that as long as Florence’s dysfunctional assumptions were maintained (for example, “if I have nice clothes and garden ornaments I have respect”) she could maintain her self-esteem. However, when a critical incident occurred (such as having arguments with staff at her children’s school or being unable to complete college courses) her bottom line was activated. Her bottom line was hypothesised to be “no one loves me” and “I am invisible”. This led to predictions that her life would always be like this, that people judge her based on what she has and has not got, and that her children did not care about her. This in turn would lead to shopping and hoarding items some of which would have to be returned due to financial difficulties. Returning items to the shop appeared to confirm her belief that she was negatively judged (by shop assistants) which would lead to self-critical thinking such as “I am a rubbish mum” which would fuel her depression and perpetuate the activation of her bottom line (“no one loves me”).
Intervention/outcome:
CBT is the recommended treatment of choice for severe depression. However, it has been recommended that patients who have significant comorbidity should be given an extended duration of treatment utilising treatments that specifically focus on the comorbid problems. In collaboration with my supervisor and Florence it was agreed that her comorbid difficulty which was extremely severe was her compulsive hoarding and shopping which made the house extremely cluttered such that it was difficult to move making her already cramped housing more uncomfortable to live in.

A cognitive behavioural approach to compulsive hoarding was utilised. Initially this included focussing on organising rather than discarding in order that trust could be developed in the therapeutic relationship and so that confidence could be built in treatment benefits. Florence identified the area of hoarded items that she would like to start with and feedback about the emotional impact of the task was regularly sought. Florence had many magazines which she wanted to discard but wanted some use to come from them. She was supported to donate them to a local hospital waiting room and she appeared to enjoy the gratitude she received from staff in the clinic for her donation. This may have indicated that another way in which she could gain social respect was being established instead of from shop assistants. In addition through looking through the magazines some of Florence’s beliefs became more evident.

Florence identified that she resorted to shopping as a “quick pick me up” but recognised that the problem was so severe that frequently the items she bought could not be taken out of her car because the house was too cluttered. Though the process of the work she identified enjoying gardening as it allowed her to “switch off” and that she would like to complete a college course. Florence started regularly walking with a friend.

During the course of the work Florence reflected upon her childhood and attachment relationships particularly with her sister and mother. In addition she talked about her
experiences at school and the difficulties of being a black child in a predominantly white area.

Review:
A review of the work was scheduled in session 13. Twelve sessions had been offered at this stage and four had been cancelled by Florence. The BDI-II was again completed. Upon firsts completion Florence gained a score of 61 and on this occasion obtained a score of 47 which remained indicative of severe depression.

At the review it was discussed that Florence had been able to engage in only two sessions on de-cluttering and had cancelled four. It was considered that perhaps she was not ready to work on her hoarding yet. In addition on sessions focussing on organising it seemed that Florence had difficulty focussing on one area and completing a piece of work. It was thought that this was related to heightened anxiety and motivational issues. A lot of the work had focussed on Florence’s beliefs and attachment to possessions which she felt was related to her early childhood experiences, her present circumstances of being a single mother on benefits, and familial deaths.

Florence during this time period had completed a flower arranging course and felt that this had helped her feel more like herself. With this came a sense that she was “emerging from a chrysalis”. She reflected that after her mother had died she had become more possessive of the children and that perhaps by keeping the house messy she kept other people away. By session thirteen Florence reported that she felt that she had almost lost her “yearning” to shop.

Florence’s difficulties were reformulated using attachment theory and work with the trainee focussed attachment relationships and familial patterns of interaction. Florence agreed for a referral to be made to family therapy. At the time of submission of this case report work with Florence was ongoing and it was anticipated that the BDI-II would be again completed.
## Placement summary: Learning Disabilities Placement, Year 2

<table>
<thead>
<tr>
<th>Dates</th>
<th>11/10/06 – 23/3/07</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title of Placement</strong></td>
<td>6 Month Learning Disability Placement (core)</td>
</tr>
<tr>
<td><strong>Settings</strong></td>
<td>Community Team for people with learning disabilities (outpatients, residential, clients homes, day centre, college, secure unit, inpatient)</td>
</tr>
<tr>
<td><strong>Theoretical Models</strong></td>
<td>Psychodynamic, Behavioural.</td>
</tr>
<tr>
<td><strong>Presenting Difficulties</strong></td>
<td>Bereavement, cumulative losses, anger management, carer anxiety, sexual vulnerability, dangerous sexual history, sexually inappropriate behaviour, schizophrenia.</td>
</tr>
<tr>
<td><strong>Range of Experience</strong></td>
<td>The age range of clients was from 34-72 years. Psychometric assessments, formal risk assessment, neuropsychological assessments, indirect work with staff and carers, functional analysis, visit to local services, individual work with clients. I took a short course in psychodynamic psychotherapy by Valerie Sinason and regularly presented my work in team meetings and psychodynamic group supervision.</td>
</tr>
</tbody>
</table>
Case report summary three

Presenting problem;
Ms. Emma Brown, a 38 year old White British woman with mild/moderate learning disabilities was referred to the psychology speciality. The referral was in relation to her residential placements breaking down when she acted out her anger. At the beginning of therapy Emma’s key worker completed the HONOS-LD with an Assistant Psychologist. It was evident that Emma’s main areas of difficulty included: severe behavioural problems directed towards others; severe anxiety; very severe attention and concentration difficulties, severe problems associated with mood changes, mild problems with relationships and having severe difficulties regularly attending her activities.

Formulation:
A psychodynamic formulation was used to understand Emma’s presenting difficulties. It was hypothesised that she had insecure working model of attachment and perhaps viewed herself as unworthy of love and the world as dangerous. It was suggested that due to her perception of not having a good-enough mother she continues to demand excessive attention from care staff. Ultimately, the care will never be what she would perceive as good enough and so she feels rejected like she felt from her primary caregiver. Emma then acts out aggressively and care staff then ask Emma to leave the placement. Thus they end up rejecting her as she perceived her mother did.

The psychodynamic perspective of pain views all mental life as a shifting flow and is maintained and influenced by interacting forces. These forces are constructed by psychic pain and the urge to avoid it through distorting or concealing knowledge of its sources. Pain has therefore been conceptualised in this model as being due to inner conflict between parts of the self. The anxiety represents an “internal danger situation” and for Emma this appears to be rejection. Her hidden feeling is that she is unlovable, impotent and disgusting. Her defence, protecting herself from rejection and acknowledgement of her hidden feelings, is anger.
Intervention/outcome:
The aims of the intervention were to provide Emma with a containing and stable environment. This would be facilitated through having the session on the same day and time each week for the same length of time (50 minutes) and to plan for breaks in therapy and its ending. In particular it would be important that I worked with Emma to facilitate communication in the therapeutic setting. I aimed to include drawing and to utilise the countertransference especially when she may have difficulty expressing herself with words.

Emma attended a total of 15 sessions and there were 3 breaks in therapy – (Christmas, illness (on my part), and my annual leave). Themes that occurred throughout the intervention included: finding a mutual form of communication, talking about emotions, family, secondary handicap, the use of the therapeutic relationship and preparing for the end of therapy.

The Honos-LD was administered at the beginning and end of the therapeutic work. The results showed that she no longer had problems with her behaviour towards others, destructive behaviour towards property, her anxiety has reduced, her attention and concentration have improved, no problems with mood changes and regularly attended activities. However, there are some surprising results which include problems in expression. The key worker explained that Emma “can’t express the emotional side but she is starting to make links”. It is surprising that this was not recorded at the initial interview. Physical problems have also increased and the key worker felt that the physical problem was Emma’s weight which she felt had been increasing since she became dissatisfied with her last group home. In addition, problems with relationships had increased from a mild problem to a moderate problem.
**Placement summary: Child and Family, Year 2**

<table>
<thead>
<tr>
<th>Dates</th>
<th>4/4/07-21/9/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Placement</td>
<td>6 Month Child &amp; Family Placement (core)</td>
</tr>
<tr>
<td>Settings</td>
<td>Child and Adolescent Mental Health Service (outpatient) and Looked After Children Team (outpatient). I ran a group for foster parents and residential workers in a local church hall in addition to seeing clients in their homes, and at school.</td>
</tr>
<tr>
<td>Theoretical Models</td>
<td>CBT, Systemic, dyadic developmental psychotherapy.</td>
</tr>
<tr>
<td>Presenting Difficulties</td>
<td>Difficulties related to parental separation/divorce; micturition; ASD; ADHD; depression; anxiety; stealing; pregnancy; difficulties related to attachment disruption, difficulties adjusting to becoming a foster parent or an adoptive parent.</td>
</tr>
<tr>
<td>Range of Experience</td>
<td>The age range of the children I worked with was from age 4-19 years. I worked both individual children and with families. I also worked with parents who were having some difficulties as adoptive parents in addition to running a group based on dyadic developmental psychotherapy to support foster parents and residential workers in their work with children and adolescents with disrupted attachment histories. In addition I conducted several psychometric and neuropsychological assessments. I presented several of my cases in multidisciplinary team meetings.</td>
</tr>
</tbody>
</table>
Case report Summary four

Presenting problem:
Jack Wood, a 7 year old White British boy, was referred to the psychology speciality for an assessment in relation to his parents concern about his behaviour. In particular this related to the perception that he was “overactive”, “always on the go” and “unable to sit still”. It had also been noted that as a result of his poor attention skills he had been in trouble with teachers at school.

Formulation:
An extended assessment was completed which included gaining a developmental history; completion of the Conners’ Rating Scale Revised; interviews with Jack his parents and the school SENCO. In addition a class room observation was conducted and the WPPSI cognitive assessment was completed as well as the Bene-Anthony Family Relations Test. This led to the formulation that Jack was experiencing significant attention and concentration difficulties which impacted his ability to learn new information. This in turn was having an effect on his academic attainments. He was observed to have significant difficulties sitting still with a need to be near adults. This need to be near an adult in turn impacted his ability to make and maintain friendships. The further information gathered regarding Jack’s developmental history suggested that his behaviour might have been related to transgenerational patterns of attachment.

Intervention/outcome:
A referral was made for Jack and his parents to the parent-child game treatment programme. In addition the family was placed on a waiting list for family therapy in order that a forum might be provided to discuss family roles. The Conners’ rating Scale-Revised showed that Jack had clinically significant difficulties with oppositional behaviours, hyperactivity and cognitive problems/inattention. Through spending time with Jack and conducting classroom observations it appeared that his behaviours corresponded with various DSM-IV criteria for ADHD. Therefore a referral was also made for the family to meet with a psychiatrist to discuss a possible diagnosis and the possibility of medication.
Some psycho educational work was conducted with Jack’s teacher through providing some literature regarding attachment behaviours and how they might present themselves in the classroom. In addition recommendations were given for how they might work with Jack to address his needs regarding academic support, attachment needs and peer relationships.
**Placement summary: Older People, Year 3**

<table>
<thead>
<tr>
<th><strong>Dates</strong></th>
<th>10/10/07-30/09/08</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title of Placement</strong></td>
<td>12 Month split older adult and psychotherapy specialist placement (core and specialist)</td>
</tr>
<tr>
<td><strong>Settings</strong></td>
<td>Community Mental Health Team for older adults (outpatients, inpatients, residential homes, clients homes)</td>
</tr>
<tr>
<td><strong>Theoretical Models</strong></td>
<td>CBT, Integrative.</td>
</tr>
<tr>
<td><strong>Presenting Difficulties</strong></td>
<td>Anxiety, depression, memory difficulties, dementia related difficulties, bereavement, interpersonal difficulties.</td>
</tr>
<tr>
<td><strong>Range of Experience</strong></td>
<td>I have worked both individually with clients in addition to working with families, staff and carers. I have run two groups one has been a memory support group for individuals with dementia and the other is a therapeutic support group. I have conducted three neuropsychological batteries with clients with memory difficulties. I am conducting an audit of service user and carer perspectives of the memory support group which will be shared with the community mental health team.</td>
</tr>
</tbody>
</table>
Case report summary five

Presenting problem:
Mr. Williams, a 78 year old White British man, was referred to the psychology speciality due to short-term memory problems and occasional confusion.

Formulation:
A neuropsychological assessment was conducted with Mr. Williams. This included administering the mini-mental state examination; the Wechsler Test of Adult Reading; the Wechsler Adult Intelligence Test; the Wechsler Memory Scale; The Rivermead Behavioural Memory Test; Hopkins Verbal Learning Test; Rey Complex figure test; Controlled oral word association test; the trail making test; Hayling & Brixton Tests of executive dysfunction; the Hospital Anxiety and Depression Scale and the Geriatric Depression Scale. Mr. Williams appeared to be performing at the expected level in visual spatial, verbal comprehension, perceptual organisation, and social reasoning. However, his performance was found to be significantly impaired across multiple domains showing particular difficulties in executive functioning, all aspects of memory and learning (both verbal and visual and visuo-spatial), sustained attention, complex cognitive processing, and processing speed. It was hypothesised that Mr. William was functioning at the level of dementia and that his neuropsychological profile suggested aspects of both vascular dementia and Alzheimer’s dementia. It was identified that the underlying cause of his difficulties could only be identified through further medical examinations.

Intervention/outcome:
Both Mr. and Mrs. Williams were offered individual and couple counselling to support them in adjusting to Mr. Williams’s dementia and to discuss possible memory strategies. In addition Mr. Williams was invited to meet with the team psychiatrist to assess his medication and identified sleeping difficulties. It was also recommended that Mr. Williams was referred for an MRI scan and an EEG to assess his sleeping. A referral to occupational therapy was also recommended to conduct a functional assessment.
**Placement summary: Advanced Competencies, Year 3**

<table>
<thead>
<tr>
<th>Dates</th>
<th>10/10/07-30/09/08</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title of Placement</strong></td>
<td>12 Month split older adult and psychotherapy specialist placement (core and specialist)</td>
</tr>
<tr>
<td><strong>Settings</strong></td>
<td>Adult Psychotherapy Department – Outpatients.</td>
</tr>
<tr>
<td><strong>Theoretical Models</strong></td>
<td>Psychodynamic Psychotherapy</td>
</tr>
<tr>
<td><strong>Presenting Difficulties</strong></td>
<td>Early childhood bereavement; abusive relationships; anxiety.</td>
</tr>
<tr>
<td><strong>Range of Experience</strong></td>
<td>Long term direct 1:1 psychotherapy work with 2 clients aged 33-36. Observation of assessments by psychotherapists, observation of weekly meeting about an Intensive Outpatients Programme for people with a diagnosis of personality disorder.</td>
</tr>
</tbody>
</table>
OVERVIEW OF THE RESEARCH DOSSIER

This dossier contains the research logbook which gives an overview of the range of research experiences gained throughout clinical training. The service related research project and an abstract of a qualitative group project completed in year one are enclosed. Finally, the major research project completed in years two and three is presented.
<table>
<thead>
<tr>
<th></th>
<th>Research Log Checklist</th>
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<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</td>
</tr>
<tr>
<td></td>
<td>search tools</td>
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<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</td>
</tr>
<tr>
<td></td>
<td>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:
Investigation into the purposes and boundaries of flirtatious behaviour using IPA

Objective:
To conduct a preliminary exploration into the rules and boundaries of flirtation using a qualitative methodology. The study was regarded as a preliminary exploration of the behaviours used in flirtation as well as an enquiry into the perceived purposes and intentions behind these behaviours. The study also sought to gain an understanding of whether or not these rules were dynamic, if they differed between genders, and the role of stereotypical behaviours, with a view to providing greater insight into flirtatious behaviour.

Design:
A non-experimental, descriptive design was utilized incorporating the use of a focus group. This is a naturalistic method that is advantageous to explore how people interact in a social context.

Setting:
The focus group was conducted on campus with university students.

Participants:
Attempts were made to recruit a homogenous sample of heterosexual young adults aged between 20 and 30. There were three males and five females, mean age 23.25. It was assumed that many would be engaged in flirting behaviour, and hence rich data would result. In addition it also reflected the socio-demographics of the researchers and so there would be less risk of cultural misunderstandings when interpreting the data. Due to the importance of gender in this discussion, one male and one female facilitator moderated the group. Participants were selected according to these criteria from those responding to posters distributed around a university campus.

Analysis:
Interpretative Phenomenological Analysis.

Results:
The analysis of the data using IPA elicited five themes: intentions; development of flirting; power; boundaries; and gender. Within the current paper 2 of these themes were discussed: gender issues and boundaries.

Conclusions:
The two themes of gender issues and boundaries were discussed in some detail. These themes are to some extent congruent in relation to previous research. For example, the focus group discussion identified that boundaries of flirting are complex, flexible and frequently transgressed. There was a lack of clarity regarding physical boundaries highlighting two conflicting perspectives – that crossing a physical boundary is inappropriate versus this being an integral part of flirting behaviour. Previous research has suggested that due to inter-gender power differentials women may be more cautious when flirting due to physical vulnerabilities and may feel pressurised to
comply with societal norms resulting in an adherence to more conservative boundaries of appropriateness compared to men (Williams et al. 1999). The current study found that although women may feel physically weaker, flirting can also enable them to feel “in control” and “powerful”. This was not observed in the existing literature. This begs the question whether future research would replicate this finding.
Returning To The Community:

An Interpretative Phenomenological Analysis of

Service Users Experiences.

The information contained within this report is confidential. Certain information has been emitted or changed in order to ensure anonymity. All names included are fictitious.

Both written and verbal consent were given service users in order for this report to be produced.
Abstract

Title: Returning To The Community: An Interpretative Phenomenological Analysis of Service Users Experiences.

Objective: To listen to the experiences that service-users have of discharge from an acute psychiatric ward in order to understand what has aided and hindered this transition and how this might impact upon service development.

Design: Nonexperimental, descriptive design.

Setting: An adult acute inpatient psychiatric ward.

Participants: Seven participants agreed to be interviewed of whom 4 were male and 3 were female. Ages ranged from 30 to 69 years with a mean age of 46.4 years. Inclusion criteria included being current inpatients on an acute psychiatric ward; having had recurrent admissions and being well enough to participate according to staff assessment.

Analysis: Interpretative phenomenological analysis.

Results: The analysis of the data using IPA revealed 6 themes. These include ward staff, ward activities, other service-users, feelings about discharge, Community Mental Health Teams, and social roles. Within the current paper 3 of these themes are discussed.

Conclusions: The findings in this study have replicated the findings of previous research. This has included fears of exclusion, loneliness, lack of activities and few financial resources (Granerud & Severinsson, 2006). The present study also replicated findings regarding the importance of employment for the development of social skills and networks and the effects that this can have upon self-esteem (Howard et al. 2000). The importance of having a caring role was identified in addition to using one's own expertise and experience in order to help another but also to enable social comparison. Directions for future research are also discussed.
Returning To The Community:
An Interpretative Phenomenological Analysis of Service Users Experiences.

Introduction:
The World Health Organisation (WHO, 2001) has stated that the main goals of rehabilitation and recovery should include empowerment, increasing an individual’s social competence and social support and the elimination of stigma and discrimination. A vital element of mental health recovery is the relationship between a service-user and their clinician. However, it has been found that during the period of discharge the relationship with hospital staff is lost and there can be a lapse in time before relationships are formed with community staff (Forchuk & Brown, 1989). This period, without a supportive relationship, may be critical particularly for individuals without other support networks.

Research has found a link between social support and psychological well-being such that individuals who have a supportive social network recover at a greater rate from serious mental illness than those who do not (Sanderson, 2004). Similarly, employment has been found to positively affect mental health; socialising with work colleagues out of work seems to increase self-esteem and social skills (Howard et al., 2000). Conversely low income and poor health may act as preventative for participating in social groups, increasing isolation and personal and social devaluation (Ramon, 2001). Indeed, researchers and clinicians have noted that individuals with mental health difficulties are frequently re-admitted to hospital within 1 year often due to difficulties with returning to their communities (Reynolds et al., 2004). For example, Granerud & Severinsson (2006) found that individuals experienced a fear of exclusion and shame as they tried to re-integrate into their communities. In particular they experienced loneliness, neglect and a struggle for equality in addition to a sense of time passing slowly and having few financial resources.

Reynolds et al. (2004) explored the effects of a transitional model of discharge for patients. This model included support from an identified inpatient nurse (the “transitional nurse”) and service user support. The role of the transitional nurse
incorporated working with the service user until a point when an agreement was reached between both the service user and the community care provider (such as a social worker or community psychiatric nurse) that a "working phase" of the therapeutic relationship had been formed. This was established utilising The Relationship Form (Forchuk & Brown, 1989) to define it operationally and to see when the relationship had reached "working phase". Signifiers of this included the service user identifying their assigned community service provider as "trustworthy", being able to identify topics to be addressed within the context of the relationship and an explicit readiness to end contact with the inpatient staff. Until the "working phase" had been achieved service users could maintain telephone contact with designated ward staff and have therapeutic meetings with them. Another significant element of this model of discharge was the provision of peer support from an identified individual who had previously utilised the mental health system. Peer support included friendship, understanding and encouragement and the nature of the support provided depended on individual preferences. Specific elements of such support included visiting the individual prior to discharge, facilitating discussions about the experience of re-integrating into the community, and taking part in joint skill enhancement opportunities including life skills and social activities. It was found that 5 months post discharge service-users participating in the transitional discharge model reported fewer symptoms, reported higher levels of functioning, had a better quality of life and they were less likely to be re-admitted into hospital.

The author has had the opportunity to observe a "recovery group" on an acute psychiatric ward and co-facilitate a group on the same ward called "looking after yourself". During these two groups a recurring theme has been service-users' fears about being discharged and, for some, leaving the community of the ward and being somewhat "alone" again. This has coincided with the closure of the day hospital which provided discharged patients with a space to socialise and receive support. This led the author to ask the following questions regarding current service provision: what are service-users experiences of discharge and of returning to their communities? What services are they finding useful or lacking?
The present study aims to explore service-users' (who are inpatients on an acute psychiatric ward) previous experiences of being discharged and their current fears and needs regarding discharge into the community.

**Method:**

**Participants:**
The inclusion criteria for the present study were as follows:

- Inpatients on an acute psychiatric ward.
- Recurrent admissions.
- That they were well enough to participate according to staff assessment.

Participants were recruited through the researcher discussing with staff and approaching patients whom staff deemed met the inclusion criteria. The aims and nature of the interview were explained to participants utilising discussion and an information sheet (please see appendix i). In addition, participants signed consent forms (see appendix ii) asking for their permission to participate, to be recorded and that information would be used in order to produce a service evaluation but all work would be anonymous and confidential.

Seven participants agreed to be interviewed of whom 4 were male and 3 were female. Ages ranged from 30 to 69 years with a mean age of 46.4 years. Ethnic backgrounds were selected by participants utilising the trusts ethnicity forms. Participants came from any other Asian background (n=1), Black British (n=1), White British (n=4) and any other white background (n=1). Three participants stated their religion as Muslim (n=1), and Church of England (n=2). Of the participants 3 lived alone, 3 lived in sheltered accommodation and 1 lived with family. Out of the 7 one worked as a volunteer and 6 stated they were unemployed.

**Data collection:**
Initially a semi-structured interview schedule was developed (please see appendix iii). This was based on the work of Jonathan Smith (2005) which advises that the schedule is designed to guide the interview rather than determine it. In this way power is shared whereby the interviewee can affect the direction the interview takes and is
positioned as the expert on the subject telling his or her own story. Smith (2005) argues that this follows the "phenomenological position" whereby the interviewer has selected an area to study and some general questions to follow but attempts to (within limits) enter the psychological world of the respondent. Within the topic area of being discharged there are 3 key areas which will be covered during the interview: being an inpatient, being discharged, and coping strategies. Interviews were recorded for the purpose of transcribing.

Analytic strategy:
This study will utilise Interpretive Phenomenological Analysis which is "an attempt to unravel the meanings contained in ...accounts through a process of interpretative engagement with the texts and transcripts" (Jarman, Smith & Walsh, 1997: 189). IPA acknowledges that it is impossible to gain direct access into someone's world and acknowledges that the researcher's understanding is mediated by his or her own experiences, assumptions and conceptions and as such IPA is reflexive in that it acknowledges that it is dependent upon the researcher's viewpoint (Willig, 2004).

Analysis of transcripts initially involved re-reading and making notes about important processes and phrases which might summarise the content or highlight any contradictions or differences within or across transcripts and tentative interpretations (In order to see a sample of transcripts please refer to appendix iv). Then, in each individual transcript these notes were used to produce primary themes which were consistent with the data. Once each transcript had been subject to this procedure all the initial themes produced were scrutinised in order to identify recurrent themes across the transcripts in order to produce a final series of super ordinate themes. The relationship between themes and the data set were again checked and re-checked.

Analysis:
The analysis of the data using IPA revealed a number of themes. These include ward staff, ward activities, other service-users, feelings about discharge, Community Mental Health Teams, and social roles (please see table 1 below). These are demonstrated in the table along with illustrative quotations. In this study 3 themes will be discussed that were particularly representative of individual experiences of
discharge. These include feelings about discharge, Community Mental Health Team and social roles. All names used are pseudonyms.

Table 1. Themes regarding discharge:
(Words in bold represent super ordinate themes and words in italics represent themes within them).

Ward staff

Communication:

“*Well, well the only thing is that before when I was being discharged someone should have took me for a 1:1 conversation [...] I wish someone could have taken me a couple of times and tried to talk to me and, then they would realise that I’m not ready for discharge*” (Sam, p.12, l. 392-401).

Support:

“*Erm, I think they could speak to the patient’s a bit more hopefully cos some of the patients like, you see them crying on their own and things like that and some of the staff don’t go round and help them but some of them do as well but like they could do it a bit more*” (Micheal, p. 15, l. 83-86).

Ward activities

Boredom

“*Erm, just hanging around passing the time it can be very boring just looking at the clock going round and round and round*” (Sophie, p. 23, l. 68-69).

Therapeutic groups

“*Erm, there was nothing there that wasn’t liked but it just seemed like more like, flat sort of like, it wasn’t like a full on discussion about the mental illness or things like that. Like sometimes they have a discussion about mental illness and what people think about the mental illness and what would help the mental illness and things like that. And some of them seem pretty interesting, but like um, they don’t have enough of them*” (Micheal, p. 14, l. 50-54).
<table>
<thead>
<tr>
<th><strong>Other service-users</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional support:</strong></td>
</tr>
<tr>
<td><strong>Adverse effects:</strong></td>
</tr>
<tr>
<td><strong>Feelings about discharge:</strong></td>
</tr>
<tr>
<td><strong>Fears about discharge:</strong></td>
</tr>
<tr>
<td><strong>Benefits of a gradual discharge:</strong></td>
</tr>
</tbody>
</table>
Community Mental Health Teams:

Task focussed: “Well, my social worker I don’t see very often but, I don’t see him very often but he does fix things when it came to fixing benefits he was very much on the case when it was about getting voluntary work he was very much on the case” […] (Sam, p. 11, l. 361-363).

Intrusion: […] yeah I feel they was intruding ‘cos like um, I was only expecting them to ring up and say like, can you make another appointment but like they would come round to the house and like almost force themselves on you” (Micheal, p. 18, l. 176-186).

Support: “And I’m glad I’m able to contact them in that way and be able to talk to them and discuss my problems and it just makes it easier to deal with my illness” (Sophie, p. 27, l. 197-199).

Social roles:

Carer: “She has been discharged. […] and this is sort of organising my day as well because I have someone to care for […] without it, it would be much more difficult. Because this way I can spend half of my day and this gives me something to do” (Sam, p. 7, l. 223-236).

Employment: “Yes, I don’t want to be looked...if I was well I would well wild horses wouldn’t stop me from working. I’d be back in full time work before you could say “Jack Robinson”. I’m not a skiver, I never have been I did 20 years before I got ill” (p. 58, l. 391-393).
**Feelings about discharge:**
This theme contains two sub-themes of fears and benefits of discharge.

**Fears about discharge:**
Fears about discharge principally concerned the barriers that one might have to tackle moving from an institution where you have both practical and emotional support into community accommodation where help and support may not be so readily available. Participants readily reflected upon this utilising their previous experiences of discharge. This was succinctly reflected by Sam:

"'cos there's a lot of sort of, thin barriers when you sort of want to go out [...] because you think that everything that you need to do and you don't know how to do it and you think that it's a big thing like cooking, like going to the shops, like organising yourself, you know and, and, trying to occupy yourself with anything."

(Sam, p. 6, l. 179-183)

In addition a fundamental fear appeared to be stigma, isolation and a desire to be regarded as "normal":

"Yeah because once you're getting well you do worry "oh am I going to be stigmatised?" because already I met someone yesterday and he knew I was ill and then he saw me get the medication and because I spoke well and I was being quite normal he treated me normally so I thought "oh it didn’t matter that I was on medication". So then it's positive for you 'cos you realise even though I'm ill I can be normal. ".

(Sophie, p. 30, l. 303-308)

Fears about coping were compounded by the fear that there was a lack of social resources in order to facilitate meeting others and the development of one's skills:
“Well, there’s not that there’s much in the community. The Day Hospital the only place that there was for people who had been discharged has closed. So, anyway people on discharge are being, are being left.”

(Sam, p. 7, l. 214-216 )

Benefits of a gradual discharge:
An important benefit noted was the fact that discharge was gradual, providing support and reassurance, thus adjustment to the community was perceived as less anxiety provoking:

“It’s good that I come and then I go if I was on the phone and they said just stay at home I think I’d say no. Because the fact that I come and then that I have that assurance that if anything goes wrong I can come back and that I have that security so then I go and see if I can cope and then you find gradually you can. So this is why I think a gradual discharge is very good.”

(Sophie, p. 28, l. 250-254)

Community Mental Health Team:
Participants in the current study belonged to two different CMHT’s. Experiences of Community Mental Health Teams were varied and 3 sub-themes were identified: support, intrusion and task focussed.

Support:
Sophie experienced her CPN as supportive in helping others understand her difficulties and enhance her confidence in the community:

“Yes, they’re very helpful my CPN took me to my surgery and I was rocking and the lady said to me “oh there’s a loo over there” and my CPN said no it’s her medication it’s not that she needs to go to the toilet and it’s nice having that support there [...]”

(Sophie, p. 26, l. 185-187)
Intrusion:
Sophie’s account contrasted to that of Michael who experienced his contact with his CMHT as intrusive:

“...I weren’t expecting them to be, like, come round to my house and, and like erm, find out why I didn’t turn up to appointments and things like that.... I was shocked. [...] yeah I feel they was intruding ‘cos like um, I was only expecting them to ring up and say like, can you make another appointment but like they would come round to the house and like almost force themselves on you”.

(Micheal, p. 18, l. 176-186)

Task focussed:
Some participants found that they saw members of their CMHT only when particular issues needed addressing:

“Well, my social worker I don’t see very often but, I don’t see him very often but he does fix things when it came to fixing benefits he was very much on the case when it was about getting voluntary work he was very much on the case[...]”

(Sam, p. 11, l. 361-363)

Thus it appears that perceptions of Community Mental Health Teams were varied depending upon individual experiences.

Social roles:
Having a personally valued social role was regarded as important. Within this theme there were 2 sub-themes that of carer and employee.
Carer:
One participant in particular referred to the importance of having responsibility via caring for another and the way that enabled him to reflect on his own health whilst giving him a facilitative role:

“[...] I am someone who keeps her company and I am someone who is better which puts me in a position where I am better [...] Which, which makes me forget that I’m ill in a way it gives me a responsibility and it gives me a sort of a false sense of being not unwell a sort of false sense ‘cos this is, comparing me and Cassie – she is much worse[...]in a sort of quiet way that I am trying to motivate someone I am trying to get someone better.”

(Sam, p. 9, l. 288-301)

In addition the role of an expert by experience and the benefits this can confer to other service users was also evident:

“I think that I have got a lot to a lot to share in the sense positively to tell people that they can get through this if they stimulate their brain it will help take the focus off “oh I’m ill, I’m ill”.”

(Sophie, p. 31, l. 354)

Employment:
Being in employment whether paid or voluntary was expressed as a desire by several service users. This was referred to in the sense of being able to be financially independent and having a structured way in order to spend one’s time:

“Yes, I hope so I would like to go back to work but not just for my son and daughter but for myself. I don’t enjoy hanging round the house 24/7 and just going out a little bit”.

(Richard, p.72)
However, how the individual viewed the form that their work took could effect their evaluation of that role. For example, Sam in his description of his voluntary position described it as an activity which he did not feel required many skills:

"I do voluntary work... which is basically typing on a computer which is, which is not anything that would require any sort of you know, proper skills".

(Sam, p. 9, l. 280-281)

This may have undermined the positive effects this role may have had upon his self-esteem.

Discussion:
This study identified 6 major themes regarding discharge: ward staff, ward activities, other service-users, feelings about discharge, Community Mental Health Team, and social roles. Three main themes have been discussed in this paper, that of feelings about discharge, community mental health teams and social roles.

The findings in this study have replicated the findings of previous research. This has included fears of exclusion, loneliness, lack of activities and few financial resources (Granerud & Severinsson, 2006). In addition a desire for and the benefits of social roles have been found in this study replicating previous research which also identified the importance of employment for the development of social skills and networks and for the ensuing effects upon self-esteem (Howard et al. 2000). The present study also recognised the importance of a caring role and using one’s own expertise and experience in order to help another but also to enable social comparison.

In the locality where the present study was conducted CMHT staff visit patients while they are inpatients. However, unlike the Reynolds et al. (2004) exploration of a transitional discharge model there is, at present, no formal check of the therapeutic relationship between community staff and service users. The work of Reynolds et al.
(2004) therefore holds the development of the therapeutic relationship as an important change agent and privileges its development as a key part of a transitional discharge. Such work may help address expectations of service users and clarify the roles of community care providers.

Peer support currently exists for the individuals in the present study on an ad hoc basis and relies upon the individuals’ ability to create opportunities and having social skills or the confidence to develop and maintain relationships. Further, in the locality where the study was conducted there are currently no longer any befriending schemes available.

Reflections:
The accounts given reveal a great awareness of the difficulties and skills needed when being discharged and re-entering the community. Participants were both pragmatic regarding the multiple issues that need addressing in addition to having hope and a degree of self belief regarding their abilities and the value of their experiences. This may be a reflection of their current state of health and the fact that many of the participants were approaching discharge.

Limitations & future implications:
The sample utilised here is by no means representative of all inpatient psychiatric service users. This, however, was not the aim of the present study being a qualitative research project we sought to collate in depth, rich data from a limited number of participants (Touroni & Coyle, 2002). This is also commensurate with the recommendations for the maximum sample size for research projects utilising Interpretative Phenomenological Analysis being no more than 10 (n=8) (Smith et al., 1999). The findings of this study suggest that future research should look at the efficacy and practical applicability of employing the use of transitional discharge nurses and monitoring the therapeutic relationship between community services and service users. In addition employing the element of peer support from the transitional discharge model (Reynolds et al., 2004) may be desirable in order to limit isolation and enhance social integration and the development of social skills.
References


Appendix i.

**Information sheet**
Information sheet

I would like to interview you to find out about your experiences of being discharged. I plan to use this in order to conduct a service evaluation, discovering what you have found helpful and areas for service development. This interview will take from 20 to 40 minutes and you can ask to stop or take a break whenever you like. I would like your permission to record the interview on audiotape in order that I can write up a report. However, the information will be confidential and anonymised. This means that there will be no information revealing your identity and the audiotape will be destroyed once I have transcribed the information.

Should you have any questions please do not hesitate to ask me, either before, during or after the interview.

Thank you for your participation,

Jane Major
Trainee Clinical Psychologist
Appendix ii.

Consent form.
I understand that ................................................, trainee clinical psychologist would like my permission to use information about me to complete a course work assignment (service related research project).

I understand that the work will not contain any information that would reveal my personal identity i.e. my name, address, when and where the work took place, other clinicians involved or other identifying details.

I understand that the only people that look at course work assignments are the trainee’s supervisor in this service and the University tutors or examiners who are qualified clinical psychologists who work in or for the NHS.

I understand the work will be checked by the trainee’s supervisor to see that my anonymity and confidentiality have been safeguarded.

I understand that course work assignments (and material relating to these) are kept in securely locked premises and are not available for public access or publication and are not kept in the University library. Assignments are destroyed by the University three years after the trainee has successfully completed the training course. If the trainee keeps copies of the assignments he/she must keep them securely in accordance with the British Psychological Society’s Professional Practice Guidelines and the Data Protection Act.

As the assignment is an academic piece of work required by the trainee as part of the training course that does not identify me personally and will not form part of my NHS record, I understand that I will not receive a copy of it. This is because the emphasis in this assignment is on the trainee’s learning process rather than adding clinical information to my NHS health record. I understand that any correspondence/reports which form part of my NHS record can be copied to me as advised by the Department of Health policy.

I understand that I do not have to allow information about me to be used in this way. I can change my mind and refuse my consent at any stage and this will have no effect on the treatment offered to me.

Name of client:

Client’s signature:

Date:
Appendix iii.

Semi-structured interview schedule
**Semi-structured interview**

First of all I would like to thank you for agreeing to talk to me today. I would like to explain that everything we discuss will be confidential. The information we discuss will be used in a report but it will be completely anonymised. This means there will be no information included identifying you. I hope that what we discuss may contribute to an evaluation of current services.

I wish to discuss with you what being discharged from the ward means to you. I would like to understand how you have found being an inpatient and your experiences of both peer and professional support. Then, I would like us to talk about your previous experiences of being discharged and what you think can enable a successful discharge.

But before we start I would like to ask for your written consent to participate and ask you if you would mind me using a tape recorder in order to record the interview? No one else will hear this tape and once I have transcribed the information (anonymously) the tape will be destroyed.
Table 1. Interview Schedule: Patient's experience of discharge from an acute psychiatric ward.

(A) Being an inpatient:

1. What is your understanding of why you have been admitted to the Ward?
2. How many times have you been an inpatient on a psychiatric ward?
3. Who is important to you on the ward?
   - Prompt: Who do you spend most of your time with on the ward?
4. How do you spend your time when you are on the ward?
5. Do you feel you are in the right place for you at the moment?
   - Prompt: Do you feel safer here than at home?
   Do you think being here will help you to feel better?
6. Are there down sides to being on the ward?

(B) Being discharged:

I would like you to think back to the last time that you were here and were about to be discharged.
7. Were you given much notice about your discharge?
   Prompt: If yes, how much
   If no, how did this make you feel?
8. Who helped you to prepare for your discharge?
   Prompt: Were your family and friends informed?
   Prompt: Housing?
   Employment?
   Emotional support?
9. What kind of areas were you given assistance with?
10. How did you feel about being discharged?

(C) Coping Strategies:

11. What did you do to prepare for returning to the community?
12. How did you feel when you left the hospital?
   Prompt: How did you feel when you went home/ to your new home?
13. What do you think now about your previous experience of being discharged?
14. Do you think that there was anything else that could have been done to support you?
Appendix iv

FURTHER INFORMATION ABOUT IPA
IPA acknowledges that it is impossible to gain direct access into someone’s world and acknowledges that the researcher’s understanding is mediated by his or her own experiences, assumptions and conceptions and as such IPA is reflexive in that it acknowledges that it is dependent upon the researcher’s viewpoint (Willig, 2004). These are not regarded as biases but necessary for understanding and making sense of another individual’s experiences. Thus, “understanding requires interpretation” (Willig, 2004; 66). The lens through which the author interprets the data will be affected by her experiential frameworks and this is the central tenet of the research method of IPA. Thus traditional means of assessing research quality (e.g. reliability) such as researcher objectivity and disengagement from the research process are regarded as inappropriate for this study (Touroni & Coyle, 2002). Therefore in order to reflect that themes are grounded in the data examples shall be quoted from the data (Elliott, Fischer, & Rennie, 1999).
Appendix v:

An example of a transcript
J: So we have to speak quite loudly so it can be heard on the tape.
SA: Fine, yeah.
J: Okay, so thank you for talking to me today. I just want to find a bit about what it's like being an inpatient and your experiences of being discharged, okay, and for use of a project I am going to keep everything anonymous and confidential.
SA: Okay.
J: And you can take a break whenever you like and just say “stop”
SA: Okay
J: Okay. So, first of all, I just want to find a bit about your understanding about why you have been admitted to this ward at the moment?
SA: Erm, I had a relapse since I wasn’t taking my medication so I started to have head pain so that took me back to here.
J: So were you explained your diagnosis or anything?
SA: No, it's not schizophrenia now its schizo affective which is a milder form of schizophrenia so it’s not so bad.
J: And did the staff help explain that to you?
SA: Erm, yeah
J: And you understand, they explained to you what your medication is for?
SA: Yes.
J: So how many times have you been an inpatient?
SA: This is my sixteenth admission because I wasn’t compliant with medication.
J: And they have explained it to you every time you have come back to that’s why-
SA: That’s right they say this time that if I don’t take it my condition will get worse which is why I realise that medication for me is a must now.
J: A must? It’s the most important?
SA: Yes
J: Okay, so being on the ward and you have had quite a bit of experience of that, when you are an inpatient who do you find that is really important to you?
SA: The staff.
J: The staff?
SA: I found them to be very caring, very helpful, very supportive and I feel that I needed all that to get me through.
J: So you feel that the staff have been quite supportive towards you?
SA: Yeah.

J: How about the other people that are on the ward as well?

SA: Um, we help each other by sympathising with each other's experiences and sometimes it can be a little bit hectic because we're all different and we've all got different illnesses so sometimes we can have, which is not very nice, and it can affect your mental health.

J: Have you had any experiences of that yourself?

SA: Yeah because I'm a friendly person and I like to get on with everyone and I used to find that I used to make extra effort – with the females especially – and then they would just not talk to me as nothing and I just put it down to their mental condition because they are unwell.

J: So it is quite good that you understood that –

SA: Yeah

J: But you got hurt?

SA: Well it didn't help my mental health

J: Yeah

SA: So it was all about you could get into rows, and things which makes you regret it afterwards.

J: So, you found that although you like having relationships with other service users sometimes you can get hurt?

SA: Yeah and it's difficult because you're all put together and you have to just get through it.

J: You don't have much choice –

SA: No.

J: So, how do you spend your time when you are here on the ward?

SA: Erm, it's difficult because it's not the same as the things I do when I'm at home so I find that the last week I just smoked and yesterday I was only here for an hour but I smoked a lot and erm, being here I just listen to music, just smoke and just pass my time by chatting to other people.

J: So do you smoke here as much as you smoke at home – can you smoke at home?

SA: Yeah I can smoke cos I live on my own.

J: So do you think you smoke more here because you are more stressed or –

SA: Yeah it's just the tension and the anxiety of being here.
J: What do you think creates that tension?
SA: Erm, just hanging around passing the time it can be very boring just looking at
the clock going round and round and round.
J: So do you feel that there is not enough activity?
SA: Yeah, there isn't I wish was more to do erm, more where we can apply ourselves
and make use of our time I think that would be more beneficial and get more out of
the system.
J: So you feel it would be more of something that is helpful, useful, using your skills
SA: Yeah 'cos I've got a lot to give and a lot to do but I can't do it because there is
nothing to do here.
J: And what have you found there is to do here?
SA: Erm, the groups that we go to. Erm, talking to the staff, going for a walk in the
garden. But, I just wish that there was more that we could do.
J: So, more kind of structured activities?
SA: Yes
J: Maybe using the skills you have got and perhaps developing them?
SA: Yeah, because if everyone was doing something then you've got less time to
think about annoying other people and cos you are busy doing something else and I
think it would be harmonious on the ward then.
J: Kind of occupying your mind?
SA: Um.
J: So you are not getting into confrontation
SA: Umm.
J: So, at the moment do you feel that being on the ward is the right place for you?
SA: Um, I'm getting better now so I'm happy that I've got more leave so it's nice
being out there being independent
J: Umm
SA: Urm, but yeah mental health wise I like to be taken off the ward slowly so, its of
benefit to me at the moment that I've got the leave and,
J: So you don't like the idea of a complete discharge but prefer gradually going.
SA: Yeah 'cos if I had a complete discharge then I'd get anxious at home and have to
come back. Because that is what happened in this week because of my medication
that's having side effects I had to ring the ward and come back and get some pills to
calm me down so medications not work. So the doctor said to me that if this new medication doesn’t work she could change it so today I am hoping that will change it so that I can go back to the one that was working.

J: So it’s good that you recognise the signs when you are not well and contacted the ward.

SA: I do that’s the good thing that I do know about my symptoms and I am glad that I’m in tune with them because before other people notice them I notice them myself it’s like when the side effects coming on and I was shaking then I realised oh my god phone the ward and I did and I got a lift from my neighbour who bought me down to the ward.

J: So that was good ‘cos you recognised it yourself.

SA: Yeah I did

J: And also having a helpful neighbour like that

SA: They were very, very concerned and they hadn’t seen me for three months and they were very, very helpful.

J: So is that quite comforting to know that your neighbours are like that?

SA: It was definitely nice and my neighbour she saw my sink and because of the anxiety I couldn’t wash up and she did all my dishes.

J: Oh, that must have been really nice.

SA: Yeah, she said that if you need any food then you are very welcome, yeah, they were very nice.

J: So do you feel a bit safer knowing that there is someone who notices if you have not been there for three months?

SA: Yeah it is nice because ‘cos they were knocking at my door and everything ‘cos they didn’t know where I was and they tried my mobile but I had binned it when I was ill.

J: Umm

SA: So I just threw everything away. So it was nice to know that I’ve got the support in the community as well.

J: Do you think there is other support in the community that’s important?

SA: yeah, my family, my friends, I’ve got a whole network of people which is nice because they don’t shun me because of my illness they are quite helpful which has really helped because its inevitably going to be in your life and if you are
accepted...’cos I think that if people stigmatised you then it would be hard you know
you’d go back to hospital so that’s rather long.

J: Umm, so your family and friends have been important. Is there anyone else in the
community that you find important like colleges, or work or-

SA: Yeah, I’m taking lessons ‘cos I go to the mosque so and they’re really nice. So,
they know I’m ill and they make sure that they don’t say anything to upset me and
they ask do I need help and if they know they can help me, friends have stayed
round just this last week ‘cos they saw I was still vulnerable and they saw my
condition they saw that I couldn’t relax and I was quite tearful so they stayed one
night at one friends, and another night at another friends and then they came and
stayed with me in my flat just to help me settle in, to show me that I don’t need to be
scared of people.

J: So you have found support at your mosque?

SA: Yeah with my friends. It’s great, it’s really nice. And, and the other night when I
was very anxious, my friend she erm, mopped my floor and hovered it and she erm,
just spring cleaned the whole flat so when I was there, I came back to the ward
yesterday and they sent me again on leave so I just enjoyed the luxury of having a

J: Does that make you feel more at home when everything is clean and as you’d like it
as well?

SA: Yeah it’s nice because you can, you can just move around in the nice fresh air its
not all cloggy and dusty.

J: And I suppose you don’t have to worry about other things you should be doing?

SA: Yeah.

J: Doing the cleaning and washing up.

SA: Yeah that’s right, that’s right ‘cos that would add to my stress. There was crumbs
on the floor and I couldn’t clean the floor and that was annoying me so that was nice.

J: So it helped. Thinking back to the last time that you were an inpatient before you
were going to be discharged do you feel you were given much notice? Was it a

SA: I can’t really remember but erm, yeah in the past when I’ve just been out you
can’t really cope it’s hard and you’ve got understand that the fact that I’m in tune with
my mental health and my friends know how to help me ‘cos they listen so they know
that oh, like my medication they said they will help if it all goes wrong for me know, so I go and see the doctor so the more in tune I am with my mental health the more my friends don’t have to go about helping me. But it is important that I am informed about my mental health.

J: So you mentioned that this time you were given leave and you can come back here as well. Do you think that that is an important part of the discharge because have you had it in the past where you have just been discharged and that’s been it?

SA: Yeah

J: And what’s happened then?

SA: I’ve just had to cope on my own. It’s hard but I’m applying too much pressure to myself it’s just not good, it’s not healthy.

J: So, presumably when you apply too much pressure do you expect things to be-

SA: I try harder like I stuck with my job and I stuck with my...my it just all fell apart because I was just trying too hard.

J: So, who has helped you this time when you were thinking about your discharge-

SA: - I think the hospital.

J: - has helped you plan for your discharge?

SA: Yeah I think my solicitor made me a plan of what to do day by day and erm I’ve got most of the support here which I think is crucial because I believe the nurses know what they’re doing and I do have faith in them. Because I’ve taken that support it really helped me out.

J: And so when you’re having this transitional discharge where you can have leave and come back to the ward have you got the community mental health team, are they in contact with you as well?

SA: Yes, they’re very helpful my CPN took me to my surgery and I was rocking and the lady said to me “oh there’s a loo over there” and my CPN said no it’s her medication it’s not that she needs to go to the toilet and it’s nice having that support there because other people they just won’t take you as being weird they realise that oh, you know, you’ve got the help that you need and they’re more supportive, so

J: So, it’s made a difference?

SA: It has made a difference this is why I’m so willing to accept the help. In the past I used to think oh, I can do it all by myself and you can’t really do it all by yourself.
J: So do you find there has been a good overlap between the help that you have got from the ward and the community mental health team?

SA: Yeah it's all coming together and I'm glad that I know where to go for that help. It's like now I've got a few issues to discuss and I've just had to leave a message with the secretary to tell the CPN to contact me. And I'm glad I'm able to contact them in that way and be able to talk to them and discuss my problems and it just makes it easier to deal with my illness.

J: And how do you think it's happened that the ward and the CMHT...are they both going to your meetings like CPA, ward round?

SA: Erm yeah. My CPN she comes to my ward round and she knows what's happening with me and erm I find her very supportive and very caring in that she talks through my problems with me and she gives me good advice. And that is positive because I take that away with me and when I'm alone I think about that and then if anything is not going the right way I know that she's there.

J: Um

SA: and I know that I need to discuss it with her, I know I can.

J: So when you were admitted to the ward did your CPN remain in contact with you?

SA: Erm, yes she did because I had a key worker who left and passed me onto the CPN and they did it gradually she introduced me first before the CPN took over the role so I wasn't just thrown in at the deep end.

J: Umm.

SA: So it was good because I saw her a few times and I saw I could trust her and when that barrier was you know, when that came down, I felt that now I could talk to her so....

J: So it sounds like a good experience?

SA: Definitely, yeah.

J: It sounds important. So, what kind of areas have you been given assistance with?

SA: Erm, I've had help with welfare rights because when I was ill I was moved to lots of different bed and breakfasts and ran up bills because I never stayed there even when I had housing benefits because I was ill. So I had about two thousand something bill and my key worker got that written off saying that my mental health was really bad and I used to roam the street without shoes on and things like that so I was told by a welfare rights officer that that's been overwritten now, that I don't owe
them that. So, that’s taken a lot of pressure off my life. My support worker she has
helped me with my debts so now that I’ve been able to get in more bedsits I know
that’s priority that I have to pay my debts. So I’ve got all the support for every area of
my mental health my medication is vital so I’ve now got a knew GP they know that,
so they’re aware that if ever I come what area to deal with and if ever, whenever I go
to the GP. And also, my period I tell them that, that the pain is lasting longer than
usual is that something they can look into? So I think that as patient’s we need to
recognise what support we need and go out there and get it.

J: So it sounds like you have got support from all different areas financially,
emotionally
SA: - I have, yeah, it’s a lot, it’s a real consolation, ‘cos I live on my own and when
you’re there in your flat on your own you know you don’t have to worry, you know
that you’re going to be all right and that helps you relax and get a good nights sleep.

J: So it’s been a bit more secure when there is a good support network set up.

SA: Yeah

J: So what have you been doing, how did you prepare for your discharge?

SA: Erm, I used my leave to clean, make sure everything is fine at home, my
paperwork and my rent is all sorted so I don’t have headache or lose my flat. Keep
myself well, go to the library sit down do some studying, listen to music. I’m waiting
to pay off my BT bill so that I can get onto the internet. And one of the patient’s he is
a professor in English so he is really helping me so he was telling me what to look up
on the internet to learn more stuff from the dictionary. So it’s all good stuff, you can
take away a lot and you realise what to occupy your hours.

J: That sounds really positive meeting another patient who-

SA: I said to him, I said to him “you’re quite handy do you want to be my tutor?”

J: So, erm, how do you feel when you are going home on your own now?

SA: It’s good that I come and then I go if I was on the phone and they said just stay at
home I think I’d say no. Because the fact that I come and then that I have that
assurance that if anything goes wrong I can come back and that I have that security so
then I go and see if I can cope and then you find gradually you can. So this is why I
think a gradual discharge is very good.

J: It’s been helpful for you
SA: Yeah

J: So, thinking about your previous discharges how do you look back on them now?

SA: I think I was maybe put out too soon and erm, I wasn’t really able to cope and plus I didn’t see any need to take medication. This is why I think that it is important that you accept, and not just listen and not take it in you have to accept that you need help and take that support where you need it. There is a real 1:1 and with mental health it can take a lot of time cos I think people live in denial that they are ill. It took me 5 years to accept that I had a problem.

J: What do you think was stopping you? Do you think it was the illness?

SA: No, it was just that I was healthy in my life till I was 24 so I didn’t want to believe that I was ill and I didn’t believe I was ill no matter what anyone told me I believed that no I don’t need any medication. This discharge has made me realise how far I need medication.

J: So it’s kind of being an inpatient again do you think or, what made you accept-

SA: No, the voice was so real and I used to think it was the voice of God. And the voice made me cut my hair off ‘cos I had long hair and I realised the voice is dangerous the voices can make me do silly things and I’m glad that the medication, taking it, because now I know, because I haven’t heard voices since I’ve taken the medication so I know that the medication actually helps my mental health – it stops the voices so that’s what made me realise that I need to take it.

J: So seeing the actual change of the voices going.

SA: Yeah so I it’s like, oh my god, you’re ill and the medication stops that. Of course I don’t want to be hearing voices, of course I want to take it. So its that realisation.

J: So its realising that the voices could be dangerous and that the medication can remove the voices for you.

SA: That’s right yeah.

J: So do you think that there is anything that can be done by the ward staff, or the CMHT or people in the community to support you in being discharged.

SA: Yeah, just erm, they’re quite good when I come back they listen like I phoned Greg and he said come back and we’ll give you something they weren’t hard, they weren’t dismissive they didn’t have beds but they still helped me and they explained that to me and I knew that I had them there if anything was to happen and know they would contact another hospital and they would do something and that made me cope
as best as I could cos I know oh don’t worry, don’t panic. So they have been very
good at a slow discharge, I would say that.

J: So, is there anything else that people in the community could do, different services
or...?

SA: Erm, yeah if you had different places to go to. Like say if you haven’t got to
occupy your time Anne at the poetry group said that she would love to have me there
to talk to other patients and poetry you can share things and make friends. So it’s all
healthy and good stuff.

J: So it’s helping you develop social networks and share your experiences

SA: That’s right yeah, definitely. ‘Cos I think with mental health I think deep down
we’re all scared that we’re not going to be accepted and the fact that you see other
people maybe better than you, you realise I can do it I can get through this.

J: So do you think that’s a really important part is meeting other people that have been
there?

SA: Yeah because once you’re getting well you do worry “oh am I going to be
stigmatised?” because already I met someone yesterday and he knew I was ill and
then he saw me get the medication and because I spoke well and I was being quite
normal he treated me normally so I thought “oh it didn’t matter that I was on
medication”. So then it’s positive for you ‘cos you realise even though I’m ill I can
be normal. And that’s a nice feeling.

J: So for people that haven’t got the support networks that you’ve got what would you
think that the ward-

SA: - I think that the staff need to be more involved with them, have more of a 1:1
with them and get to the core of their needs and trust is important. ‘Cos sometimes
when you see someone in authority like a nurse talking to you, you don’t open up
necessarily and as patient’s they need to know that they can open up. And a lot of the
time that I was here I was doing the nurses job

J: - So king of giving them the support and helping people open up to you?

SA: Yeah and sometimes it was too much because I thought I’m not a nurse and
sometimes I wanted to avoid those people and go to bed early because I thought it was
affecting my mental health because I was giving so much and it was taking a lot out of
me. So then when I used to see them in trouble I used to get a nurse to go instead ‘cos
I realised that I, I’m not trained in this.
J: So you learnt how to kind of prioritise your own needs.

SA: Yeah.

J: But I guess it's important to realise that those people trusted you.

SA: They did. It was nice 'cos I made friends at the same time I knew they needed more than me just being there and that's when I'd say “talk to the nurse”. Like one of the patients said the nurses treat you nicely. And then I realised that they treat me nicely because I'm not rude to them you know, I don't swear at them and I don't demand medication and that's because I realise the role that they play, they're hear to look after us. And if you give them that respect and you treat them with respect they will in return be nice to you. And when I had a pain they gave me medication straight away. I will say to the patients when they complain about the staff “no you need to talk to them and not have an attitude”. ‘Cos even though we are ill there's times when we know what we're doing so you can't use your mental illness as an excuse to get away with bad behaviour. I think that’s wrong ‘cos I've been very ill and even in my worst moments I'm not rude and it's only when I have had incidents when I just can’t take it. But most of the time I control myself that’s why I know when I look at other patients I know sometimes that they are deliberately doing this and I don't want to be involved in all that.

J: So it sounds like you've kind of had a lot of, in some ways, positive experiences you've realised that people find you easy to talk to, that must be quite nice to feel like that.

SA: That is nice ‘cos just yesterday the said “God you're so friendly” and I said don’t worry I’ll be here tomorrow and then it will be lively [laughing].

J: So what do you think you are going to do to use these skills, because it is clear you have good people skills.

SA: Yeah erm maybe get a job because I like working with people and I like worked in Sainsbury's for 8 years and I used to do customer service and I get on well with people. So I know that I like being around people which is why I know that I need to take my medication to be normal so I can uphold that which makes me happy.

J: So do you think that you are going to go to the poetry group and share your experiences with other people?

SA: Yeah definitely, yeah, yeah

J: That sounds like it would be important.
SA: I think that I have got a lot to share in the sense positively to tell people that they can get through this if they stimulate their brain it will help take the focus off "oh I’m ill, I’m ill".

J: Well thank you very much for talking with me today it sounds like you have had some really interesting experiences

SA: That’s okay, that’s all right, glad I can share it what I’ve been through because I’m sure that it will help a lot of people.

J: And I think that’s important realising how much knowledge you’ve got yourself and you’re good at relating to people. Also you’ve recognised how important it is to meet other people experiencing difficulties.

SA: Yeah definitely

J: I guess going away and using that positively

SA: Yeah definitely.

J: Thank you very much.

SA: That’s all right.
Dear Charlotte,

Re. Jane Major, Trainee Clinical Psychologist
Service Related Research Project (SRRP)

Jane has contacted me to say that my original letter confirming her completed work on the SRRI has been misplaced. I am afraid I did not keep a copy myself.

Therefore, I write to confirm that Jane did complete her SRRP whilst on placement with me during her first year of training, and that she presented her outcomes to the multi-disciplinary team within which she was based.

I hope this is satisfactory.

Yours sincerely,

Dr. Momotaj Islam
Chartered Clinical Psychologist
Major Research Project

Family members’ perceptions of therapy at a specialist older adult family therapy service

Year 3

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Appendix O
Feedback to Participants
1. Abstract

Background:
The evidence base for systemic family therapy has increased in relation to families of working age adults and families adjusting to difficulties raising children. More recently there has also been an increase in qualitative research exploring the phenomenological experience of family therapy from the perspective of family members. However, there exists a sparse evidence base for family therapy where the identified client is an older adult and even fewer studies which explore the experience of family therapy from the perspective of older adults and their family members. Frequently referrals to older adult mental health services involve the older adult and his or her family or support network. Therefore research exploring how family members perceived the experience of systemic family therapy at an older adult family therapy service and what they found contributed to or hindered the process is important. It was hoped that the findings could contribute to good practice with this client group in the local service and possibly the wider domain of systemic family therapy.

Aims:
This study aimed to qualitatively explore how therapy was perceived by family members at an older adult family therapy service in the South of England. This included understanding their expectations of therapy, their relationship with the therapist and team, and the perceived impact of therapy.

Method:
Semi-structured interviews were conducted with six individual family members to gain their perspective of their experience of therapy. Interviews were transcribed and then analysed using Interpretative Phenomenological Analysis to construct themes that captured the participants’ experiences.
Findings:
Three master themes were identified across participants’ transcripts: ambivalence about engaging with therapy, the facilitative aspects of therapy, and constraints to change.

Discussion:
The findings are discussed in relation to the relevant literature. In addition a critique of the study is made in addition to discussing recommendations for future research and implications for practice.
2. Acknowledgements

I would like to express my appreciation to Dr. Paul Tibbles, research supervisor, and Annie Turner, field supervisor, for their guidance, time and enthusiasm during the completion of this research. I would like to extend my appreciation to Noreen Rooney, the clinic administrator for her administrative and moral support. I am very grateful to the family members who participated in this project and made this study possible. Finally, I would like to thank my family, colleagues and friends for all their support during the last two years that I have spent working on this project.
3. Introduction:

This research project explored how family therapy was perceived by family members at one of the few older adult family therapy services in England. This chapter will explore how ageing has been regarded in contemporary Western societies and the influence of social policy, particularly in relation to mental health care provision. The rationale for systemic family therapy and its relevance to older adults will be laid out including an exploration of what family therapy can offer older adults and their family members. Gaps in the literature will be highlighted in addition to a discussion about why this study is using a qualitative methodology.

3.1 Social narratives of ageing:

Mandatory retirement, the growth of biomedicine and the welfare state have been identified by Phillipson (1998) as having a significant role in redefining ageing in the Western world as a time of decline. Biggs (2001) has argued that social policy can legitimise certain issues, make resources available to them and allow certain social issues to be identified and therefore addressed. He also suggests that social policies can legitimise the extent to which members of society are able to establish socially acceptable identities. Biggs (2001) therefore argues for a critical exploration of the impact of social policy upon older adults and their positioning within society.

The Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission in 2006 published a report ("Living Well In Later Life") of their joint review of the National Service Framework for Older People. In particular they drew attention to the division of services between working age adults and older adults. This divide was identified as resulting in a discriminatory system where the range of services available to working age adults is markedly different to those available to older adults. In Northern Ireland, Wales and England "working age adults" refers to people between the ages of 18 to 65. Therefore in relation to policy documents for mental health (e.g. National Service Framework: Department of Health 1999) people over the age of 65 are excluded, no longer considered adults but older adults” (Age Concern, 2007). Situating older age as a separate category within the lifespan in
addition to the meaning of what it is to be old (developed through particular historical and social processes; Berger & Luckman, 1972) has been argued to have contributed to the creation and growth of a separate place for older people both physically and socially within society (Biggs, 2001).

In response to the identified age discrimination embedded within policy documents, and therefore the services available to older adults, the Department of Health (2006) published “A New Ambition for Old Age” confirming that the Government was committed to age equality. However, it has been found that the division between services to working age adults and older adults remains (Age Concern, 2007). Therefore, it has been argued that direct ageism remains embedded in the National Health Service wherein the upper age limit on services disadvantages people over the age of 65 (Age Concern, 2007). For example, the “Living Well in Later Life” (2006) report found that the range of services available to working age adults and older adults is significantly different. Out of hours services for crisis management and psychiatric advice for older adults were identified as being under developed compared to those for adults of working age. Further services identified as being not as developed as those available to working age adults, and/or not routinely made available to older adults, included crisis resolution for people with severe mental health problems, psychological therapies, rehabilitation, homeless mental health services, alcohol services, and early intervention teams. In addition, it has been recognised that older adults receive a greater amount of inpatient treatment and less long term psychotherapy on an outpatient basis than working age adults (Knight, 1986). However, the differentiation in the quality and availability of services to older adults is not due to their experiencing less mental health problems than younger members of society. For example, it has been identified that the proportion of the overall population experiencing mental health difficulties remains relatively stable across the lifespan (Gatz, Kasl-Godley & Karel, 1996).

There is some variability in the types of difficulties experienced by older adults and in particular there is a greater frequency of suicidality, dementia and specific forms of major mental illnesses (Ivey, Wieling & Harris, 2000). When older adults are referred to mental health services they frequently have a combination of social, physical and
psychological difficulties impacting upon them (Curtis & Dixon, 2005). Such combinations can be complex for example depression in the older adult is also related to chronic ill health and social disruption as a result of separation, bereavement and other significant life events (Murphy, 1982; 1983). Although it has been recognised that social factors can result in the referral of older adults to mental health services the importance attached to physical health difficulties has contributed to the perpetuation of biomedicine dominating older people’s services (Curtis & Dixon, 2005). Stockwell (2005) has argued that the process of diagnosis and biomedical approach to the mental health of older adults can result in their becoming medicalised and viewed as almost “non human” (pp. 17) which can result in their further marginalisation within society.

Services for older adults in the United Kingdom are underdeveloped and the situation for those who care for them, typically family members, have been described as being even worse (Lima et al., 2003). In England over five million people provide care to friends and relatives with over seventy percent of this care being given to older adults (Audit Commission, 2004). Age Concern (2007) found that frequently family members are the only source of support for older adults experiencing mental health problems. In addition, family members who provide care are more likely to experience deterioration in their own health compared to those who do not (Audit Commission, 2004).

Families can be highly significant social relationships for older adults and therefore family therapy could be an important resource (Shanas, 1979). An increasing number of families comprise between three to four generations with older adult family members reporting regular contact with their grandchildren. Approximately 60% have stated that they see their grandchildren weekly while 60% also report having frequent contact by letter, email, fax or telephone (National Statistics, 2003). The significance of multigenerational familial relationships with older family members both giving and receiving support has gained increased recognition (Brody, 1981; Jerrome, 1996). Similarly, referrals to older adult mental health services frequently highlight the importance of families. For example, Ratna & Davis (1984) conducted an audit of 142 referrals to an older adult psychiatric service. Sixty percent of the
referrals were related to family issues and points of transition in the family life cycle including retirement, illness or death of a carer, family conflict and bereavement. It has therefore been suggested that it can be difficult to work with this client group without involving their social or family network (Benbow & Marriott, 1997). Therefore understanding what older adults and their family members find helpful when in receipt of family therapy could contribute to the development of better working practices with this client group not only in specialist family therapy services but also in community and inpatient settings.

3.2 Definitions of systemic family therapy:

There is no firm agreement on the use of the term “systemic family therapy”. Jones & Asen (2000) asked family therapists to define their understanding of the work of systemic family therapy. Through this consultation process there was consensus that the main aim of systemic family therapy was to work with an individual, couple or family to place their difficulties within the context of their current and past relationships. This process takes into consideration both social and cultural factors and discourses. The term Systemic family therapy will therefore be used here to describe a wide range of techniques and models which are reflective of family based practices.

Systemic family therapy has been described as having three phases. The first of these phases was influenced by systems theory which is a theory of parts being organised so that they make a whole (Weiner, 1961). Systems theory argues that families are self regulating and as such will attempt to maintain stability (homeostasis) in response to change (Robinson, 1980). Therefore, in response to changes in one family member another member might make complementary changes.

Within this phase Salvador Minuchin founded the structural school of family therapy. Structural family therapy assumes there is an unseen set of rules that controls and organises people’s behaviour (Hayes, 1991). Minuchin (1974) suggested that structural therapists explore family subsystems, boundaries, hierarchies and alliances in order to understand the family style of communication and organisation.
with members in the later stages of the life cycle maybe adjusting to changes in boundaries between sub-systems. For example, grandparents may take an increased role in the care of their grandchildren or alternatively might need more support from their own children. This might require a renegotiation of boundaries to allow the family to continue functioning (Benbow & Marriott, 1997).

Within the first phase the Mental Research Institute (MRI) was established and its work was known as “strategic” therapy. Strategic family therapists believe that families organise themselves according to a particular pattern of interaction and that problems occur if an unsuccessful adjustment is made at critical transition points in the family life cycle (Hayes, 1991). The family responds to a disturbance in its usual manner and attempts to solve resulting difficulties in a similar way. As a result a vicious cycle can be established where an unhelpful solution is continually applied (MacKinnon, 1983). The solution to the problem can then become the problem (Hayes, 1991). It has been argued that strategic therapy is particularly appropriate for working with older adults and their family members because the work is short-term with defined goals (Bonjean & Spector, 1988).

In the second phase the systemic/Milan school of family therapy was established (Israelstam, 1988). They delineated three principles for conducting interviews with families including: circularity, hypothesising and neutrality. They emphasised the importance of exploring the meaning that a family gives to the symptom and making links between the symptom and all parts of the system. Due to circularity systemic therapy views the therapist as part of the system he or she is observing (Hayes, 1991). This way of working acknowledges the constructivist position that individuals exist in relation to and are therefore social (Tomm, 1984). Therefore, they argue that there exists no absolute reality but instead meaning is relative and is gained through an understanding of contexts and relationships (Hayes, 1991). It has been suggested that this is particularly useful when working with issues related to later life when families face situations that may be unlikely to change such as chronic physical or mental illness. Roper-Hall (1992) has suggested that if the family’s perceptions and beliefs change this may help them cope differently with essentially the same situation.
Recently postmodernism has had an impact upon systemic family therapy. Postmodernism rejects the idea that there can be an ultimate truth and emphasises the co-existence of a variety of situation-dependent ways of life and multiplicity (Ashworth, 2004). The postmodern process of therapy has been described as collaborative (Hoffman, 1993) and with the therapist adopting a “not knowing” position (Anderson & Goolishan, 1992). Coleman (1999) suggests that social constructionism and the idea of “grand narratives” can help to deconstruct how social views about ageing are perpetuated and facilitate the generation of alternative discourses to the dominant medicalisation of mental health difficulties in older adults. Through using systemic techniques such as externalisation problems and behaviours can be seen as being outside the individual: that the problem is the problem and not the person (Freedman & Combs, 1996).

Reflecting teams are frequently used within systemic family therapy and can involve the use of a one way screen with a team of observers behind the screen who listen to the family’s interaction with the therapist and then reflect on this interaction in the form of a conversation between team members in front of the family (Andersen, 1987). The purpose of the reflecting team is to offer different perspectives which family member’s may or may not choose to use to help them understand their difficulties in a different way (Andersen, 1987).

Systemic family therapists, through attending to the lived experiences that clients bring to therapy, are likely to try and work with these experiences with a range of theory and practice ideas to meet the complexity and needs of the individual families they work with (Flaskas, 2005). Flaskas (2005) has observed that models of therapy are not “pure” and that therapists in their everyday practice use multiple skills and bodies of knowledge. Pocock (1997) suggests a plausible consequence of postmodernism might be that therapists use multiple lenses through which to view theory and practice.
3.3 The evidence base for systemic family therapy:

Outcome research has demonstrated family therapy is effective with a variety of clinical problems and client groups (Larner, 2004). The research reviewed will discuss the findings of recent quantitative and qualitative research studies in relation to family therapy with adults generally followed by later sections exploring the evidence base and qualitative studies in relation to systemic family therapy with older adults.

Evidence has been found for the use of family therapy with a range of difficulties including distress in couple relationships; mood disorders; chronic pain management; management of neurologically impaired adults; major depression and bipolar disorder; severe mental illness; and chronic physical illness (Asen, 2002; Carr, 2000; Sprenkle, 2002). Shadish & Baldwin (2003) conducted a meta-analysis of 20 meta-analyses in couple and family therapy and concluded that this model of therapy is effective when compared to no treatment. In addition they found that family therapy is as effective as other modalities such as individual therapy and may be, in some cases, more effective. However, there was sparse evidence suggesting that one model of marriage and family therapy was more effective than another (Shadish & Baldwin, 2003). Stratton (2005) notes that it is likely that in everyday practice family therapists draw upon a wide range of techniques to meet the specific needs of the families they are working with. Further, an explicit integration of approaches when working with families has been called for in order that families might benefit from a wide range of techniques (Rivett & Street, 2003). The evidence therefore suggests that family therapy is an effective treatment for most disorders of adulthood (Stratton, 2005).

Pinsof & Wynne (2000) suggest that in order for systemic family therapy research to influence practice it needs to start with an analysis of the phenomenological experience of therapy. They note that therapy itself is progressively idiographic. Although therapy might begin with the therapist approaching the family as a particular type of system, with particular difficulties, after the initial sessions the therapist is less guided by what works for what diagnostic category but by the client’s
responses to preliminary interventions (Pinsof & Wynne, 2000). They suggest that research should seek to explore, perhaps in a phenomenological manner, change that occurs as a learning process both inside and outside of therapy (Pinsof & Wynne, 2000).

3.4 The experience of therapy:

Through listening to the experiences that clients have had in therapy it has been suggested that researchers, clinicians and theoreticians can gain a greater understanding of the process and action of psychotherapy (Elliott & James, 1989). In addition the National Service Framework for Mental Health (NSF: Department of Health, 1999) has highlighted the importance of working in partnership with service users and carers in order to provide a service that meets their specific needs. A short review will now be conducted of some of the studies that have been conducted exploring the experience of therapy from the perspective of family members accessing adult family therapy services.

Kuehl, Newfield & Joanning (1990) interviewed 37 individual family members from 12 families about their experience of family therapy using an ethnographic methodology. Participants had received an average of ten sessions and therapy was structural-strategic in its orientation. The qualities of the therapist that participants frequently referred to included regarding the therapist as being understanding and caring and able to generate relevant suggestions. Kuehl, Newfield & Joanning (1990) found that success in the later phases of therapy was dependent upon success in earlier stages. For example if early on in therapy a relationship was developed wherein the therapist was perceived as genuinely caring and interested in individual family members then it was more likely that family members would share information and be open and honest.

The importance of the therapeutic relationship was also identified by Bischoff & McBride (1996) who interviewed 28 participants from nine families, thirteen couples, and four individual cases. Findings highlighted the importance of therapist empathy as a foundation upon which the work of therapy could be built. In particular clients
emphasised the importance of perceiving that their therapists were invested in them as people and in the work of therapy. Clients talked about the value of just coming to therapy which Bischoff & McBride (1996) referred to as the “inherent value of therapy” (pp. 123). They hypothesised that perhaps deciding to come to therapy in itself can symbolise commitment to one’s family or partner.

Further studies have found that family members have consistently reported the importance of the therapeutic relationship as being helpful rather than specific factors designed to impact skill acquisition or behaviour change (e.g. Budd & Hughes, 1997). These findings highlight the importance of the common factors of therapy. It has been estimated that there are four common factors that contribute to change in therapy. This includes expectancy (15%); relationship factors (30%); client and extra-therapeutic factors (40%) and model/technique (15%) (Hubble et al., 1999). Crane et al. (1986) found that the only variable to reliably predict user’s ratings of the outcome of treatment was “fit of treatment” to family members expectations. They suggested that in order to increase the likelihood that therapy might be congruent with the expectations of service users there should be an emphasis on the therapeutic relationship. This should be based on collaboration and developing a common agenda and agreeing the pace and length of therapy (Crane et al., 1986). Similarly, Stanbridge et al. (2003) using both qualitative and quantitative data to explore family members’ satisfaction with a family interventions service found that family members liked to feel that the therapist was not following his or her own agenda and that they were able to have open discussions together. This perhaps highlights the therapeutic relationship as an important context within which the work of therapy can be negotiated (Flaskas, 2004).

Within family therapy the therapeutic alliance is multifaceted. Pinsof & Catherall (1986) have suggested that family therapists should attend to both the alliance between the therapist and family as a whole (between-systems alliance); between the therapist and individual family members (the individual alliance) and the alliance between family members (within systems alliance). Beck et al. (2006) explored the therapeutic alliance with three families using both semi-structured interviews with family members and their scores on Pinsof’s Family Therapy Alliance Scale-Revised.
In addition, observer ratings were made of alliance behaviours during sessions using the System for Observing Family Therapy Alliances. They found that each individual family member's sense of safety was determined more by "within-system" (within the family) factors rather than between-system (between family and therapeutic team) factors. Further, it seemed that what contributed to a strong between systems alliance was good emotional connections with the therapist, confidence in the therapist's ability to foster change and agreement with the therapist on goals. In contrast what was found to contribute to a weak between systems alliance was disagreement over goals or a general mistrust of helping professionals. This suggests that the therapeutic alliance is extremely complex in family therapy and can have a significant impact on the process and outcome of the work.

Reviewing qualitative research that has explored the experience of family therapy from the perspective of family members accessing adult mental health services is useful in highlighting what was considered helpful and constraining to the process of therapy and change. However, older adults and their family members accessing family therapy services may have specific needs and requirements that may not be highlighted in the existing research. Nevertheless the qualitative research reviewed suggests areas that may be of importance to explore when conducting a qualitative study looking at the experience of family therapy from the perspective of older adults and their family members such as the therapeutic relationship.

3.5 Systemic family therapy research about older adults and their families:

Reviews of the content of family therapy literature have found that later life issues have not been significant themes of concern for systemic family therapists (Flori, 1989; Van Amburg et al., 1996). Flori (1989) conducted a review of systemic and family therapy journals that had published issues related to ageing over a ten year period. She found that older adult family members were conveyed as peripheral in family life. Further, family therapy had continued to remain preoccupied by the difficulties families experience parenting children.

Curtis & Dixon (2005) suggest that one reason for the lack of research into older
adults and family therapy is that very few family therapists actually choose to specialise in working with this demographic group and access to family therapy for older adults is limited. Therefore, when compared to child and adult family therapy services there are less people available to do the research or receiving such a service in order to be evaluated. Researchers including Spark & Brody (1970) and Knight (2004) have argued that clinical work and academic research with older adults is avoided due to it bringing to the fore painful subjects of death and disease. They hypothesised that professionals may protect themselves through avoiding work with this client group.

Gilliard, Lieberman & Peeler (1992) conducted a study exploring professionals’ beliefs about the benefits of family therapy for older adults and their family members. This study was conducted in response to a low number of referrals to a recently established older adult family therapy clinic. The authors interviewed fifteen General Practitioners’, fifteen nurses and ten social workers about their knowledge of family therapy and their referring practices to an older adult family therapy clinic. They found a significant amount of pessimism about the benefits of family therapy for this client group and their family members. This included that beliefs and behaviours of older adults are too “ingrained” to change and that they lack flexibility. Some of the professionals thought that family therapy might not be appropriate because they thought that it was the family members who needed support including practical advice and education. It is interesting that a perception of family members needing support would prevent professionals making referrals to an older adult family therapy service where such issues could be explored and addressed. Such findings have important implications for the mental health services which older adults can access and the support that is or is not made available to their family members.

It is also important to consider that older adults and their family members may be reluctant to engage with services themselves. The UK enquiry into mental health and well-being in later life found that many older adults associated the word “mental” with madness and viewed having a mental illness as something irreversible that would ultimately lead to institutionalisation (Age Concern, 2007). Similarly, when Anderson (2005) first set up on older adult family therapy clinic the referrals were
lower than had been expected. She considered that this may have been due to the title of “family therapy” which may have carried implications that the family had caused the difficulties experienced. Anderson (2005) found that changing the name of the clinic from “family therapy” to “family consultation” made a significant difference in the number of referrals received. She hypothesised that this may have been related to the word “consultation” being less stigmatising than “therapy”. These findings indicate that not only can being an older adult in society be marginalising but being an older adult with a mental health problem can result in a double stigma and therefore may make accessing therapy less likely (Benbow & Reynolds, 2000).

There are a lack of formal reports about the effectiveness of family therapy with older adults and their family members. Richardson (2005) addressed the gap in the research literature and published the findings of clinical outcomes from the older adult family therapy clinic she worked at in South East England. She compared the outcomes for family therapy with the outcomes for the other psychological therapies offered within the service—cognitive behavioural therapy and psychodynamic psychotherapy. One hundred and sixty eight clients were included in the study aged 45-98 with the mean number of sessions being 4.7 with a range from 1 to 65. Clients clinical status was evaluated both pre and post therapy using standardised instruments. Comparative outcomes were found for all three models of treatment with significant increases being found in therapist estimated levels of functioning following treatment and significant reductions in self-reported distress. Richardson (2005) suggested that the results indicated that the outcomes of family therapy for older adults were comparable with the results of CBT and psychodynamic psychotherapy. She noted that the results for family therapy were achieved in significantly less sessions than for the other two treatment models suggesting that it is a cost-effective intervention. In addition it was highlighted that the results related to the identified client whereas family therapy impacts all family members and therefore research that explores the experience and impact of therapy on all family members would be valuable.

The Department of Health (2005) has stated that mental health and social care provision for adults should be based on the need and appropriateness of the intervention not on age alone. This highlights the importance of listening to what the
needs are of older adults and their family members and the significance of utilising a person-centred approach. There are very few published studies exploring the phenomenological experiences of family therapy from the perspective of older adult family members. Butler (2003) conducted a research project looking at older adults views on systemic therapy after their initial sessions. This study included four clients two of whom were interviewed after one-off consultations, one interview was conducted after an assessment session with a couple, and one interview occurred within the first two sessions of ongoing therapy. The age range of participants was from 65-85 years. Some service users had negative expectations of therapy and utilised reference points such as the media and anticipated Freudian-like therapists. However, if significant others had had positive experiences of therapy this helped to shift their expectations. Regarding the reflecting team it was found that perceptions ranged from embarrassment to being regarded as helpful. Service users’ reflections on systemic questioning ranged from feelings of awkwardness to comfort. Not all participants felt that therapy had helped them view their situation in a different way or that it had helped them in any way. In particular the age of the therapist appeared to be very important to service users preferring an older therapist in addition to the qualifications of the therapist being valued.

Butler’s (2003) study only included the identified client individually or with his or her husband or wife. It might be significant to explore the impact of therapy on different types of “family” constellations and support networks that might present at an older adult family therapy service. In addition, Butler (2003) suggested that a study that has been conducted once therapy has been completed might allow participants a greater amount of time to reflect upon the process of the therapy and its impact. This might produce a richer description of family members’ experiences of therapy (Butler, 2003).

3.6 Aims of the present study:

The present study aimed to provide an in-depth service user perspective of family therapy at an older adult family therapy service in the South of England. This was facilitated through interviewing family members retrospectively after therapy had
been completed. This study used a qualitative exploratory design. It was anticipated that this would facilitate a rich description of what family members thought about the process of therapy. It was hoped that the findings could contribute to good practice with this client group in the local service and possibly the wider domain of systemic family therapy.

3.7 Research question:

The main research question was: What were the perceptions of family members of their experience of family therapy at an older adult family therapy service? More specifically this involved trying to understand their expectations of therapy, their relationship with the therapist and team, and the perceived impact of therapy.
4. Method:

4.1 Qualitative research methods

Qualitative research tries to understand the phenomenon being investigated as much as possible from the perspective of the individuals taking part (Elliott, Fischer & Rennie, 1999). As such this method of research is interested in the meaning that participants have given to a particular experience or event and the texture and quality of that experience (Willig, 2001). Qualitative research facilitates an enrichment and revision of current understandings rather than attempting to verify theory or research (Elliott, Fischer & Rennie, 1999). Therefore a qualitative research design was the most appropriate for the current study which was concerned with the meanings that participants had given to the experience of family therapy. Qualitative research emphasises the voice of participants and therefore complements the National Health Service agenda of prioritising the voice of the service user as a central component of service research, design and delivery (NHS Plan: Department of Health, 2000).

A phenomenological approach to qualitative research was used because it facilitated an exploration of participants’ experiences and the way in which they viewed the world (Barker, Pistrang & Elliott, 2002). Two methods of phenomenological analysis were considered: grounded theory (GT) and interpretative phenomenological analysis (IPA).

A criticism of grounded theory is its epistemological roots (Willig, 2001). It works with induction where observations allow new ideas to arise. However, a limitation of induction is a lack of emphasis on the role of the researcher such that it assumes that the data speaks for itself and that categories are just discovered. It has been argued that grounded theory is a form of inductivist positivism because it fails to acknowledge that all observations are subject to the observer’s position (Stanley & Wise, 1983).

Social constructionist versions of grounded theory have recognised that categories cannot fully illuminate a concept in its entirety and that the categories do not purely
emerge from the data but are constructed by the researcher through the process of the research (Willig, 2001). However, a social constructionist approach to grounded theory could possibly require more than simply recognising the important role of the researcher in the process but also a recognition of the role of language in constructing categories and therefore the notion of "discourse" (Willig, 2001). Research methods that focus on discourse have been critiqued for their limiting focus on the function of language. It has been suggested that for discourse analysts it is difficult to apply findings to the "real world" (Reid et al., 2005; pp. 21) because the real world itself is regarded as a construction. This is a limitation in relation to the purposes of the present study which seeks to apply the findings to systemic practice with older adults and their family members.

Whereas grounded theory was designed to facilitate research into basic social processes IPA facilitates insight into the psychological worlds of individual participants (Willig, 2001). Willig (2001) suggests that IPA is an explicitly psychologically based research method whereas grounded theory can be better applied to researching sociological questions. IPA was therefore considered the more appropriate method for the present study.

IPA facilitates a detailed investigation of participants' lived experiences and how they have made sense of these experiences (Smith, 2004). Willig (2001) suggests that in this way IPA takes a realist approach to the production of knowledge. Whilst being phenomenological in its involvement with participants' perceptions of events or objects, IPA also recognises the important role of the researcher in making sense of that experience. IPA states "access is both dependent on, and complicated by, the researcher's own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity" (Smith, 1996; pp. 264). Therefore the knowledge that is produced through IPA is reflexive in acknowledging its dependence upon the researcher's own viewpoint (Willig, 2001). The primary researcher has included her own reflections about her motivations, biases and assumptions about the topic area investigated later in this chapter.
IPA studies usually comprise small sample sizes (Smith, 2004) and aim to say something detailed about the perception and understandings of the group being studied rather than to make general claims (Smith & Osborn, 2008). It is therefore an idiographic mode of enquiry (Smith et al., 1995) and the recommended sample size is no more than 10 (n=8) (Smith et al., 1999).

Smith (2004) has discussed the different levels of interpretation that are possible when using IPA. He suggested that interpretation should be grounded in empathy and meaning recollection. At the same time IPA allows the researcher and reader to interpret the data using critical engagement whilst making suggestions or positing questions that “the participant would be unlikely, unable or unwilling to see or acknowledge themselves” (Smith, 2004; pp.46). A focus on meaning and critical questioning has been argued to allow a more complete understanding of participants’ lived experiences and ways of viewing the world (Smith, 2004). It was anticipated that this would allow a rich understanding of participants’ experiences of therapy.

4.2 Ethical approval:

Ethical approval was sought for an IPA project exploring family members and therapists’ perceptions of family therapy (please see Appendix A). The study presented here represents one part of this study, that of the perceptions of family members. However, it should be acknowledged that the primary researcher interviewed both therapists and clients. Ethical approval for the present study was gained from three bodies – the NHS Trust Research and Development Officer, the NHS Trust Research Ethics Committee and from the University of Surrey’s Ethics Committee. One of the original exclusion criteria for the study was that if the index client did not consent to participate in the study other family members would not be able to participate. However, it became evident that the health of some of the identified clients had deteriorated since participating in therapy and it remained important to hear the experiences of other family members that had participated in therapy. As a result an amendment was made to the inclusion and exclusion criteria and approval for the amendment was also sought (please see Appendix B).
4.3 Sampling and recruitment procedure:

Participants were recruited from an older adult family therapy service in the South of England. This sample was considered fairly homogenous in that participants shared the particular experience of having had systemic family therapy at a specialist older adult family therapy service (Smith & Osborn, 2004). This service works using mainly post-Milan and social constructionist approaches to systemic family therapy. In addition it is a teaching clinic where some therapists are in training to become systemic psychotherapists whilst other professionals work as therapists or reflecting team members in the service as part of the requirements for their continuing professional development. All therapists receive live supervision from a qualified systemic psychotherapist. The therapists of the families included in the present study included two psychiatrists and one clinical psychologist.

Exclusion criteria were developed for participation in the present study. These included:

- No family member could participate who had completed therapy more than 12 months ago. It was considered that it might make it more difficult to recollect the experience of therapy.

- No family member would be able to participate if they had cognitive difficulties impairing their ability to give consent or to reflect on the process of therapy. This was assessed by the family therapy clinic checking to see if cognitive problems were identified in the family case records, through GPs being written to (once consent had been obtained) and through discussion with family members.

- No family member would be able to participate who was considered too distressed or unwell to participate as assessed through correspondence with the GP or mental health key worker and through an initial screening procedure.

- No family would be invited to participate where there was evidence of
This left a fairly broad inclusion criteria and the Consultant Family Therapist at the older adult family therapy service reviewed a list of all families who had attended the clinic and completed therapy in the last 12 months. Eight families were identified that could potentially be included using the above exclusion criteria. The Consultant Family Therapist sent out the invitation letter (Appendix C) and information sheet (Appendix D) initially to the index clients (client for whom the original referral to family therapy had been made) in each family according to the original design of the study. The letter included a consent form and a stamped addressed envelope to the family therapy clinic for respondents to notify the primary investigator if they would like to meet with her for a preliminary meeting. The consent form also asked for consent for their GP or CMHT key worker to be contacted (please see Appendix E for copy of letter to GP). The purpose of contacting the GP and CMHT was in order to share risk and health information if necessary. Within the letter to potential participants it was explained that if the researcher had not heard from them within two weeks they would be written to again. If they did not contact the primary researcher after the second letter it was assumed that they did not wish to participate in the study.

Three families telephoned the clinic (having received the first letter) saying that they would like to participate and invited the primary researcher to telephone them in order to discuss the research. Two families explained that the index client would not be able to participate due to a deterioration in their cognitive functioning. Although the second letter (please see Appendix F) was sent out to families that had not responded to the first invitation letter no further replies were received.

4.4 Screening procedure:

Consent forms were received for the initial meeting with the researcher and the researcher telephoned family members who were interested in participating in the research, and arranged to meet with each individual family member in their home (as was their expressed preference) in order to discuss the research, conduct a short-screening procedure and gain informed consent (please see Appendix G for consent
form). It was anticipated that through meeting with family members on two occasions (once for the initial screening and once to conduct the interview) that participants would have time to think over their participation between the two meetings and that rapport might be built.

Through consultation with two Consultant Clinical Psychologists who worked with older adults it was advised that the General Health Questionnaire-12 (GHQ-12) (Goldberg, 1972) could be used as one part of the screening procedure (please see appendix (H) for the validity and reliability of the GHQ-12 and appendix (I) for a copy of the GHQ-12). Because participants had completed therapy up to twelve months prior to the interview the screening procedure was an opportunity to explore if participants were well enough to participate (as their circumstances may have changed since therapy) and to build rapport. Obtaining “caseness” on the GHQ-12 did not exclude potential participants from participating in the study. The GHQ-12, although a self-report measure, was completed out loud and afforded an opportunity for participants to share their current situation and means of support. Three participants shared they were in receipt of psychological support, one reported no difficulties, and two said their physical health problems were monitored by their GP. Thus scores obtained on the GHQ-12 were discussed and evaluated both quantitatively and qualitatively with the researchers’ university research tutor who is also a Clinical Psychologist. Clinical judgement was used to decide if participants could be included in the study.

The GHQ-12 results in a score of 0 to 12 for each individual. Goldberg et al. (1997) recommend that a score of three or more is defined as a case of a common mental disorder. Scores obtained ranged from zero to five with an average score of 3.17. Given the ongoing difficulties experienced by family members the scores seemed reflective of the ongoing adjustments family members were making. It was considered that all participants were eligible for inclusion in the study with no participants demonstrating risk or distress that meant that they could not calmly reflect upon their experience of therapy.
4.5 Participants:

Six participants, from three families, consented to participate in the research including two men and four women. All participants were interviewed individually. Please see table one below to view the basic demographic information of participants.

<table>
<thead>
<tr>
<th>Information category</th>
<th>Characteristics of those who participated in the interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>2 men, 4 women</td>
</tr>
<tr>
<td>Age</td>
<td>Range: 35-65 years</td>
</tr>
<tr>
<td></td>
<td>Average: 49 years six months</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>5 White British</td>
</tr>
<tr>
<td></td>
<td>1 White Dutch</td>
</tr>
<tr>
<td>Profession</td>
<td>2 retired</td>
</tr>
<tr>
<td></td>
<td>1 working</td>
</tr>
<tr>
<td></td>
<td>2 full-time carers</td>
</tr>
<tr>
<td></td>
<td>1 student</td>
</tr>
<tr>
<td>Marital Status</td>
<td>3 married</td>
</tr>
<tr>
<td></td>
<td>1 single</td>
</tr>
<tr>
<td></td>
<td>2 cohabiting</td>
</tr>
<tr>
<td>Identified client or family relation</td>
<td>1 identified client</td>
</tr>
<tr>
<td></td>
<td>1 daughter</td>
</tr>
<tr>
<td></td>
<td>1 daughter’s partner</td>
</tr>
<tr>
<td></td>
<td>1 husband</td>
</tr>
<tr>
<td></td>
<td>1 wife</td>
</tr>
<tr>
<td></td>
<td>1 son</td>
</tr>
<tr>
<td>Identified mental health problem</td>
<td>1 Bipolar Depression</td>
</tr>
<tr>
<td></td>
<td>1 personality disorder and cognitive difficulties</td>
</tr>
<tr>
<td></td>
<td>1 memory difficulties (later diagnosed as Alzheimer’s dementia)</td>
</tr>
<tr>
<td>Family members who attended therapy</td>
<td>1 couple (Isobel (GHQ score 4) and Mike - Mike (aged 71) was not able to participate in the study)</td>
</tr>
<tr>
<td></td>
<td>1 couple and son (Samantha (GHQ score 3), William (GHQ score 0) and Gary (GHQ score 4))</td>
</tr>
<tr>
<td></td>
<td>1 couple and father (Charlotte (GHQ score 5), Lisa (GHQ score 3) and Danny – Danny (aged 68) was not able to participate in the study)</td>
</tr>
<tr>
<td>Number of therapy sessions attended</td>
<td>Range: 2-7</td>
</tr>
<tr>
<td></td>
<td>Average: 3.5</td>
</tr>
</tbody>
</table>
4.6 Data collection:

4.61 Semi-structured interview:

Smith & Osborn (2008) have suggested that the use of a semi-structured interview allows power to be shared more equally between interviewer and interviewee as the respondent can influence the direction the interview takes and introduce to the interviewer issues not covered by the interview schedule. It was anticipated that using a semi-structured interview would allow the researcher to build rapport in addition to being flexible and producing a richer set of data (Smith & Osborn, 2008).

A semi-structured interview was developed in consultation with both the primary investigators University Research Tutor and her field supervisor who was the Consultant Systemic Psychotherapist at the older adult family therapy service. Both are experienced clinicians within the field of systemic family therapy. Discussion involved thinking about the broad area that might be covered in relation to people's experiences of therapy without using closed or leading questions. In addition the researcher reviewed relevant literature and reflected on her own experience of working in family therapy. Once the interview schedule was compiled the questions were again discussed with both the University Research tutor and the Consultant Systemic Psychotherapist at the older adult family therapy clinic. Adaptations were made based on the feedback received. The main topics covered in the interview included:

1. Expectations of therapy
2. Initial impressions of the therapist and team and if this changed over time, what it was like being in therapy together, and if he or she felt able to say everything they wanted.
3. How they thought therapy had affected their lives and those of family member's.
4. Debrief after interview and feedback about what it was like participating in the interview.

Please see Appendix J for a copy of the semi-structured interview.
4.62 Interview procedure:

Interviews were completed individually in the homes of participants as requested. Family members were interviewed individually in order that they felt free to express viewpoints that they may not necessarily wish to disclose in front of other family members. Each interview lasted approximately 45 minutes to 90 minutes with breaks as requested. Interviews were audio recorded so that they could be transcribed verbatim. All identifying information was anonymised at the time of transcription. Each participant was given a £20 Marks & Spencer voucher to thank them for their participation.

4.63 Ethical considerations:

It was possible that talking about the experience of therapy might have caused participants distress. In consideration of this, the semi-structured interview was specifically designed in order that there was a focus on process rather than content issues. Each participant was given time to de-brief after the interview and to talk about how they experienced the interview and how they felt as a result of participating. In addition if any issues that arose during the interview or screening procedure which caused the researcher concern, these would be discussed with the participant and consideration given to informing their GP and the family therapy service. Participants were advised to contact their GP if they experienced distress, as a result of participating in the interview, and were given a list of supportive telephone numbers. They were also informed that they could withdraw from the interview at any time. Participants were reminded that the interview was anonymous and confidential and that findings would be discussed anonymously with the researcher’s supervisors. They were informed that participating in the research would not impact future services they might receive from the family therapy clinic specifically or the National Health Service.
4.7 Data analysis:

There are guidelines for using IPA which are intended to be adapted and developed rather than being formulaic or prescriptive (Smith, 2004). The primary investigator read one of the transcripts and then re-read it making notes in the left hand margin about important processes and phrases that summarised the content or revealed contradictions or differences within or across the transcript and tentative interpretations. The researcher then returned to the beginning of the transcript and used the notes in the left hand margin to document themes which were consistent with the data in the right hand margin. This was continued throughout the whole transcript. The themes that emerged in the right hand margin were then listed on a separate piece of paper in a chronological order. The researcher then looked at which themes clustered together as master themes (Smith & Osborn, 2004). As the themes were clustered the researcher checked and re-checked with the participant’s original transcript to check that the connections reflected what was said. The master themes were then named and put in a table ordered so that it reflected the process expressed by the participant. The researcher then read the next transcript and repeated the process being mindful of the themes that emerged from the first case whilst looking for divergences and convergences in the data. Once each transcript had been analysed using this interpretative process a final table of master themes was constructed. This required an iterative process whereby if different themes arose from later transcripts the researcher revisited earlier transcripts in the light of these new themes. Please see Appendix K for examples of annotated transcripts and appendix L for an example of an interview transcript.

4.8 Criteria for evaluating the quality of the research

Various authors have suggested how the trustworthiness and quality of qualitative research might be evaluated (Elliott, Fischer & Rennie, 1999; Salmon, 2003). There is no unified agreement about how qualitative research should be assessed as being good (Salmon, 2003) or trustworthy. However, the present research will attempt to use Elliot, Fischer & Rennie’s (1999) guidelines, which are particularly comprehensive, in order to try and address issues of quality and trustworthiness.

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4.81 Owning one’s perspective:

Elliot, Fischer & Rennie (1999) suggest that the researcher should make explicit his or her own personal, theoretical and research orientations and experiences. At the beginning of the research and throughout the process of completing the project the researcher noted her own assumptions, expectations, motivations and beliefs which are highlighted in the self-reflective summary at the end of this chapter.

4.82 Situating the sample

The researcher has provided basic descriptive data about participants whilst maintaining confidentiality and anonymity.

4.83 Grounding in examples

The researcher of the present study has provided substantial direct quotations from the interviews which are representative of each identified theme. In addition examples of annotated pages of transcripts and an entire interview have been included in the appendices.

4.84 Providing credibility checks:

Elliott, Fischer & Rennie (1999) recommend that researchers check the credibility of their accounts or themes. In the present study this was achieved through the primary researcher discussing themes with the university research supervisor who has extensive experience in family therapy and qualitative research with him looking over the primary analysis and supporting data. In addition themes and interpretations were given in writing to participants who were invited to give feedback.

4.85 Coherence:

Findings are presented to form a coherent narrative and in order to facilitate a greater
understanding of the experience of therapy whilst maintaining the nuances of the findings (Elliott, Fischer & Rennie, 1999). The findings of the study are presented showing master themes for participants whilst the analysis also shows the similarities and differences between participants.

4.86 Accomplishing general versus specific research tasks:

A specific research task of this project was to explore the perception of therapy as experienced at a specialist older adults’ family therapy service by family members. Six family members participated and so their specific experiences are explored. Therefore this research represents a sample of client experiences at this particular service.

4.87 Resonating with the reader:

It is anticipated that the way in which the findings have been described and presented brings to life the experience of participants. It is hoped that the findings are of interest to those who have experience of both providing and receiving therapy.

5. Self reflexivity:

In this section I will be using the term “I” to refer to myself as the primary researcher in order to reflect upon my initial assumptions, biases, motivations and experiences related to the current research project.

I am a twenty eight year old White British woman in her final year of training to be a Clinical Psychologist. I embarked upon this research project due to my interest in and experience of working systemically. In my first year of training I was a member of a reflecting team in a systemic family therapy service for adults from age 18 to 64 years of age. This was based at the same clinic as the current study was conducted. However, I did not feel that I was conducting research on the work of a service that I knew well as the older adult clinic was completely separate to that of the working age adult clinic I had worked in. I did not know the staff working there other than my field supervisor who I also conducted an interview with in order to gain greater
understanding of the work of the clinic (please see Appendix M and N). I interviewed therapists at the clinic as part of a wider study about the work at the service and I was aware of the need to try and bracket what therapists had said when analysing the data of family members. This did not prove challenging as I became fully immersed in the data of family members facilitated by forming a strong relationship with participants enhanced by the two meetings with each family member and through discussing with them the findings of the study.

Throughout my training I have been interested in attachment theory. It has been a useful way for me to consider the individual and family cases that I have worked with in addition to reflecting on my own attachment history. This interest has continued into my final year whereby I have elected to have my final placement divided between an older adult community mental health team and a specialist psychodynamic psychotherapy service. Within my older adult placement I have noticed the continued importance of families for older adults and that attachments formed early in life and early traumas continue to have an impact throughout the life course. Thinking about attachment and the issue of containment has also been at the forefront of my mind in my psychotherapy placement. The therapeutic relationship has been something that I have been interested in since before training and my interest in this particular and, I believe, fundamental aspect of my work is one of the reasons that I was drawn to exploring service user perceptions of therapy. I was aware of my biases in analysing the data and it was therefore important for me to consider other ways in which the data could be interpreted through discussions in a qualitative research group and with my university research supervisor.

I anticipated that that a number of complex issues would be present in the experiences of participants in the research and I felt that in order to do justice to them and hear their voices that a qualitative methodology, specifically IPA would be most appropriate. Whilst being aware of the amount of time that qualitative research can consume, I also thought that it could be a potentially rewarding project and one where I would be privileged to listen to the perspectives of family members. I enjoyed meeting and interviewing family members and discussing the findings with them. It seemed that being involved in the project conveyed to participants that their voices
were valued. This aspect of the project was very rewarding. I did feel very privileged that family members had spoken to me so openly about their experiences of therapy and their difficulties which led them to attend. Having completed this research project, I continue to value systemic psychotherapy but also have a greater awareness of the complexity of the process and when working with older adults and their family members.
5. Results

From the analysis of the data, three main themes emerged: ambivalence about engaging with family therapy; facilitative aspects of therapy and constraints to change. Although these themes were distinct in their categorisation there was considerable overlap between themes. Some sense will be made of the extent to which findings were common across interviews or reflected the nuances of one or two interviews. Quotes of participants are presented in italics. The use of [...] indicates the author’s break in the text and the use of bold indicates when participants raised their voice to give particular emphasis. Text surrounding participant quotes contains the author’s narrative report of the findings which includes tentative interpretations (Reid et al., 2005). Some quotes are presented more frequently from particular participants due to them succinctly expressing the particular theme or sub-theme described or because the theme/sub-theme discussed had more relevance to them. Please refer to table two below to see the compositional structure of the IPA themes. The themes will be explained below.

Table 2: Compositional structure of the IPA themes

<table>
<thead>
<tr>
<th>Thematic level</th>
<th>Theme title</th>
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<tbody>
<tr>
<td>Main theme</td>
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<tr>
<td>Sub-theme</td>
<td>Potential costs of engaging with therapy</td>
</tr>
<tr>
<td>Sub-theme</td>
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</tr>
<tr>
<td>Main theme</td>
<td>Facilitative aspects of therapy</td>
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<td>Sub-theme</td>
<td>The experience of the relationship with the therapist</td>
</tr>
<tr>
<td>Sub-theme</td>
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<tr>
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<td>A space to talk, listen and understand</td>
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<td>Main theme</td>
<td>Constraints to change</td>
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<tr>
<td>Sub-theme</td>
<td>Difficulties negotiating the tasks of therapy</td>
</tr>
<tr>
<td>Sub-theme</td>
<td>Time constraints</td>
</tr>
<tr>
<td>Sub-theme</td>
<td>Limitations to the perception of safety</td>
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</tbody>
</table>
5.1 Ambivalence about engaging with family therapy:

Four out of the six participants seemed to describe what they thought might be both the costs and benefits of engaging with therapy. It seemed that the potential costs of engaging with therapy existed in parallel to the potential benefits. This was interpreted by the researcher as reflecting ambivalence about engaging with family therapy.

5.12 Potential costs of engaging with therapy:

Four out of the six participants appeared to hold some apprehensions about engaging with therapy. This apprehension was regarded as the costs or negative aspects of engaging with therapy. The potential costs of engaging with therapy included feeling that therapy could be a source of stigmatisation; that the therapeutic environment might not be safe; and that therapy might not be effective.

Both William and Gary discussed concerns about the potential for stigmatisation through association with mental illness and mental health services. William explained that he preferred to keep family difficulties within the boundaries of the family:

[...] when the wife's ill I don't tell them at work and I go sick for a few days [...] well, as far as I say well, no one at work knows. And this is how it's been over the, you know it's been going on for years, it's been going on you know? I prefer it that way myself –

It appeared that William feared that his work colleagues would judge him for having a wife with mental health difficulties. William was the only participant who had not experienced therapy before although he had extensive experience of mental health services due to his wife's illness. Gary also referred to the stigma related to mental health difficulties and suggested that the word "therapy" itself can hold negative connotations which can result in prejudice:
Yeah, yeah I think a lot of people get this pre-assumption that as soon as you say “therapy” there’s a problem.

For Gary and William there was the suggestion that accessing therapy was a disappointment and was perhaps perceived as failure:

[…] disappointed that, from my point of view that we had to do it, cos you know. […] Well, I mean you know, really from my point of view you should sort things out amongst yourself you know, but…(William).

Not only were fears about social judgements identified in some accounts but four participants also feared whether or not the therapeutic environment itself would be safe. This seemed to relate to a lack of certainty about what other family members might say and what the therapist could ask. Gary expressed being particularly worried about how therapy might affect his parents and issues that might be discussed:

[… ] counselling […] hits you after you know […] I didn’t know if my mum would deal with it properly or how my dad would deal with it. […] I just thought it might have brought up things that maybe should be buried and forgotten really.

Similarly, Samantha who, like Gary, had some experience of counselling, seemed apprehensive about how intrusive the questions might be. However, her fears seemed to be allayed after she had experienced family therapy:

Counselling can be a difficult thing because you don’t know what to expect. But when I went there it was so friendly and not first of all not deep down questions […]
Four participants doubted whether therapy would be of any benefit. Such doubt was particularly evident within Isobel’s narrative. Isobel and her husband Mike had had family therapy several times over the course of their marriage. On this occasion Isobel explained that they had accessed therapy due to her husband’s memory problems. She explained that her reluctance to engage with therapy, on this occasion, related to her previous experiences of therapy:

\[
\text{[...] each time we had been in on previously it hadn’t really done an awful lot for us and I had my doubts about it whether it was going to be a waste [...]
}\]

The apprehension that family therapy could be ineffective not only related to previous experiences of therapy but also to family members mental health at the time of therapy. For example, Isobel was concerned that due to her husband’s memory problems therapy might not have been a good idea at the time:

\[
\text{[...] but I already had my doubts again because my husband was (coughs) although he was not then officially diagnosed as er, as Alzheimer’s because that only happened after, you know scans, and various tests that they do [...] but you see he already had this fading memory so some of the things that he said were just not so [...]
}\]

Two other participants expressed a similar fear that therapy might not be beneficial due to the poor mental health of the index client within their family.

5.13 Potential benefits of engaging with therapy:

All participants expressed what they hoped to gain through engaging with family therapy and this was defined as the potential benefits of engaging with therapy. Hopes about the benefits of therapy were varied and seemed to be related to the specific difficulties and needs of each family as a whole and the needs of individual family members. Participants’ hopes for engaging with therapy resided in parallel to
their doubts about engaging with therapy. For example, although Isobel had expressed doubt about the benefits of engaging with therapy, hope was also prevalent throughout her interview. It appeared that this residue of hope was the motivating factor that had enabled her to re-engage with family therapy:

But I was always hoping that the experts would be able to solve sort of making things- [...] And that is why time, and time again I said “okay let’s go for it again” [...] 

Isobel’s hope for therapy was particularly evident when she talked about her husband and the potential that she continued to see within him. The emotionality of her hope appeared especially significant:

[...] I felt I had to hold on because I feel inside him there was this little, sensitive, little boy who from circumstance – [...] And that’s also I think what gave me the hope [...] on occasion he will come out with things and I then I think yes but you have got all these feelings and why did you fucking well hide them! (crying)

It appeared that Isobel remained in touch with the little boy within her husband and continued to hope that he might be able to share his feelings. The emotional quality of Isobel’s hope was also evident in Lisa’s narrative when she tearfully described her hopes for her relationship with her father.

All participants expressed hope that accessing family therapy might facilitate understanding between family members. Gary, for example, explained that he hoped that therapy might offer some understanding about the difficulties experienced within his family particularly in relation to his mother’s long-standing mental health problems:

Why as in why it all happened why has it been like this for the last twenty-five years? [...] why has it affected everyone, you
know? Why has it, why does, why does my mum get like that

[...]

In addition it seemed that perhaps his hopes about the potential benefits of therapy outweighed his doubts because he felt that his resources for coping were depleting:

We just all opened up: to be honest we were just like fed up with it. And I was fed up with it as well because like I, I've had problems and that with mental health as well and I was getting a bit fed up with dealing with my mum's stuff as well as my own.

It seemed that some participants felt their families were experiencing a crisis and perhaps a reduction in their resilience at the time of referral to therapy. For example, William explained that despite his hope that family difficulties would remain within the family he was “fed up” with his wife’s accusations when she was unwell:

[...] I've been, I mean as I said trying to keep it within the family but I mean the fact last time I was a bit fed up being accused of things.

Perhaps for William the potential benefit of doing something about what was happening when his wife was ill outweighed his apprehension about the potential stigma of accessing mental health services.

Charlotte and Lisa, in their individual interviews, were the only participants who did not express any doubts about engaging with therapy. However, Charlotte perceived that there was ambivalence about engaging with therapy within her family:

[...] I was over optimistic as to what they could offer us [...] I felt that she had a much more realistic view than what I did of how it was gonna be. She didn't expect anything from it so getting nothing wasn't so much of a let down.
It seemed that on reflection Charlotte perceived that she had more to lose from engaging with therapy as she had expected more from it. In contrast she perceived that her partner Lisa did not expect much from therapy so faced less of a disappointment.

5.2 The facilitative aspects of therapy:

All participants talked about how they thought they had benefited from participating in family therapy. For some participants facilitative aspects of therapy included the experience of the relationship with the therapist and the opportunity to hear different perspectives through the use of the reflecting team. Participants also talked about how they thought therapy had acted as a space within which they could listen and talk to one another. For some family members this appeared to have facilitated some understanding about themselves and other family members.

5.2.1 The experience of the relationship with the therapist:

Four participants discussed how they perceived their therapist. In particular, it appeared that therapist warmth and credibility were particularly significant. Gary reflected on his experience of the therapist and appeared to contrast his experience of family therapy with his previous experiences of therapy in a more positive light:

*I mean my experience of therapy isn't great but erm, er it was just different in the way that erm what she said er, it was just like talking to a friend or something you know, which was a good thing cos you could open up a bit to her.*

Having a therapist who conveyed herself as friendly may have enabled Gary to talk openly to her. Similarly, William's description might suggest that he experienced his family therapist as being in tune with family members needs:
Yeah I thought, I thought she got more sympathetic which is what was needed I think, you know.

Samantha, who was an inpatient at the time she accessed therapy, also seemed to experience the therapist as particularly friendly and it seemed important to her that the therapist acknowledged her when she saw her on the hospital grounds:

*Oh she was a lovely person! They was all nice. [...] Oh, but she was lovely. [...] And when we was out or wherever I was she would always say hello to me.*

The importance of the therapist representing a caring figure also appeared to be present in Isobel’s narrative. She explained that each time she went to therapy she hoped that the therapist might be more expressive and in-tune with her feelings:

* [...] at the one level rationally I realise it is ultimately for the best and it is not a good thing to have somebody there who is constantly, you know sort of with your mood or the other person’s mood you’re with [...] but the other hand I’m hoping might be like that – you know what I mean?*

From Isobel’s narrative it appeared that whilst expressing hope for a therapist in-tune with her mood, she rationalised why this might not be beneficial. However, despite hoping that her therapist might be in tune with her mood Isobel recollected that her therapist was:

* [...] doing it on the intellectual side and she was leaving out any emotional side [...]*

However, Isobel explained that this may have been beneficial to her husband enabling him to regard the therapist as “capable”: 180
I think it did work for my husband because he probably respected that you know that she was, that she was, that you know, she was quite, that she was clever, she came across to him as very clever and so on and, and must be capable.

It appeared that although Isobel did not have her expectations about the qualities of the therapist met she was able to identify aspects of the therapist that may have suited her husband’s needs. Perhaps this highlights the difficulty of one therapist being able to meet all family members’ needs. It may seem that this aspect of Isobel’s experience of therapy should be placed within the theme “constraints to change”. However, it has been placed here to highlight that whilst the qualities identified in the therapist were not what Isobel hoped for it was rationalised as perhaps for the best because it was facilitative for her husband. It should be acknowledged that the mismatch between Isobel’s expectations of the therapist and her actual experience may have been a constraint to change and to her experience of therapy on this occasion.

It was noted that in Charlotte and Lisa’s interviews they did not refer to the qualities of the therapist but referred to the “team”. It is possible that they did not view the therapist as separate from the reflecting team.

5.22 The experience of the reflecting team:

All family members talked about the value of the reflecting team although Lisa and Charlotte also discussed some difficulties with the team they worked with which will be discussed under the theme “constraints to change”. Participants particularly appeared to value hearing diverse perspectives. William explained that he was receptive to the presence of the reflecting team and that he found it valuable:

[…] I thought it was a good idea in a way you know cos I mean you know like yourself you know what you think but you, you might get more feedback from other people, you, you know
William appeared to value the different perspectives shared by the team. Gary explained that the very fact that team members had listened to what family members had said and were able to repeat it back allowed him to have the experience of being understood:

*You know in a way that erm, they understand you, they you, being able to erm, recite what you just said yeah, that sort of element of being understood is quite nice, yeah.*

In addition to hearing different perspectives from team members it was noted that it was helpful when the team itself had a diverse membership. For example, Isobel talked about how she thought that the presence of a man in the team was important for her husband:

*...so I think he was rather pleased that there was a man there someone who could sort of give a man’s interpretation of what he had viewed and heard you know when we were talking to the therapist.*

Isobel recollected that a member of the team had some of the warm qualities that she had expressed as being absent in her therapist:

*...she had this very reddy, smiling face and I think she was the one I would really, I, I felt very, I, I thought well, hmm, if you would be in that chair, like that you know (laughing). She was warm, yes, she was warm, she was warm she was cuddly* ...

Perhaps Isobel imagined what therapy might have been like had this team member been the main therapist. Diverse team membership was also valued by William who explained that it could have been beneficial if the reflecting team comprised a more diverse age group:
Probably could have done with a young, young person there you know really. [...] A different viewpoint more I think. Twenty years is say a different generation- [...] You know it's they've got different ideas than say my generation which I think helps you know.

In addition to family members valuing hearing diverse perspectives on their situation, Charlotte recollected that she was particularly struck by how effective it was that the team's reflections were given in an indirect manner:

[...] we just thought what brilliant therapy this is great we're listening about us [...] when things are directed at you, you naturally put a defence up [...] And from that we just from that thought "we're gonna use that at home" whether it's about the kids, whether it's about Danny and we use it all the time.

Charlotte seemed to identify that the indirect way in which the reflecting team worked was particularly beneficial and that it was a technique that she used at home with her father-in-law and children.

5.23 A space to talk, listen and understand:

From the recollections of some participants it appeared that therapy had facilitated a place to talk and listen and for some this led to greater understanding about other family members and about themselves. Three participants referred to therapy leading to greater understanding. For Isobel this included seeing different sides of her husband within the therapeutic environment:

[...] but I think the pockets of, of feeling that I have for him, [...] in therapy I have been able to see other sides of him which I haven't been able to see of him at home. So I have
been able to sort of take that on board and to store it somewhere then occasionally it sort of surfaces, you know [...] 

It seemed that in therapy Isobel discovered feelings for her husband in addition to seeing other sides of him. She had been able to store these feelings away which occasionally resurfaced. Perhaps these stored feelings existed as a resource for Isobel to draw upon.

For Gary it appeared that therapy had facilitated a different understanding about his mother’s illness. He described thinking about family difficulties in a different way whereby they were not just located in his mother:

Maybe it’s all of us that are having an affect. [...] Yeah it opened up possibilities that it’s not just mum’s fault and it’s not her fault anyway but it’s all of us.

The experience of hearing one another’s perspective appeared to be particularly significant for nearly all family members. Gary described this experience succinctly:

[...] we usually just talk about general things but we were talking about issues that we haven’t talked about in the past. [...] Yeah which was a very sort of rare moment really.

The value of talking and listening as a family was valued by all family members. Lisa recollected that she thought that this was of benefit to her father:

I could talk as I am now and my dad could see that I was being honest about how is, how I am, how we are, and um it helped a little bit that way.

Perhaps Lisa’s felt that her father seeing that she was being honest was a demonstration that she was trying to work at their relationship.
Similarly, it appeared that therapy had enabled William, who initially had explained that he adhered to the family rule of keeping things within the family, to see that talking was perhaps a good way of dealing with difficult issues rather than avoiding them:

"Probably we were talking about it more, you know, whereas over the years, we've probably just, as things got better, we just think oh well that's history, just carry on you know—[...]"

5.3 Constraints to change:

 Whilst family members were able to recognise the facilitative aspects of going to therapy, all family members noted constraints to the extent to which family therapy contributed to change. Family members spoke about aspects of therapy that they perceived as less beneficial and may have made change more difficult for the family. This included difficulties negotiating the tasks of therapy, time constraints and limitations to the perception of safety.

5.31 Difficulty negotiating the tasks of therapy:

 Both Lisa and Charlotte explained that there was a mismatch between their expectations about the tasks of therapy and those of the team they worked with. This sub-theme was not evident in the interviews of other participants. The tasks that were difficult to negotiate included both the goals of therapy and the end of therapy. Lisa explained that there was a mismatch between her expectations about where change might be possible and the expectations of the team she worked with:

"[...] but, they kept saying it won't change. But we know he won't change but there is room for improvement. [...] He's still, he's changed more now in the last three years than, than, the years of his life, the other years of his life. [...] No they,
they, they think that just because he has got a personality disorder [...] 

This extract suggests that Lisa had identified that there had been changes in her father's behaviour and had hope that there might be continued improvement. However, her perception that the team had suggested that her father could not or would not change appeared particularly emotive for her. It seemed that Lisa felt that the professionals were basing this judgement on her father's diagnosis of a personality disorder.

Charlotte also stated that she felt there was a mismatch between her expectations of therapy and those of the team. In particular a mismatch appeared to occur in relation to the ending of therapy:

[...] if they'd said to us at the beginning this is our last session we could have said hang on a minute we haven't addressed any of the issues we've raised [...] 

It seemed from Charlotte's description that the ending of therapy was unexpected and that the issues that she had wanted to be discussed had not been raised. Charlotte emphasised the difficulties that she strongly felt needed addressing but had not been:

And I kept saying to them you don't understand that from the moment my partner's mother was on that floor she has taken over the role of her mother she hasn’t had time to grieve. [...] every morning she gets up the first thing she thinks is “I better ring my dad oh why have I got to do that – because my mum’s dead”.

The unexpected ending of therapy may have mirrored the unexpected loss of Charlotte’s partner’s mother and the changing dynamic of family roles due to becoming carers. The perception of an unexpected ending may have been in direct conflict with Charlotte’s wish to be treated “equally”:
I wanted, I didn’t want really to be I didn’t want to feel that I was being fobbed off. I wanted to go in there equally you know as a service provider and service user.

Similarly, Lisa talked about her experience of the ending of therapy and it appeared from her narrative that she felt that the team had ulterior motives for ending therapy:

[...] on the last session they said what we, what me and Charlotte have done for my dad taking him out [...] That was okay but I feel like they were passing the buck a bit like, you know, to make us feel good so we can stop a bit, like.

It seemed that the team had praised Lisa and her family for the way that they had helped her father. However, Lisa perceived that the team were perhaps doing this in order that the therapy sessions could come to an end. This might suggest that Lisa thought that the team was working to its own agenda rather than to the agenda of the family. The unexpected ending of therapy seemed to leave a negative stain upon Charlotte’s experience of therapy:

[...] my opinion of the process changed after the last session when we left [...]. And then when we came out and then a day later Lisa sort of went “you do realise we’ve been fobbed off” I was like “yeah, we’ve been fobbed off”. They have made us feel so wonderful what have we actually left with?

Charlotte may have felt discarded by the team in her use of the term “fobbed off” in addition to a sense that they had left empty handed because all issues had not been addressed.
5.32 Time constraints:

Time constraints on therapy were defined as including the timing of therapy in relation to family member's mental health; the scheduled time of sessions and the number of sessions offered. Gary explained that he thought that the timing of therapy in relation to his mother's mental health was perhaps not beneficial to her:

Yeah, yeah, cos she was going off in different directions and to the questions that they were asking so I didn't think it was beneficial to her [...].

Three other participants also explained that the poor mental health of family members was a constraint to the process of therapy. However, Samantha recalled that her daughter thought that when she went to therapy she was not well enough to benefit. This seemed to upset Samantha particularly as her daughter was unable to attend therapy:

And my daughter said the other night, which I thought was a bit of a cheek [...] but she said I think Mum when you first started it, when you started it you wasn't well enough to do it. But I thought to myself how does she know? – She wasn’t there.

This may reflect the complex nature of family therapy whereby family members may have different perceptions about what is and is not beneficial and when therapy may be of more or less help.

A further perceived time constraint was that therapy sessions were scheduled during the working day:

That was the only thing I could say against it was the time factor, you know, there doesn't seem to be any allowances for people working (William).
For family members who were worried about the potential stigma associated with accessing mental health services having to take time off work to attend sessions may have made regularly attending difficult. For some family members the fact that all family members could not regularly attend led them to question if this really was “family” therapy:

Yeah that was the main concern I had was that you know it was either me and my mum and my dad sometimes and my sister wasn’t there, she couldn’t make it. So it wasn’t really family therapy in the end it was sort of like a bit of this, bit of that sort of thing (Gary).

Perhaps the term “family therapy” implies that all family members should be present.

Five participants said that more sessions would have been helpful. Gary explained that from his point of view, given the length of time that his family had been experiencing these difficulties, a greater number of sessions were required:

And when you’ve got something like family like this family’s been had like had the mental health thing in the family for a long time about 25 years now you can’t really resolve that in about 6- 4 or 5 sessions you know I think it takes a bit longer than that so you know […]

Perhaps there was a perception that the number of sessions offered had not taken into account the length of time in which families had been coping with their difficulties.

5.33 Limitations to the perception of safety:

Limitations to the perception of safety was defined as including difficulties being open in front of other family members both in therapy and at home and the long gap between sessions. Both Isobel and Gary discussed the difficult task of being open
with family members both at home and within the therapeutic environment. Isobel considered why therapy had not benefited her and her husband as much as she thought it helped others:

 [...] a lot of people they go in and things are a hell of a lot better. [...] perhaps because both of us don’t want to [...] Erm, and maybe because we felt that if we really do let go and make ourselves more vulnerable vis a vis the other person that we are, are frightened [...] [...

It appeared that Isobel was using a form of social comparison to consider why others benefited from therapy where her and her husband had not. One of her considerations appeared to be whether or not her and her husband really wanted to do things differently or if perhaps they were too scared to act differently and perhaps make themselves vulnerable in front of one another at home. This might suggest that Isobel’s ambivalence about the benefits of engaging with therapy remained with her.

Gary also talked about the extent to which family members felt able to express themselves within therapy:

 [...] it’s erm a good thing after years to have it in groups but have it separate as well. So that the real issues can be aired. Cos you’re, you know you’re gonna have reservations [...] [...

This may suggest that although Gary had referred to the friendliness of the therapist, and had noted that his family had been able to talk about some issues that they had never talked about before, some issues might still have been more appropriately discussed between individual family members and the therapist.

Four participants referred to the amount of time between sessions. Although this might be considered a time constraint rather than a limitation to the perception of safety it was interpreted as being related to safety. For example, Charlotte discussed how she felt about the amount of time between sessions:
They don't have another appointment for another six weeks. So you’re talking about three months between. [...] Cos I'm thinking okay well we could kill each other within this time or Danny could be going back into crisis or, what do we do for six weeks?

It seemed that for Charlotte the large gap between sessions appeared somewhat dangerous and that it was unknown what could happen to the family in this time period.

5.4 Outcome from credibility checks:

Family members were sent summaries of the findings of the study (please see Appendix O). The findings were discussed with participants’ over the telephone and appeared to fit with the analysis.

In relation to the master themes and sub-themes identified participants referred to them as “thorough”, “complete”, and “accurate”. Participants largely referred to the aspects of the service they thought could be developed to better meet their needs. In particular this referred to the long gap between sessions and the time of sessions.

William asked if sessions could be scheduled in the evening. In addition Gary thought that his family seemed to be offered sessions when a family member was unwell which meant that it was difficult to hear the perspective of this family member. It was suggested that if family members could be seen individually they might feel more able to talk openly. Gary and William reflected on their ambivalence about engaging in therapy particularly referring to hope and the “depleted resources in the family” and the fact that difficulties had become “debilitating”.

Charlotte and Lisa expressed that they felt that the family therapy service was “thin” and did not justify the amount of money that they understood that such sessions cost. They reflected hearing the expression that “counselling is like a tangled ball of wool and that together we must try and untangle this ball of wool one strand at a time”.

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However, they felt that in the sessions the beginning of the ball had not been found to start the process of untangling it. They identified the difficulties with the service as related to the lack of resources available in relation to the number of service users requiring services.

Isobel said that she particularly recalled feeling ambivalent about the benefits of therapy "as I was doubtful but at the same time hopeful it might help my husband and thus our own relationship". She noted that the therapist was very competent.
6. Discussion

This chapter will review the findings of the present study and compare it to the findings of previous research and psychological theories. A critique will be offered in addition to recommendations for future research and a discussion of service implications.

6.1 Ambivalence about engaging with family therapy:

Participants' hopes about the potential benefits of engaging with therapy appeared to exist in parallel to the perceived costs of engaging with therapy. This was interpreted by the researcher as indicating ambivalence about engaging with therapy.

The ambivalence expressed by family members was similar to Miller & Rollnick's (2002) notion of the "decisional balance" whereby individuals might experience competing motivations because they can identify both benefits and costs associated with the conflict they are in. Ambivalence can be very complex and frustrating and Miller & Rollnick (2002) suggest that it can continue to be experienced no matter what option a person decides to exercise.

6.12 Potential costs of engaging with therapy:

In the present study the potential costs of engaging with therapy included that therapy could be a potential source of stigmatisation; that the therapeutic environment might not be safe; and that therapy might not be effective.

Beck et al. (2006) found that family members sense of safety was determined more by within system (family) factors than between system (between family and therapeutic team) factors. This included mistrust within the family, cross blaming and concerns about privacy with some family members feeling that there were some issues that should not be shared in therapy. The within system alliance has been defined as including family members working together on common family goals and to improve family relationships; individual family members valuing time spent in therapy; and a
sense of working at change together (Friedlander et al., 2006). Perhaps before going
to therapy family members, in the present study, may have felt uncertain about what
other family members wanted to work on and discuss. In addition, concern was
expressed by participants about the mental health of the identified client within their
families at the time of therapy. This may have resulted in family members wondering
if it would be possible to work collaboratively to establish, and work on, therapeutic
goals.

In contrast to Beck et al.'s (2006) study the present study found that it was not only
within-system factors that contributed to fears about safety. Some of the participants’
expectations of family therapy, in the present study, appeared to be based on their
previous experiences of therapy. All participants in the present study had had
extensive experiences of mental health services generally and only one participant had
never experienced therapy before. Some family members were apprehensive about
the questions that might be asked and noted that the impact of therapy can hit you
afterwards. Perhaps this led family members to wonder if they would be able to cope
with these difficult feelings and issues outside of the therapeutic environment.

Some family members particularly referred to the stigma of mental health difficulties
and accessing mental health services. It has been found in previous research that a
perception of stigma and prejudice resulted in the coping mechanism of secrecy and
concealment in families (Lefley, 1992; Wahl & Harman, 1989). This can result in
families not receiving the social support they need. A contributor to the stigma
experienced in the present study may have been that the family therapy clinic was
located on the site of a large mental health hospital. Participants did not refer to the
stigma associated with being older or of accessing an "older adult family therapy
service". This could have been due to the number of years that family members had
been accessing mental health services and as a result perhaps did not regard this
service as being different to those accessed at other stages of the life course.
6.13 Potential benefits of engaging with therapy:

Kelly (2002) in her unpublished dissertation (cited by Anderson, 2005) explored what motivated older adults participants to begin therapy. She found that family members felt desperate and attended because they had run out of alternatives. In the present study some family members seemed to express that they were “fed up” and it seemed that their resources were depleting at the time of the referral to therapy. Marsh & Lefley (1996) conducted research exploring family resilience in relation to mental illness. They identified that families frequently have their own “restorative powers” which facilitate them to “survive” crises they may experience and meet ongoing challenges with “mastery, dignity and empathy” (p.4). However, they note that resilience does not occur in a vacuum and that it can be tied in with a “powerful family burden” (p.5). Perhaps at the time of the referral family resources were particularly low and a potential benefit of engaging with therapy was the feeling of gaining outside help to contain difficulties that had perhaps become unmanageable.

Flakas (2007) has suggested that despair can exist in parallel to hope. Both hope and hopelessness can carry with them strong emotions and it has been argued that ignoring the emotionality of hope and despair can risk empathic engagement with clients through not acknowledging the power of these emotions (Flaskas, 2007). Both Isobel and Lisa became particularly emotional when expressing their hopes for therapy. It has been proposed that the therapeutic environment may be regarded as the frame for witnessing despair and a place to “do” hope with those who come to therapy (Weingarten, 2000). The findings emphasise the importance of engaging with the expectations and fears of individual family members when they come to therapy. The therapeutic alliance, expectations and client extra-therapeutic factors are therefore important to explore and continually revisit and such factors can interact in a complex manner (Hubble et al., 1999). For example, Keithy, Samples & Strupp (1980) found that the client’s initial level of motivation had an impact upon the behaviour of therapists. In addition, when therapist behaviours have been found not to be responsive to client pre-treatment characteristics this has been found to result in poorer treatment outcomes (Beutler et al., 2001).
6.2 The facilitative aspects of therapy:

All family members discussed the aspects of therapy that had been helpful to them. This included, for some family members, the relationship with the therapist, the experience of the reflecting team and therapy being a space within which family members could talk, listen and understand.

6.2.1 The experience of the relationship with the therapist:

Byng-Hall (2008) suggested that anxiety and fear can activate the attachment system. It is possible, in the present study, that the presence of ambivalence about engaging with therapy in addition to the critical transitions participants were facing could have activated their attachment systems. Therefore participants might have been looking for something or someone to help them feel more secure (Byng-Hall, 2008).

Studies exploring the therapeutic relationship in family therapy have found that clients valued a caring therapist who they felt demonstrated qualities of warmth, informality, trust and security (Christensen et al., 1998; Sells, Smith & Moon, 1996). Byng-Hall (2008) has highlighted the importance of the family developing a secure enough attachment to the therapist in order that they may feel safe enough to explore new ways of relating to one another. The therapist then, in turn, might try to facilitate the development of secure attachments between family members so that they will be able to continue to support one another outside of the therapeutic environment (Byng-Hall, 2008).

Four participants referred to the experience of their relationship with the therapist in the room. In particular this seemed to relate to particular qualities demonstrated by the therapist. Some family members referred to the warm qualities of the therapist such as being like “a friend” (Gary); “sympathetic” (William) and “lovely” (Samantha). Perhaps the presence of a responsive and empathic therapist conveyed to these family members that their feelings of ambivalence could be contained (Bion, 1967). Although Isobel expressed that her therapist did not demonstrate the warmth that she had hoped for, she identified that the therapist conveyed herself as competent
and this may have been important for her husband to regard her as credible. This is similar to the findings of Butler (2003) where for some service users at an older adult family therapy clinic, the qualifications of the therapists were very important. Kuehl, Newfield & Joanning (1990) found that if the therapist was perceived as caring and genuine family members were more likely to be open and honest. In the present study it seemed that it was facilitative if not only the therapist was perceived as caring and genuine but also members of the reflecting team. For the four family members who discussed the personal qualities of the therapist and/or team members that were facilitative it seemed that they perceived they had benefited more from the experience of therapy on this occasion than did Lisa and Charlotte. They did not refer to their relationship with the therapist in the room but referred to "the team" as a whole throughout their individual interviews. Further, they did not refer to personal qualities of team members.

6.22 The experience of the reflecting team:

The reflecting team was positively valued by the majority of participants. In particular participants commented on the benefits of receiving feedback and gaining insight into multiple perspectives. This is similar to the findings of previous research that has found that the diversity of opinions presented by reflecting teams is regarded as a strength allowing multiple facets of difficulties to be recognised, questioned and supported (Smith, Winton & Yoshioka, 1992). This also contrasts with other research where family members reported finding the reflecting team intrusive (Kuehl, Newfield & Joanning, 1990). Perhaps the different perspectives given by reflecting team members contributed to a sense of greater self-understanding and a perception of being understood. This in turn might have contributed to a greater perception of safety. There may also, therefore, be an important therapeutic relationship between members of the family and members of the reflecting team.

William said that he would have liked there to have been greater diversity in relation to the age of team members, particularly noting there were no young members, and thought that this would have offered a greater variety of perspectives. This contrasted with Butler's (2003) qualitative study where one of the four older adult participants
felt that the therapist was too young to understand his viewpoint. In addition Isobel identified a member of the reflecting team who demonstrated some of the warm qualities that she felt were not present in her therapist. Perhaps having this member of the team present gave Isobel some of the safety she was looking for to enable her to express her emotions. Similarly, she described how her husband valued the presence of a man in the team. These experiences appeared to indicate the importance of diverse team membership in order for clients to gain a rich set of meaningful options in relation to how they understood or viewed their difficulties or even the extent to which they felt understood (Smith, Yoshioka & Winton, 1993).

Charlotte noted the value of being able to sit back and listen without feeling defensive because the reflecting team’s discussions were not directed at the family but to other team members. Prest et al. (1990) described this as a “fly on the wall” phenomenon whereby someone is positioned at a meta-level to the process. This allowed people to view themselves as outside the problem, listening without being able to interrupt. Charlotte described the importance of being treated equally within the therapeutic environment and perhaps this way of working, wherein she could listen to team discussions and offer feedback, may have fitted with her expectations.

6.23 A space to talk, listen and understand:

In addition to specifically talking about the experience of the therapist and of the reflecting team, family members discussed the importance of being able to talk and listen to one another which in turn, for some, led to new understanding. For example, some family members referred to hearing about other family member’s feelings and becoming more aware of their own emotions. For some family members the increase in communication appeared to continue outside of therapy. Other participants appeared to identify that talking was a good solution to dealing with family difficulties compared to previous solutions of avoiding difficult issues. This is similar to the strategic family therapy notion of the solution becoming the problem (MacKinnon, 1983). In addition it seemed that for some participants the experience of family therapy created a new way of viewing family difficulties such that difficulties were not just located in one family member. This might suggest that
family difficulties were deconstructed and perhaps externalised although it is difficult to know this from the descriptions given (Freedman & Combs, 1996). It seemed that the very act of being able to sit, listen and be heard was an important factor in the process of therapy. Flaskas (2004) has suggested that gathering as a family might demonstrate to family members that they value one another and are prepared to hear and witness one another’s experiences. This is similar to the findings of Bischoff & McBride (1996) where attending therapy was regarded as a powerful symbolic gesture of the commitment to one’s family or partner. It seemed that participants in the present study valued both the specific elements of therapy related to the systemic family therapy model (e.g. the reflecting team) and the non-specific elements of therapy. This contrasts with the findings of some previous family therapy studies where participants tended to focus on the non-specific elements of therapy as being helpful (e.g. Stanbridge et al., 2003; Budd & Hughes, 1997).

6.3 Constraints to change:

Constraints to change described by participants included difficulties negotiating the tasks of therapy, time constraints and limitations to the perception of safety. These constraints fitted with the doubts some participants expressed about engaging with therapy.

6.31 Difficulty negotiating the tasks of therapy:

A perceived mismatch between family members’ expectations of therapy and those of their therapists has been well documented (Burck, 1978; Lishman, 1978; Hunt, 1985). In particular Crane (1986) found that the only variable to reliably predict user’s ratings of the outcome of treatment was “fit of treatment” to family members’ expectations. It is possible that because neither Lisa nor Charlotte expressed doubts about engaging in therapy in their interviews that they were more vulnerable to being disappointed about the process and impact of therapy. Research has highlighted the importance of a fit between the model and the client’s worldviews (Johnson & Talitman, 1997). A mismatch appeared to be evident in the interviews with Lisa and Charlotte between what they expected from therapy and what they experienced. This
was particularly evident in relation to negotiating the goals of therapy with the team (they did not refer to the therapist and team separately) and mutually agreeing when and why therapy would end. Charlotte particularly highlighted the importance of collaboration and perhaps she experienced the decisions about what issues would be discussed and the ending of therapy as non-collaborative.

Events highlighted by clients as being particularly unhelpful in individual therapy have included the perception of being judged and therapists making assumptions (Glass & Arnkoff, 2000). In contrast clients have reported valuing a collaborative relationship wherein the therapist sees beyond the client’s diagnosis (Glass & Arnkoff, 2000). Beck et al. (2006) found that what contributed to a strong between systems alliance, was good emotional connections with the therapist, confidence in the therapist’s ability to foster change and agreement with the therapist on goals. In contrast what was found to contribute to a weak between systems’ alliance was disagreement over goals or a general mistrust of helping professionals. In the present study Lisa perceived that the team had suggested that her father could not change and that this was based on his diagnosis of a personality disorder. The mismatch between Lisa and the team about her father and his ability to change is perhaps an example of two systems finding it difficult to develop congruent goals. Perhaps Lisa needed her hope for her father to be witnessed and validated (Weingarten, 2000). It has been observed that damage to one part of the alliance with one family member may damage alliances with other family members (Blow, Sprenkle & Davis, 2007). It is possible that the impact of Lisa feeling that her father was negatively judged by the team may also have impacted the team’s alliance with her partner Charlotte.

Lisa and Charlotte perceived that the end of therapy was unexpected. Gelso & Woodhouse (2002) suggest that endings may be more difficult for families and therapists who have a history of upsetting losses. Lisa had recently experienced the death of her mother which had resulted in changing family dynamics wherein her and Charlotte became her father’s carers. Perhaps the perceived unexpected ending of therapy may have mirrored the family’s unexpected loss. Systemic terminology would refer to this as “isomorphism” which refers to similar patterns occurring across systems (White & Russell, 1997). For example, a pattern in the client family may
manifest itself in the way in which the therapist and family relate to one another (Van Trommel, 1987). Gelso & Woodhouse (2002) suggested that the aim of working towards termination with clients is to help them leave therapy feeling valued and helped instead of feeling dismissed or abandoned and without dismissing the therapeutic relationship. The perceived unexpected ending of therapy could have resulted in Charlotte and Lisa feeling dismissed and "fobbed off" (Charlotte) making it difficult to value the work of therapy. Charlotte nevertheless in her reflections of therapy continued to value the reflecting team but this seemed to refer to the indirect technique rather than the relationship or changes that had occurred. Charlotte and Lisa had only three sessions of therapy which may have meant there was little time for a "tear and repair" (Bordin, 1979) process to occur within the relationship between the family and the team.

Perhaps Lisa thought the team had their own agenda when she referred to the team making "us feel good so we can stop a bit, like" (Lisa). Previous research by Metcalf & Thomas (1994) explored client perceptions of brief solution focussed family therapy. They found that termination was not linked to client perceptions of the process of therapy but to how therapists viewed the goals of therapy and what they thought had been achieved. Metcalf & Thomas (1994) suggested that therapists regularly and directly asked clients about their expectations of therapy in addition to expectations regarding goals and termination.

6.32 Time constraints:

Time constraints on therapy included both the timing of therapy in relation to family member's mental health, therapy being held during working hours, and limitations to the number of sessions received. It was identified that some family members thought that therapy was not beneficial when a family member was in poor mental health but differences in opinion about this appeared to be present. This may have had an impact on the within system alliance (Pinsof & Catherall, 1986). Family members highlighted the difficulty of having sessions during working hours. This may have been compounded by fears that work colleagues would find out due to having to take time off from work and this also made it difficult for all family members to
consistently attend therapy. Five participants expressed that they would have liked more sessions. For the majority of participants this appeared to be related to the long-term nature of the difficulties experienced. Perhaps the word “therapy” itself carries the implication that the work might be long-term and therefore families coming to family therapy at an older adult service might both expect, and fear, an exploration of the history of their relationships and difficulties which may have been perceived to take more time than was available.

6.33 Limitations to the perception of safety:

Fears about safety were initially discussed when family members discussed the potential costs of engaging in therapy and when they referred to constraints to change. This was in relation to being afraid of being vulnerable in front of other family members both within therapy and outside of it. Bischoff & McBride (1996) found that when family members expressed a desire to see their therapist individually, this was because they thought that individual concerns had not been adequately addressed. In the present study this was also found, in addition to a perception that not everything could or should be said in front of other family members. It seemed that for some participants their apprehensions about the potential costs of engaging with therapy had remained.

Several family members referred to the long gap between sessions and this appeared to relate to a feeling of uncertainty about what might happen in this time period. Longer gaps theoretically occur between sessions in family therapy once a secure base has been built within therapy (Byng-Hall, 2008). However, in the present study it appeared that some family members experienced long gaps between sessions early on in the course of their short-term work. It might have been helpful to have sessions closer together at this stage to keep the momentum of the work going and in order that a sense of safety could have been built up between family members.
6.4 Summary of findings:

The majority of participants appeared to experience ambivalence about engaging in the therapeutic enterprise. Their fears about engaging with therapy, in addition to the life cycle transitions experienced, may have activated their attachment systems resulting in family members needing to feel secure. What contributed or detracted from a feeling of safety appeared to be a complex interaction between several factors. This included both within system (within-family) factors, between system factors, the alliance between the therapist and individual family members and social and cultural factors (particularly the impact of stigma). Alliances were also impacted by the presence of the reflecting team and by whether or not congruent goals could be developed between the various systems involved. The goodness of fit between family member's expectations and the experience of therapy was also significant.

Flaskas (1997) suggests that engagement is not a static issue to be considered at the beginning of therapy but is an ongoing process throughout therapy and a "precondition of therapeutic change" (pp. 268). She has highlighted the importance of a good-enough relationship between the therapist and family members in order that the work of therapy can occur. The findings of the present study also highlight the importance of engagement and the therapeutic relationship in addition to the important relationship between family members and members of the reflecting team. Engagement was an important issue for family members throughout therapy where, for many family members, the presence of ambivalent feelings about engaging with therapy remained. This was probably more likely in the present study where some family members had only been able to attend two sessions. Blow, Sprenkle & Davis (2007) argue that most key changes in therapy are either influenced by or initiated by the therapist's ability to identify and magnify change opportunities and that this impacts on the success of therapy. This may highlight the importance of both the therapist and reflecting team members having an awareness of family members' expectations and readiness for change through regularly exploring their hopes and fears about engaging with therapy. In this way Sutherland & Couture (2007) suggest that therapeutic collaboration (defined as "participation in a common effort" (pp. 177) is created and maintained through repeated collaborative interactions with each
individual, family subsystem and with the family system as a unit (Pinsof & Catherall, 1986). In the present study it seemed that some family members did not perceive their interactions with their therapist and or team as collaborative.

The findings of the present study perhaps emphasise that therapy, within the postmodern era, can still result in a power imbalance wherein the client can experience distance from the therapist and team and perceive elements of the work as non-collaborative or judgmental (Flaskas, 2004). The findings emphasise the importance of clinicians reflecting on their own biases and assumptions about ageing and mental health diagnoses.

6.5 Critique:

6.51 Generalisation:
This research project achieved its aim of gaining rich perspectives from family members of their experience of family therapy at an older adult family therapy service. This was an exploratory study designed to highlight the perspectives of family members who accessed family therapy at this particular service. Therefore the findings should only be cautiously applied beyond this setting and the participants involved. Elliott et al. (1999) suggest that researchers should situate the sample by providing basic descriptive data about participants in order that readers might be able to ascertain to whom the research findings might be applicable.

Participants in the present study were in the age range 36-65 and the range of difficulties the family members were adjusting to included long-term mental health difficulties, memory difficulties, bereavement, and changing family roles. The participants included were representative of the clients that access this particular service although this sample did not include family members experiencing cognitive difficulties. Two families informed the researcher that the health of the family member for whom the original referral to family therapy had been made had deteriorated. Therefore the experience of therapy from the perspective of family members with cognitive difficulties is missing from this study.

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The therapists that family members saw were not qualified in systemic family therapy but were in receipt of live supervision and came from varied professional backgrounds. The training nature of the clinic and the professional background of therapists may have impacted the participants’ experiences of therapy. This was not explored in the semi-structured interview and was not an issue raised by clients but could be a limitation to the findings in terms of applicability to family therapy received in non-training settings with qualified systemic family therapists.

Participants had received a minimum of two and a maximum of seven sessions of therapy. Therefore the findings of this study may not be as helpful in relation to longer-term work. The findings of this study might be helpful when working with older adults and their family members in other settings including inpatient and community settings.

6.52 Methodology:

The use of the GHQ-12 as part of the screening procedure was perhaps an overly cautious measure and may have reflected a paternalistic approach to assessing family members who access therapy at an older adult family therapy service. Rather than using this tool it may have been just as appropriate to meet with family members to discuss the study and clinically assess their ability to participate through a conversation. Obtaining “caseness” did not prohibit anyone from participating in this research project. However, the GHQ-12 did prove helpful with the building of rapport and facilitated an exploration of potential risk. For example, participants discussed with the researcher their current support and difficulties.

The semi-structured interview schedule was facilitative in allowing participants to influence the direction of the interview and introduce topics that the researcher had not thought of. Participants reported enjoying the interview and that it gave them the opportunity to reflect on the experience and give feedback to the service.

The findings of this study were reliant upon the retrospective recollections of family members which could be biased by the overall impact they felt that therapy had on
their lives at the time of the interview rather than a reflection of the experience of therapy at the time. However, their retrospective reflections possibly gave a greater indication of the impact of therapy on their lives subsequent to therapy in addition to having had more time to process the experience than if they had been interviewed at the time of therapy (Clarke, Rees & Hardy, 2004).

The use of IPA facilitated an in-depth exploration of participants' complex and subjective perceptions of therapy. However, this method has been critiqued for diluting individual participants' data due to the "unitisation of the data" (Collins & Nicolson, 2002; pp. 627). In the present study, it was found that although this was possible through aggregating themes, it was found that the process of writing up allowed a reflection upon and narrative of the divergences and convergences across and within participants' experiences to re-emerge (Smith et al., 1999). IPA's critical realist epistemology assumes that language represents reality (Reicher, 2000). As such, this method does not facilitate an exploration of participants' use of language and the particular ways that language was used to convey and construct meanings in response to particular questions (Willig, 2001). However, it is possible that had there been a focus at the level of the text rather than meaning, then some of the richness of participants' experiences might have been lost.

6.6 Recommendations for future research:

Participants in the present study had a range of between two to seven sessions of therapy and it might be important to conduct research exploring clients' perceptions of family therapy at different stages of therapy and after a greater amount of sessions. This might give a more immediate picture of the experience of therapy and the process of change over time. For example, this might include interviewing family members before they access therapy, after their initial session, half way through therapy, after the last session, and up to one year after. This could be done with one family or several families to explore what family members perceive is happening in therapy that contributes to engagement and to change. A study interviewing family members with cognitive difficulties immediately after a therapy session may make it easier for them to reflect upon their experience of therapy which would be a valuable
contribution to research. In addition, interviewing family members who chose not to accept an invitation to participate in therapy and those who dropped out of family therapy at the older adult family therapy service may also inform therapeutic practice and service delivery.

6.7 Implications for practice:

The findings of this study have several implications for therapeutic practice. These include:

1. Being clear about the service that is available. It seemed that “family therapy” carried the implication of long-term work and this was desired by the majority of participants’ in the present study. If a service is only able to see participants for a brief amount of time, such as for three sessions this should be made explicit and perhaps called “family consultation”. If the number of sessions offered is dependent upon an assessment or consultation with the family this should perhaps be made clear in the service leaflet and to referrers.

2. It might be helpful to send questionnaires to individual family members to explore their expectations, fears, difficulties and strengths prior to therapy. This might help the service prepare for where sessions might be held, with whom and at what time in addition to framing the work of therapy as focused on both strengths and difficulties. This might enable the service to think about how stigma and other potential barriers to accessing the service might be addressed.

3. The findings of the present study indicated that for some family members ambivalence about engaging with therapy remained. The therapeutic relationship is an important medium through which to facilitate an exploration with family members, throughout therapy, their specific expectations, goals and fears. This could include their previous experiences of mental health services and therapy and what they found more or less helpful. It may be important to have sessions close together initially in order to facilitate a feeling of safety to do things differently both inside and outside of therapy. The findings of the present study highlight the importance of attending to all
aspects of the therapeutic relationship. This also suggests the importance of ongoing self-reflection and perhaps supervisory groups for clinicians to explore their own biases and assumptions.

4. Some participants valued diverse membership of the reflecting team. Therefore it may be important to ensure that the membership of the reflecting team is as diverse as resources can facilitate.

5. Participants reported valuing the opportunity to give feedback via the research interview. It may be important for services to make anonymous feedback available for service-users. Feedback forms and boxes to post them in areas where family members may feel they are not observed such as the waiting room may facilitate this.

The findings of the study have been shared with the Consultant Systemic Psychotherapist who was the field supervisor of the researcher. She was very interested in the findings and to share them with members of the older adult team and management in order that the recommendations and perceptions of family members could be acted upon.
References


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Appendix A

Evidence of ethical approval from NRES, R&D and University

Ethics
Dear Ms. Major,

Full title of study: Older Adult Family Therapy: Retrospective accounts of family members experiences of therapy.

REC reference number: 07/H0803/194

Thank you for your letter of 8th December 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Sub-Committee of the REC held on 21 December 2007. A list of the members who were present at the meeting is attached.

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.

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.

This Research Ethics Committee is an advisory committee to London 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.
Approved documents

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

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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.

Guidance on applying for R&D approval is available from [http://www.rdforum.nhs.uk/rdfom.htm](http://www.rdforum.nhs.uk/rdfom.htm).

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.

*An advisory committee to NHS London*
After ethical review

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

Here you will find links to the following:

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

b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

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

07/H0803/194  Please quote this number on all correspondence

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

Yours sincerely
Dear Jane

Reference: 202 - PSY- 08
Title of Project: Older Adult Family Therapy: Retrospective accounts of family members experiences of therapy

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

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

Yours sincerely
Dear Jane,

Research Title: Older Adult Family Therapy: retrospective accounts of family members' experiences of family therapy

Project ID: PF369

Following various discussions your project has now been approved. This letter ensures that you and the researchers holding a Trust/NHS contract are indemnified by the Trust under DoH HSG (96) 48 (only for non-commercial research). Under your contract of employment you are required to adhere to the Research Governance Framework and Trust research monitoring procedures.

In addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, you need to ensure the following:

- **Patient contact:** Only trained or supervised researchers holding a Trust/NHS contract (honorary or full) are allowed to make contact with patients.

- **Informed consent:** is obtained by the lead or trained researcher according to the requirements of the ethics committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.

- **Data Protection:** All data involving patient data will remain anonymised, where possible, and held on protected systems so as not to compromise the Data Protection Act.

- **Adverse events reporting:** Adverse events or suspected misconduct must be reported to the R & D department, in conjunction with the Ethics committee.

- **Annual review:** An annual review form will be sent to you, which you will be required to complete and return to the R & D Department.
Terms and conditions of Approval

- **Closure Form:** On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the R & D Department.

- **Publications:** Any publications will need to be reported to the R & D Department. This is vital in ensuring the quality and output of the research for your project and the Trust as a whole.
Appendix B

Evidence of approval of amendment from NRES, University Ethics and R&D
Dear Ms. Major,

Study title: Older Adult Family Therapy: Retrospective accounts of family members' experiences of therapy.

REC reference: 07/H0803/194
Amendment number: 1
Amendment date: 20 May 2008

The above amendment was reviewed at the meeting of the Sub-Committee of the REC held on 30 May 2008.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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<tr>
<td>Notice of Substantial Amendment</td>
<td>1</td>
<td>20 May 2008</td>
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<tr>
<td>(non-CTIMPs)</td>
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Membership of the Committee

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

This Research Ethics Committee is an advisory committee to London Strategic Health Authority. The National Research Ethics Service (NRES) represent the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

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.

07/H0803/194: Please quote this number on all correspondence

Yours sincerely
Dear Jane,

Research Title: Older Adult Family Therapy; retrospective accounts of family members' experiences of family therapy.

Project ID: PF369 - extension

Thank you for your letter of 7th July, advising of the substantial amendment to the above research proposal.

Please accept this letter as official notification, on behalf of the R&D Committee, that these revisions have been accepted and the terms of R&D approval given in my letter of 6th February 2008 still apply.

If you have any queries regarding the above points please contact Enitan Eboda, R&D Co-ordinator on 020 8725 3463 (St. George’s), e-mail: eeboda@sgul.ac.uk.

Yours sincerely,
Dear Jane

Reference: 202 - PSY- 08
Title of Project: Older Adult Family Therapy: Retrospective accounts of family members experiences of therapy

Thank you for your submission of changes to the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

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

Yours sincerely
Appendix C

Invitation letter
Dear ,

I am writing to you to ask if you would be willing to take part in an evaluation of your experience of receiving family therapy at the clinic. This aims to explore what family members, attending family therapy at the clinic, found helpful or unhelpful about the therapy they received. My name is Jane Major and I am training to be a Clinical Psychologist at the University of Surrey working with the (Consultant Family Therapist). This study will contribute to a research project which comprises the research component of my Doctorate in Clinical Psychology.

The clinic have given me your name as someone who might be willing to participate in this research project. What I would like to find out from you, if you choose to participate in this study, is:

- What were your expectations of family therapy?
- Do you think that family therapy had any effect upon you and your family?
- What was helpful or unhelpful about family therapy?

The aim of this research is to improve service delivery to older adults receiving family therapy at the clinic. This will be achieved through feed back of my findings to the service. Research regarding how older adults and their families experience family therapy is lacking. Older adults are infrequently offered family
therapy and medication is often used without the addition of psychological help or support. For this reason it is important for services and practitioners to gain a good understanding of how older adults and their families experience family therapy – what aspects of the therapy they have found has supported them in making change possible. In addition this study intends to interview family therapists about how they think their work with families contributes to change.

In order to gain this information (which will help to develop family therapy services) I would like to interview you and members of your family who have completed therapy at the clinic. Each family member agreeing to participate will be interviewed individually. All information will be remain anonymous and confidential. Participating in this study will not impact on any future services you receive from the National Health Service.

The interview will focus on how you felt therapy contributed to change. The interview will not be asking for details about the content of the family therapy you received. It is anticipated that the interview will last between 40 minutes to one hour.

If you would like to participate in this study please complete the attached consent form and return it to me in the enclosed stamped addressed envelope. In the consent form I also ask for your permission to contact your GP and/or Community Mental Health Team (if you are open to one) in order to inform them that you are interested in participating in this study. I will also inform them if I have any concerns about your health whilst you participate in this
study but I will inform you about this. If I have not heard from you after two weeks from the date on this letter I will write to you again. If I do not hear from you after this time I will assume that you do not wish to participate in the study and will not contact you again.

If you would like some independent advice about whether or not you should participate in this study please do not hesitate to contact your GP or mental health worker from your Community Mental Health Team.

Once I have received your consent form I will then telephone you to arrange to meet with you either at your home or at the Clinic, whichever is more convenient for you. At this initial meeting I will answer any questions you may have about the study and discuss it with you in greater depth. In addition I would like to conduct a screening assessment with you at this meeting to ensure that you are currently in good health to participate. If you are eligible for inclusion in this study we will then need to arrange a time and date to conduct the individual interview. This can be conducted either at your home or at the clinic. If you would like to complete the interview at the clinic your travel expenses will be reimbursed. Further more, all participants will receive a £20 gift voucher for Marks & Spencer.

I look forward to hearing from you,

Yours sincerely,
Jane Major
Trainee Clinical Psychologist.

Consent form for initial meeting

I .................(please write your name here) consent/do not consent (-delete as appropriate) to participate in the study about my experience of family therapy at the Clinic. I understand that Jane will need to contact my GP or Community Mental Health Team to inform them that I wish to participate in the study. I am also aware that Jane will need to complete a brief health questionnaire with me in order to see if I can participate in the study. I understand that the interview will be recorded but that no one other than the interviewer will listen to the tape. All information will remain confidential and anonymous and kept under lock and key until all written work has been submitted.

Signature: _____________________________

Date: ________________________________
Appendix D

Information sheet
Information sheet about the research
Older adult family therapy: Retrospective accounts of family members experiences of therapy

I would like to invite you to participate in a research study about your experience of attending family therapy at the

Before you decide if you would like to participate I will explain the purpose of this study and what it would involve for you. Please take your time to read the following information carefully. Please talk to others about participating in the research if you wish.

If you consent to participate in this study I would like to make clear that this will have no impact on the future services you receive from the National Health Service. If you have any questions that you would like to ask me directly please leave a message for me with (Clinic Secretary) on and I will contact you and respond to any questions you may have.

As part of this study you are required to complete questionnaires in order to check your health and well-being for participation.

(Part 1 of this information sheet will tell you about the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study).

Part 1:
What is the purpose of the study?
The purpose of this research is to explore what both you and your family members feel was helpful or unhelpful over the course of therapy. This will be conducted through individual interviews with family members. This interview intends to explore your expectations of family therapy; how you think that therapy affected you at the
time and how it has affected you now. The interview does not seek to ask any personal questions about the content of the therapy you received rather it seeks to focus on the process of therapy and what you think contributed to or hindered change for your family. Interviews will also be conducted with the Clinic Family Therapists to explore how they think the service supports and works with families. This research will contribute to the major research component of my Doctorate in Clinical Psychology. In addition it is anticipated that this research will inform the future practice of family therapy at the .

Why have I been invited?
You have been invited to participate in this study because you attended family therapy at the . I would like to talk to you about your experience of family therapy in order to find out what your initial expectations were, how you experienced the therapy and if it has contributed to any changes for you and your family. (Consultant Systemic Therapist at the Clinic) has sent this information to you on my behalf. Until I have your written consent to participate I will not have access to your contact details and I will never have access to any of your personal information that is held by the clinic.

Do I have to take part?
It is up to you to decide if you would like to participate in this study or not. Initially I would like to informally meet with you in order to explain in person the purpose of the research study and to obtain your consent. This will include me going through this information sheet with you. Should you then agree to take part I will need you to sign a consent form to show you have agreed to participate. You are free to withdraw from the study at any time, without giving a reason. This would not affect any future treatment you might receive from the National Health Service.
What will happen if I take part?

If after initially meeting with me to informally to discuss the study you should give your written and verbal consent to participate it will be necessary for me to contact your Community Mental Health Team (with your consent). If you are not in contact with a Community Mental Health Team, with your permission I would like to contact your GP in order to inform him or her that you have consented to participate in this study. It will be necessary for me to contact your GP or Community Health Team again should you or I have any concerns about your well-being after the interview.

If you give consent to participate in the study there is a short health questionnaire that I would like to complete with you at this initial meeting. This is in order to assess your current state of health in order to check that you are in good health to participate. After this first meeting, if you agree to participate in the study I will contact you again to arrange a date and time for the interview. If you are unable to come to the clinic for interview I am happy to travel to family members homes in order that interviews are completed. At the initial interview I will ask you if it is okay for me to write to the other members of your family who completed therapy with you to see if they would like to participate in the study. If they consent, in writing, to meet with me I would meet with them informally at first to explain the purpose of the study and to obtain informed consent. In addition, I will also complete a short health questionnaire with each individual family member in order to check that they are well enough to participate in the study. If they consent to participate I will contact them again to arrange a date and time to be interviewed.

The interview will take from 40 minutes to a maximum of 1 hour. You are very welcome to ask to stop or take a break whenever you
like. I would like your permission to record the interview on audiotape in order that I can write up a report. However, the information will be confidential and anonymised. This means that there will be no information revealing your identity and the audiotape will be destroyed once I have transcribed the information. I would then like to write to you after the interview has been completed and after I have typed it up in order to check with you that the themes I identify in your interview are ones that you feel are representative of your experience of therapy. All information gained through the interviews will be kept under lock and key and will be destroyed after final papers for the research have been submitted.

Each family member that wishes to participate in the study will receive a £20 Marks and Spencer's voucher. Any travel costs will be reimbursed.

*What are the possible disadvantages and risks of taking part:* Minimal risk is anticipated through participating in this study. However, if talking about participating in therapy does make you upset or distressed you will be advised to contact your GP or Community Mental Health Team and all participants will be given supportive telephone numbers.

*What are the possible benefits of taking part:* Some people find that talking about their experiences of therapy help them to process their experience and revisit it with the experience of hindsight. However, although I cannot promise that participating in this study will help you the information that you give about your experience of family therapy will help improve future family therapy service provisions.
What if there is a problem?
Any complaint about the way that you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in part 2.

Will my taking part in the study be kept confidential?
Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes Part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2.

What will happen if I don't want to carry on with the study?
If you choose to participate you can still withdraw from the study at any time and all of the information that you have given me up until that point will be destroyed.

What if there is a problem?
If you have a concern about any aspect of this study please do not hesitate to contact me, in the first instance (by leaving a message with , Clinic secretary on ) and I will do my best to answer your questions. If you remain unhappy and wish to complain formally you can do this through the NHS complaints procedure. Details can be obtained from the Clinic.

Should you have any questions please do not hesitate to ask me, either before, during or after the interview.
Thank you for your participation,

Jane Major
Trainee Clinical Psychologist
Appendix E

Copy of letter to GP
Dear Dr.

Re:

I am writing to you regarding who has agreed to an initial meeting with me in order to discuss participation in my doctoral study exploring the experiences of older adults and their family members who have completed family therapy at the clinic. This study is being completed in collaboration between the clinic and myself. Please see the enclosed information sheet for further details.

At this initial meeting with I will discuss in further detail the purpose of the study and obtained informed consent to participation. In addition if should wish to participate in the study a short health questionnaire will be completed in order to evaluate his/her current health status.

Should any concerns arise in relation to health or wellbeing then I will contact you immediately. If you have any concerns about suitability to participate in the study or any risk issues that I should be aware of then please do not hesitate to contact me on the above telephone number or to write to me at the clinic.

Yours sincerely,

Jane Major
Trainee Clinical Psychologist.
Appendix F

Second letter to potential participants
Dear [Name],

I wrote to you 2 weeks ago inviting you to participate in a research project exploring your experience of receiving family therapy at the Clinic. I am writing to you again to remind you about this study and to let you know that you are still welcome to participate should you wish to. The study aims to explore what family members, attending family therapy at the clinic, found helpful or unhelpful about the therapy they received. My name is Jane Major and I am training to be a Clinical Psychologist at the University of Surrey working with the [Consultant Family Therapist]. This study will contribute to a research project which comprises the research component of my Doctorate in Clinical Psychology.

The clinic have given me your name as someone who might be willing to participate in this research project. What I would like to find out from you, if you choose to participate in this study, is:

- What were your expectations of family therapy?
- Do you think that family therapy had any effect upon you and your family?
- What was helpful or unhelpful about family therapy?

The aim of this research is to improve service delivery to older adults receiving family therapy at the clinic. This will be achieved through feedback of my findings to the service. Research regarding how older adults and their families experience family therapy is
lacking. They are frequently not offered family therapy and medication is often used without the addition of psychological help or support. For this reason it is important for services and practitioners to gain a good understanding of how older adults and their families experience family therapy –what aspects of the therapy they have found helpful or unhelpful.

In order to gain this information (which will help to develop family therapy services) I would like to interview you and members of your family who have completed therapy at the clinic. Each family member agreeing to participate will be interviewed individually. All information will be remain anonymous and confidential. Participating in this study will not impact on any future services you receive from the National Health Service.

The interview will focus on how you felt therapy was helpful or unhelpful. The interview will not be asking for details about the content of the family therapy you received. It is anticipated that the interview will last between 40 minutes to one hour.

If you would like to participate in this study please complete the attached consent form and return it to me in the enclosed stamped addressed envelope. In the consent form I also ask for your permission to contact your GP and/or Community Mental Health Team (if you are open to one) in order to inform them that you are interested in participating in this study. I will also inform them if I have any concerns about your health whilst you participate in this study but I will inform you about this.
If I do not hear from you after this time I will assume that you do not wish to participate in this study and will not contact you again.

Once I have received your consent form I will then telephone you to arrange to meet with you either at your home or at the Clinic, whichever is more convenient for you. At this initial meeting I will answer any questions you may have about the study and discuss it with you in greater depth. In addition I would like to conduct a screening assessment (using a questionnaire) with you at this meeting to ensure that you are current in good health to participate. If you are eligible for inclusion in this study we will then need to arrange a time and date to conduct the individual interview. This can be conducted either at your home or at the clinic. If you would like to complete the interview at the clinic your travel expenses will be reimbursed. Further more, all participants will receive a £20 gift voucher for Marks & Spencer.

I look forward to hearing from you,

Yours sincerely,

Jane Major
Trainee Clinical Psychologist.
Consent form for initial meeting

I ................................(please write your name here) consent/do not consent (-delete as appropriate) to participate in the study about my experience of family therapy at the Clinic. I understand that Jane will need to contact my GP or Community Mental Health Team to inform them that I wish to participate in the study. I am also aware that Jane will need to complete a brief health questionnaire with me in order to see if I can participate in the study. I understand that the interview will be recorded but that no one other than the interviewer will listen to the tape. All information will remain confidential and anonymous and kept under lock and key until all written work has been submitted.

Signature: _____________________________

Date: ________________________________

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Appendix G

Consent form to participate in the research
Consent form to participate in the research project on older adult family therapy.

- I ........................................... voluntarily agree to take part in the study about the experiences of family members and therapists who have participated in family therapy.

- I have read and understood the Information Sheet provided. I have been given a full explanation by Jane Major of the nature, purpose, and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I agree to the investigators contacting my general practitioner about my participation in the study, and I authorise my GP to disclose details of my relevant medical or drug history, in confidence.

- I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I acknowledge that in consideration for completing the study I shall receive the sum of a £20 Marks & Spencer’s voucher. I recognise that the sum would be less, and at the discretion of the Principal Investigator, if I withdraw before completion of the study.

- I understand that in the event of my suffering a significant and enduring injury (including illness or disease) as a direct result of my participation in the study, compensation will be paid to me by the University subject to certain provisos and limitations. The amount of compensation will be appropriate to the nature, severity and persistence of the injury and will, in general terms, be consistent with the amount of damages commonly
awarded for similar injury by an English court in cases where the liability has been admitted.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (BLOCK CAPITALS)

........................................

Signed ..............................................................

Date ............................................................

Name of researcher/person taking consent (BLOCK CAPITALS)

..............................................................

Signed ..............................................................

Date ............................................................
Appendix H

Validity and reliability of the GHQ-12
Reliability and Validity of the GHQ-12 (Goldberg, 1972).

Hardy et al. (1999) conducted a study exploring the validity and reliability of the General Health Questionnaire-12 using a sample of employees from the National Health Service.

The internal consistency reliability of the GHQ-12 was high and the coefficient alpha for the GHQ-12 using both binary and Likert scoring was .88. A test-retest correlation with a two week retest interval was r=.73. They found the GHQ to have good reliability and convergent validity and found an alpha coefficient of .88. Using ROC curves they identified a cut off score of 3/4 to identify caseness.

Similarly, Goldberg et al. (1997) explored the validity of the GHQ-12 in a World Health Organisation study looking at mental illness in general healthcare. The GHQ-12 was compared to the GHQ-28. The results were consistently good. The average area under the ROC curve was 88, range 83-95. Although minor variations were found in the criteria for defining a case this made little difference to the validity of the GHQ-12. Goldberg et al. (1997) translated the GHQ-12 into ten other languages and the validity coefficients were found to be as high as they were in English. The validity of the GHQ was not significantly effected by educational level, age or gender.

References


Appendix I

Copy of GHQ-12
The General Health Questionnaire

Name............................................Date............................................

We want to know how your health has been in general over the last few weeks. Please read the questions below and each of the four possible answers. Circle the response that best applies to you. Thank you for answering all the questions.

Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

HAVE YOU RECENTLY:

1. been able to concentrate on whatever you're doing?
   Better than usual  Same as usual  Less than usual  Much less than usual

2. lost much sleep over worry?
   Not at all  No more than usual  Rather more than usual  Much more than usual

3. felt that you are playing a useful part in things?
   More so than usual  Same as usual  Less useful than usual  Much less useful

4. felt capable of making decisions about things?
   More so than usual  Same as usual  Less so than usual  Much less capable

5. felt constantly under strain?
   Not at all  No more than usual  Rather more than usual  Much more than usual

6. felt you couldn't overcome your difficulties?
   Not at all  No more than usual  Rather more than usual  Much more than usual

7. been able to enjoy your normal day-to-day activities?
   More so than usual  Same as usual  Less so than usual  Much less than usual

8. been able to face up to your problems?
   More so than usual  Same as usual  Less able than usual  Much less able

9. been feeling unhappy and depressed?
   Not at all  No more than usual  Rather more than usual  Much more than usual

10. been losing confidence in yourself?
    Not at all  No more than usual  Rather more than usual  Much more than usual

11. been thinking of yourself as a worthless person?
    More so than usual  About same as usual  Less so than usual  Much less than usual

12. been feeling reasonably happy, all things considered?
    More so than usual  About same as usual  Less so than usual  Much less than usual
Appendix J

Semi-structured interview
Interview Schedule: Older adults' & their family members' experiences of family therapy

As you know I would like to interview you to find out about your experience of attending family therapy at the . The purpose of this research is to explore what both you and your family members feel was helpful or unhelpful over the course of therapy. This will include exploring what your expectations of family therapy were; how you think that therapy affected you at the time and how it has affected you now. The interview does not seek to ask any personal questions about the specific details or content of the therapy you received. Rather it seeks to focus on the experience of receiving it and how it unfolded. In particular what you feel contributed to, or hindered change for your family. This research will contribute to the major research component of my Doctorate in Clinical Psychology. In addition it is anticipated that this research will inform the future practice, here at the clinic, of family therapy for older adults.

The interview will take from 45 minutes to a maximum of 1 hour. You are very welcome to ask to stop or take a break whenever you like. I would like your permission to record the interview on audiotape in order that I can write up a report. However, the information will be confidential and anonymised. This means that there will be no information revealing your identity and the audiotape will be destroyed once I have transcribed the information.

Should you have any questions please do not hesitate to ask me, either before, during or after the interview.

Thank you for your participation,
(A) The first set of questions I am going to ask you will be about what your expectations were of family therapy.

1. What were you expecting from participating in family therapy?
   
   Prompt: What did you think it would be like?
   
   What did you think the purpose of therapy was?
   
   Have you or any of your friends and family had therapy before?
   
   Was family therapy explained to you beforehand?

2. Can you remember who suggested it and why

3. How did you respond to this suggestion?

4. How did other members of your family respond to this suggestion?

4. What did you think were the issues that resulted in you being referred?

5. Do you think that view was shared by other family members?

(B) Thank you. Now I am going to ask you some questions about your first impressions of the therapist and the team.

6. What were your initial impressions of the family therapist?

7. Did your impressions change over time?

8. Do you think that other family members had different views about the therapist?

9. Do you think their views changed over time?
10. What were your initial impressions of the “team”?

Prompt: The therapists who would sit behind the mirror and share their thoughts with your family, usually mid way through a therapy session.

11. Did your impressions change over time?

12. Do you think that other family members had different views about the reflecting team?

13. Do you think their views changed over time?

14. What was it like being in therapy together?

15. Did you feel able to say everything you wanted to?

(C) Thank you. Now I would like to ask you some final questions about how you think therapy affected you and your family.

17. Did you notice any changes in you or your family during the time that you were attending therapy?

Prompt: When did you notice how therapy affected you?

18. What do you think contributed to any changes that occurred in your family during the time that you were attending therapy?

Prompt: Were you ever aware of anything that the therapist did or said that brought about change?

19. Were there aspects of therapy that you found unhelpful?

Prompt: Was there anything that you did not like about therapy or that you felt may have made things more difficult for you and your family?

20. If there was anything that was unhelpful, did you feel able to address that within therapy?
Prompt: Were you able to let the therapist know what you thought about the therapy sessions as they progressed?

21. Did you find the reflecting team helpful?

Prompt: Did you find that the thoughts shared by the team helped you and your family in anyway?

22. Now that family therapy is finished do you think that anything in your life is different now as a consequence of the therapy?

23. What do you think was the most significant contributor to change in therapy?

24. Are these changes what you expected at the beginning of therapy?

25. Is there anything that you would like to add that we haven’t addressed?

(D) Thank you very much for participating in the interview. Now I would like to find out what participating in this interview was like for you?

- What was it like for you talking about your experience of therapy?

Prompt: How did talking about your experience of therapy make you feel?

- Have you got any feedback you would like to give me about how the interview was conducted or the questions that were asked of you?

- State here if any issues arose during the interview that caused you concern and discuss what the next steps might be (as discussed when reviewing information sheet and consent prior to interview).
• Here are some supportive telephone numbers should you experience any distress as a result of participating in this interview.

• When I have analysed participants’ interviews I would like to contact you in order to check with you that you agree with the themes I have identified in your interview. Is it okay if I telephone/write to you in order to arrange this?

Thank you very much for your participation.
Appendix K

Sample of annotated pages of transcripts
G: I don't know because you sort of even though they're there you didn't notice them, you didn't speak, erm leaves you to speak more openly.
I: So you weren't distracted by them?
G: No, weren't distracted by them but even so if they were in the room you wouldn't have been distracted you would have been, I don't know you would have been, erm, I don't know you would have been prompted more I think erm cos there would have been three opinions in the room instead of one main person and two people just observing so I found that was quite beneficial, not just to me but to Mum.
I: Yeah and were you given any information about it beforehand?
G: None.
I: None?
G: None. But, I think it's quite a good thing cos like your pre-assumptions of how it's gonna be three people in the room you know talking to you, it wasn't like that at all. It was quite good, no not quite good but I thought it was good. It was quite an forward thinking way of doing things.
I: Erm when it was suggested how did you respond to that suggestion?
G: What the-I: Of going?
G: Erm first of all I thought yeah okay but then I was thinking about it was thinking I don't know what they're gonna talk about and erm at the time my mum was in hospital anyway so I thought I don't know if it's a good idea because she's not like what she is now she, she can, she's better she's not, you know she was quite unwell then.
I: So you were worried that the timing might have been-G: Yeah, yeah cos she was going off in different directions and to the questions that they were asking so I didn't think it was beneficial to her and I didn't think it was beneficial to the people doing the counselling really to be honest.
I: So the timing was-G: The timing was a bit wrong, cos er, I just felt it would be better now to do it.
I: So the worries you had were about your Mum. Did you have any-G: Er, I was a bit worried about my dad because my dad tends to speak his mind and you know even though, you know it was good for him to say that but, I just thought it might have brought up things that maybe should be buried and forgotten really.
I: Worried that it might-G: Yeah, yeah cos I live away from home as well so it's better
without a toothbrush just brushing my teeth like this
(demonstrates brushing her teeth with her finger)
I: Oh no.
S: Awful it was.
I: Hmm. So is it, is it difficult for your husband?
S: So my husband brought them up again but then he used to
come I used to, when I was in there I used to see him about once a
week I spose – when I wasn’t coming home at weekends and then
sometimes he might come on a Sunday. Because he’s working
and he’s a postman, he goes out at about five in the morning.
today he came home early, he came home at twelve o’clock I’d
only just got in I’d been up the road done all me shopping and
was, was emptying the dryer and putting all the stuff away. But
he’s cooking the dinner tonight. Because I was in there so long
he got the hang of how to cook.
I: So some skills developed in some other areas.
S: Yeah.
I: So your husband had no experience of therapy before?
S: No.
I: Is that right? So kind of going to family therapy was quite a
new experience for him?
S: Yeah.
I: And how do you think-
S: And my daughter said the other night, which I thought was a
bit of a cheek, don’t, don’t tell her I told you this, but she said I
think Mum when you first started it, when you started it you
wasn’t well enough to do it. But I thought to myself how does
she know? – She wasn’t there.
I: I remember you saying this to me last week and it seemed like
it quite upset you that she said that.
S: Yeah well I should have said, I should have turned round and
said to her “well you wasn’t there Trace” but I didn’t I just let it
go because if you pick everything up you’ll only start an
argument but I do stick up for myself now.
I: Yeah and is that something you think you’ve been learning to
do, to kind of be more assertive?
S: Yeah because I know a lot since I’ve been in there when I was
in there I used to work on the computers, I used to do everything.
There was an occupational therapist, Henry, I used to go, I forget
what day it was, but one day I used to go over to the boys café
and work on the computers then I used to go and do sport and
things like that then I’d go on the outings with him I went
bowling with him, I went to emm, Lol Park, went to no where,
where was that house called – oh beautiful it was Lane House I
think it was, something like that, big mansion But I had an
ulcerated leg then and I couldn’t walk that far.
could. And after that the man came out from behind the glass and
they sit there talking about what we erm, were discussing and
erm, saying that erm, we can’t really tell you what to do and we’d
like to have another session with you and er, which we did and we
had another session. And then, because my dad went to
hospital we had a couple of sessions we couldn’t turn up at
because we had Charlotte’s mum to look after. But erm, what I
think they could do help with is more they’re understaffed
and-
1: what, at the family therapy?
L: Yeah, you know they’re not really, they haven’t got a lot of
time it’s all done, you, you know.
I: So you felt like-
L: Yeah we were hurried a little bit but erm, they did assess us
good and it did help us in the end when they summed it all up and
they said your Dad’s not gonna change he’s got a personality
disorder but what I was trying to get across to them – I know he’s
not gonna change but he could learn to understand and erm, help
us a little bit just by doing a little bit what he’s supposed to do
you know. But they always think that you’re trying to change
him. I know I can’t change him you know.
I: Yeah
L: Plus his age but you know, but I think they should be a bit
more attentive with it say er come on Dan work with your
daughter now because…. But they don’t do that they do it…
I: You would have liked the family therapist to be suggesting to
him-
L: Yeah a bit more like Dan come on…
I: Be more directive?
L: Yeah but they don’t beat around the bush a little bit you
know they don’t come out with. Which I’d rather erm say look
Dan your daughter, we know you’re a little bit difficult we
understand that you’ve got a personality disorder and your
daughter, if you don’t work with your daughter and her partner
then other things are gonna occur. You know they were a bit…
I: Were they a bit too tentative, they weren’t really coming out
with what you wanted them to say?
L: Yeah, Yeah. But because we went back to therapy again, on
our own, just me and Charlotte on our own while my dad was
still in hospital what we, cos we told them we’ve been to Berlin
and we’ve done this, and we haven’t give in, and we’ve worked
together doing – to get my dad up and to get him to make his bed
in the morning to run his bath and put the stuff round the bath–
he’s been doing that.
I: Yeah.
reaction to basically where the problem was lying. So we've had
a little bit of therapy there at the Leepole clinic. Ahhm we have
also had again, ahhm, again at our initiative we asked for some,
some, when, when I found that our marriage was really at a very,
very low ebb I then contacted the local authority and we went for
some er, well we went for some counselling in all systems and
therapy ahhm and that didn't really do an awful lot of good. And
the last time it was when my husband was being followed because
he was getting, his memory was going a lot. So I said to him go
and see the doctor and eventually he did go and then he was put
you know in touch with the Hospital and then Doctor Sophie
Trixi who was at the time the consultant psychiatrist erm. She
then er, did quite a few sessions with my husband. First of all on
his own because he flatly refused for me to be there. Er, and she
came here. And then she did say to me once that she would prefer
it if you know, if we could both be there. Ummm, then she er,
well, then she left and she finished her sessions with him er and
also she left the service, she went to another hospital. Ahhm, she
did suggest that perhaps we might benefit from some er, some
family er therapy. And then she asked us whether we would you
know consent to that. And so we said er well, er, well my
husband said yes. I had my doubts because I felt that each time
we had been in on previously it hadn't really done an awful lot for
us and I had my doubts about it whether it was going to be a
waste of first of all whoever was going to see us – their time and
also a waste of our time but, less so because you know... But and
then I thought, so my first reaction was "no" I just it doesn't serve
any purpose. But then I thought well maybe perhaps there is a
chance and also I didn't want to be the person who afterwards
could be accused of you know, "well this was on offer and you
decided you know to sort of veto it or to torpedo it and not go" so
I thought "no I will go". So I said "yes" and this was then how
we came you know to be seen by the family therapy clinic. But, it
never was "family" in the strict sense cos when I asked "family
therapy what do you mean do you want to see the whole family?"
and I said that will be very difficult because all our children are
now not living at home anymore so it's very difficult to get you
know, together. So they said well family therapy means , you
know, as many as wish to be included. And it just was my
husband and myself. And, erm, so that is why we got that but I
already had my doubts again because my husband was (coughs)
although he was not then officially diagnosed as er, as
Alzheimer's because that only happened after, you know scans,
and various tests that they do. And (coughs) he was only then
diagnosed last summer or last march actually, we came back from
I: Are you okay to start?
W: Yes, yes.
I: So as you know I'm going to be interviewing you about your experience of family therapy at the Clinic.
W: Yep.
I: Okay, it's not going to be answering personal questions about the content just more what your expectations were.
W: Yeah
I: What you thought about it
W: Yep
I: If you thought therapy contributed to any changes or not at all.
W: Yep, Yep.
I: And this is confidential and will be fed back to the service but without your name. So the first few questions I'm going to ask you erm, about what your expectations were of the family therapy. Can you remember who suggested it and why that was?
W: Well, I think, um, I'm not sure. But, I think the wife, erm someone at the hospital suggested it to (pause)
I: To?
W: To the wife, yeah. Ern, I think, I think that was what I can't, I can't remember rightly it came via the wife as far as I know –
I: Yeah when she was at Hospital.
W: Yeah, yeah, yeah.
I: Okay, how did you respond to the suggestion of family therapy?
W: Er, better than I would have done a few years ago, because there was, um, a build-up to going into hospital you know, it was things that she came out with, you know, I thought really this needs sorting but I say the, um, you know, as when we did go it, I think it was the wrong time cos she wasn't very well, you know.
I: So you-
W: It would be better to go now (in audible) than really-
I: So you could kind of see the rationale for family therapy-
W: Yeah
I: But the timing was a bit off.
W: Yeah, yeah, yeah. I mean it wasn't their fault that the timing was off-
I: Yeah-
W: But it was, you know.
I: And it sounds like you were more open to it than you might have been-
W: Yeah, yeah.
I: Previously
W: Yeah, yeah I think so, yeah.
I: And is that just because things had-
Appendix L

An example of an interview transcript
I: Okay, So I’m just going to initially go through what the rational is of doing this again-

PP: Yah.

I: So, it’s to interview you about your experience of attending family therapy at the clinic at . And the purpose of this is to explore both what you and your family thought was helpful or unhelpful over the course of therapy. And this will include looking at what your expectations were before going, um, and how you think therapy affected you at the time, and how it’s affecting you now – if at all.

PP: Umm.

I: Erm, the interview isn’t seeking to ask any personal questions so it’s not going to look at the exact content of the therapy rather the process – so how it unfolded at the time and how you understood it. Erm, and in particular how you think it might have helped or hindered your family and what you went for and where you are now.

PP: Hmm.

I: And this will contribute to the major research part of my Doctorate in addition to kind of feeding back to the service but anonymously without names.

PP: Hmm, hm.

I: So they know what areas they are doing well in and what areas they could -

PP: what people they are thinking about it without saying well mr. or mrs. So and so thought about it this there you know in such and such a way, you know.

I: Exactly. So it’s quite private so you should feel free as I am not connected to the clinic I don’t work for them-

PP:Hmm yep.

I: So this should take about forty-five minutes to an hour

PP: Okay.

I: Feel free to ask to stop or no to any questions you don’t like.

PP: Yeah, yeah. Okay.
I: So the first set of questions will ask you about what your expectations were of family therapy. So first of all I was wondering if you can remember who suggested it and why they-

PP: Well that was actually the last therapy we have had. Ah, we've had therapy over a number of years because the marriage between my husband and myself hasn't always been always -Dolly could you close the door for mum I think you've met your lenses are on the telephone - over the years when we found that our teenage children were getting a little bit problematic you know we went and we went to the Tree Hill clinic and then after a couple of sessions they realised that the problem wasn't really the children it was more sort of their reaction to basically where the problem was lying. So we've had a little bit of therapy there at the Tree Hill clinic. Ahhm we have also had again, ahhm, again at our initiative we asked for some, some, when, when I found that our marriage was really at a very, very low ebb I then contacted the local authority and we went for some er, well we went for some counselling in all systems and therapy ahhm and that didn't really do an awful lot of good. And the last time it was when my husband was being followed because he was getting, his memory was going a lot. So I said to him go and see the doctor and eventually he did go and then he was put you know in touch with the Hospital and then Doctor Sophie Trixie who was at the time the consultant psychiatrist erm. She then er, did quite a few sessions with my husband. First of all on his own because he flatly refused for me to be there. Er, and she came here. And then she did say to me once that she would prefer it if you know, if we could both be there. Ummm, then she er, well, then she left and she finished her sessions with him er and also she left the service, she went to another hospital. Ahm, she did suggest that perhaps we might benefit from some er, some family er therapy. And then she asked us whether we would you know consent to that. And so we said er well, er, well my husband said yes. I had my doubts because I felt that each time we had been in on previously it hadn't really done an awful lot for us and I had my doubts about it whether it was going to be a waste of first of all whoever was going to see us - their time- and also a waste of our time but, less so because you know... But and then I thought, so my first reaction was "no" I just it doesn't serve any purpose. But then I thought well maybe perhaps there is a chance and also I didn't want to be the person who afterwards could be accused of you know, "well this was on offer and you decided you know to sort of veto it or to torpedo it and not go" so I thought "no I will go". So I said "yes" and
this was then how we came you know to be seen by the family therapy clinic. But, it never was “family” in the strict sense cos when I asked “family therapy what do you mean do you want to see the whole family?” and I said that will be very difficult because all our children are now not living at home anymore so it’s very difficult to get you know, together. So they said well family therapy means, you know, as many as wish to be included. And it just was my husband and myself. And, erm, so that is why we got that but I already had my doubts again because my husband was (coughs) although he was not then officially diagnosed as er, as Alzheimer’s because that only happened after, you know scans, and various tests that they do. And (coughs) he was only then diagnosed last summer or last march actually, we came back from holiday, and then but you see he already had this fading memory so some of the things that he said were just not so.

I: Hmm.

PP: So and I couldn’t all the time, because, and this happening now as well so now I just switch off because I think well there is no purpose being served. But I mean when sometimes he presents things, you know, as facts they were not like that. You know, I mean, even things like, like that you could actually check back on. I mean obviously how a person feels you can’t check back on – that you can’t say “well you didn’t feel like that at that time because I thought that or not” – But I mean facts that you can check that what he’s done, what he’s said you know, then he’s said often things that he’s done and I know he never did that or he did do that but you know. So I felt that also that the info that he was giving was not very reliable because of his Alzheimer as well.

I: Hmm.

PP: And so again we went for, I think for about ten sessions at.

I: So you were feeling a bit unsure of-

PP: I really, I really didn’t feel. I mean it did give me a chance perhaps to air a little bit of my sort of you know, sort of, er disappointment and my I don’t know, don’t know what you want to call it. So from that point of view it was positive in the same that now they have offered me some counselling I feel I don’t want to sort of go back on the path, well I will probably have to go over certain elements on the path, but I don’t feel erm, that I really want to sort of redress the balance now. But, I, for me now the need for me currently now is to basically occasionally to unload to find that the pressure that
I'm under now – and I do find that more difficult – that I can sometimes just talk to somebody you know that sort of – it doesn't alter a situation but it does give me a little, an opportunity, to er, to talk (coughs). Excuse me. So er, that’s why also I felt there, there was at least sometimes there was a possibility of bringing somethings out just saying well “this is what I feel”. But then, then we this family therapy I did occasionally bring up some things that have, that I felt were difficult in our marriage and so on and then you know they would say to my husband “well what is your view about it?” and he would say somethings er, (pause). I did, I felt on the whole er, it was interesting but it wasn’t really very helpful. Apart from the fact yes it did help me and so that in itself is a positive point you know that I...

I: What were your expectations of what they could....?

PP: I think also the wrong expectations quite frankly. I thought that - I’m eternally optimistic for me the glass is always still half full rather than already half empty – you know. And I had hoped that with the help of experts we would really get down – and maybe that was blinding me as well – so you know I’m not sort of putting the blame on my husband I’m saying that you know that I’m very, very responsible for this sort of thing as well. I was secretly hoping that it would get us together and we would have a more harmonious sort of you know, life together. Er, there are cultural backgrounds. My husband is Jewish and that has paid, played an – in fact last night talking my Dolly our youngest daughter and that came into it and you know (inaudible) and erm its played a major part. I mean I come from a home, my Father was a Catholic but left sort of religion when he was about sixteen or seventeen. My Mum came from a very, very strict Dutch Reformed background where she felt utterly stifled so when she was about eighteen she left home and I mean you know I’m talking quite a few years back you know. Ahm (coughs) and she left that and when they got together although they were both Christians they left the religion very much, you know it was left in the middle. I mean if, if we wanted to go and attend a sort of bible classes at the school we went to sort of a public one, well a public school as you know it in this country, but you know everybody could go – all religions could go there that is what daddy wanted us to go not to either a Catholic or a Protestant school. We went to school where everybody could go. But there always were optional bible classes and things like that. So if sometimes my sister and I wanted to go my parents would never say “no don’t go” there was never a problem, you know? But usually after about two or three lessons
(whispering) we thought we would rather sort of do something else and so then we didn’t go anymore – but that was also okay (coughs). We were never forced anything and my parents always said well when you are eighteen or nineteen or twenty-one you can make up your own mind and choose whatever you want to choose. They were very, very, ...

I: So there was freedom of choice.

PP: We had very much a freedom of choice. Coming from Holland as well which is a fairly liberal culture. Erm, that’s sort of, you know, basically a little bit of my sort of attitude as well. So then when I met my husband who was Jewish and because he was still, although he comes from a very, very strict orthodox family then through all sorts of circumstances he went away. And then when I met him he was certainly a more sort of liberal Jew you know he was eating pork and he wasn’t going to synagogue every Saturday and all that sort of thing. (coughs). And I thought well I can cope with that and also he felt very strongly that there should just be sort of one sort of voice in the family that you know there shouldn’t be sort of two different religions and Mum doing one thing – and I thought, sort of, well I can go along with that because I didn’t really basically have to renounce any religion because I didn’t really have that strong religious link that I completely had to renounce.

I: Hmmm.

PP: So I thought okay so I studied a bit what I had to do and then I converted to Judaism – Liberal Judaism because the Orthodox didn’t want to know because they are not interested – anyway, but okay, (coughs). I did that because I thought I can cope – on Friday night light a candles and all that and that was absolutely fine for a number of years it was absolutely fine and my husband went to synagogue on sort of days equivalent to Christmas days – very important days in the Jewish calendar. And this (coughs) excuse me this was fine. Then when the children arrived on the scene and that was still for the first five years when Julie our eldest arrived basically again, this was fine. But then, it was the business of the Sunday school my husband wanted the children to go. And again, I thought well that’s fine and of course it gave a little bit more because, again, our children went to local schools so there was no sort of Jewish things there. And then my er, er, then, er when Julie was five my husband said “well, she can start going to Sunday school” so I said well look lets leave it till six because she’s already got to be from Monday to Friday at a school where she’s got to go and then if on Sundays she’s
got to go again – lets just leave that for another year. And he actually, consented to that and he said “okay we’ll let her start at six”. Which is what she did. And for the first year she absolutely enjoyed it because it was drawing and this and that. She quite enjoyed it. In the second year when she realised with the regularity of clockwork she had to go, you know, she was less interested. And then my husband had started going there, taking her on a Sunday morning then, cos it used to be just up the road here. Taking her there and then he stayed and watched what was going on and that at that time and it was very much all learn and dad’s could sort of come and go and so on. So he did that. And then staff or the people there, a lot of voluntary teacher’s there, they thought oh what is this man doing staying around so they said to him well they are doing orange juices and things in the break time erm perhaps you could help us serve the orange juice. And he said “yes”. And of course my husband has got a very, very good knowledge of Judaism having been brought up in a very, very strict background I mean you know, he really does know his stuff as far as religion is concerned. (coughs) And the Old Testament and all that stuff. So basically, they said, and because at that time they were working primarily with voluntary teachers, they said well perhaps you would sort of like to take a class and become a you know, part-time teacher? And this he did and then from the moment onward, you know, it was just (cough) like that all the time the children had to go every Sunday morning they had to go whether they liked it or they didn’t like it and even to the extent, and this is where my objection came in, where I said things you know. My husband’s parent’s – and this is partly the reason I think why he was like that on as far as his religion – his parent’s most of his family apart from one sister who now is in Australia and has Alzheimer’s and is completely unaware of anything that goes on around her – which is of course also very upsetting for my husband.

I: Umm.

PP: Erm, all his family perished in the concentration camps. Not because they were you know anything, because at that time Hitler decided Jews were not the flavour of the month then so lets eliminate them all and they you know, obviously they killed and gassed them and my husband’s family was completely killed and he came here as a refugee in 1939 he and his sister both came here on the children’s transport and then they were you know they had a home life. And you know, well it’s all very, very complicated anyway from his point of view. And, and that was I think he had a guilt complex about having survived and, and the rest of his family

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died. And a lot of Jewish survivors suffer from this sort of a thing. And he felt that the thing that he had to do for the memory probably of his parents was to at least continue tradition a bit. So that is I think he was much, much more insistent on the children always going – there was never a let up. And, where I found it sometimes a bit hard to take and, was, er, that was for instance, so therefore there was no family on my husband's side well, I come from Holland so my family was in Holland my Father died already at a relatively early age and it was only my Mum who was the granny. So the children all they had was just one granny and then the aunts and uncles in Holland – you know my sisters and brothers.

I: Um hmm.

PP: But that's in Holland. So, she used to come over once a year in summer and then my sister would put her on the plane in Amsterdam and then I would collect her here from Heathrow and on Sunday morning because my sister then was working at the time and brother-in-law they could only do it in summer so fine. Granny you know came over on a Sunday and left again a fortnight, or three weeks later, on a Sunday. So the children said oh can we come with you and meet granny and so on and so forth. The only grandparent they had. "no can't Sunday school". And I said to him look, you know, why can't you just for once let go, why can't they want to come with me to pick up granny from the airport why. He said "no because once I allow them not to go then they will ask again". So that became already something, the way he was - I mean I've got nothing against the Jewish religion, because after all my kids are Jewish themselves so I'm not you know. Cos he sometimes said to me "you're anti-semitic" and I said "how could I possibly be my children are anti-semitic – I mean my children are Jewish how can I possibly be anti-semitic? So therefore, I said but you know, the way you are handling your religion that is something you know, that, and that became a really, you know, every Sunday morning in term time there were battles galore and I'm you know, because the children didn't want to go. And I sometimes, said "oh god" you know, and also I resented it because Sunday was the only family day we had because my husband had a business, worked very hard always throughout his life, always was the perfect provider for the family you know I won't say anything there. From Monday to Saturday and Saturday was the busiest day, always in the shop. So, from Monday to Saturday he was always away from home during the day. Sunday was the only day we had as a family and that was ruined because of the and early the children had
to wake up and “oh we have to go” and they would try and you know go slowly so they could sort of miss half an hour-

Laughs

By being late, you know what kids are like. And of course that would make him angry because he was supposed to be the teacher and he would be like “come on come on come on” and so on. So this is what happened and that’s how things started and then of course the financial thing — my husband of course had everything under control I had absolutely nothing at all of my own not that I wanted a lot of money but I said well “why can’t we have a joint account?” and just like. He would always give it to me if like I said you know the children need a new pair of shoes he would give me the money, or if I said oh I need a blouse. And then when Julie, our eldest child became, well she reached the age of about thirteen - fourteen, or something like that and all of friends were being given a dress allowance — a dress allowance you know where you they could buy you know.

I: Hmm.

PP: And Julie asked and my husband gave it to her. You know. And then I thought hey just a minute this is really daft! A fourteen year old child will get some money to spend of her own, but I, mother, you know, and I was like forty-five or whatever it was, and I had to ask my husband would always give it but I would say I need a pair of shoes or I borrowed it out of the housekeeping money because he would give me housekeeping money and that was it. And then I would buy say a new pair of shoes out of that and I would say well, you know I bought myself a new pair of shoes you know, but I had to ask. And I found it really skew-whiff.

I: Hmm.

PP: So I did say something about it. And I will say then he said yes I think there is something right. Then he would give me every two months he would give me a little dress allowance. But it wasn’t never paid on time, never, never, never I always had to ask and beg for it “and oh yes, yes, yes, I’m a bit short of money”. — Nonsense, because, you know, there was cash in the shop. So, all of that they really were our points of friction you know our major, major, major things and so on. And that got worse but of course I probably stuck it out a lot — I mean I had said several times that I thought “I can’t stand it anymore I’m leaving”. But then I thought ah, most of the week he is away, Monday to Saturday and so basically you know, it’s it’s manageable. But of course since 2000 when he retired things have become somewhat more
difficult because now he’s home all the time. But I always, to come right back to your question, after this long story (laughs) I always had a hope that perhaps if I were to go for therapy and we could bring some of these points out my husband would sort of, perhaps realise, perhaps that perhaps that a little bit of an adjustment somewhere might ease the situation.

I: Hmm.

PP: And things would be better. And I always had this hope but, basically things just were then back to normal and that was that and so...again –

I: What do you think your husband was expecting do you think he shared the same kind of idea as you for going to –?

PP: It was always me who had to take the initiative because he would say – “well if you think it’s of any benefit I’ll go” you know but, he would never have taken it. In fact years ago I had a very dear friend who unfortunately died now Rupert Shovel er he was a psychotherapist in fact he taught at university as well. And, erm, and I knew him and er, then I remember once saying to him that, that you know – it was really quite early on in our marriage and that I found that there were certain ways that my husband wasn’t reacting in sort of a normal way which I think was due to the fact that when he came to England you know he was brought up, well he was in a sort of a boarding school. So obviously things were fairly rigid not like in a family in a family you know you can let things slip or you can sort of do something for one child. But of course you can’t do that in a boarding school with about a 100 kids there because if you give one person a privilege you’ve got to give it to the others as well or you’ve got to get you know. So my husband had always had a much more institutionalised idea of how you deal with children how you discipline children. Whereas I’m a little more laissez faire because I know oh well the world won’t come to an end if they don’t eat their soup or something like that you know. So there was also this attitude that my husband was very rigid when he was around and I was a little bit more sort of easy going. So, er, hmm, I was hoping that perhaps he might sort of become a little bit more sort of you know flexible. Oh yes, and then, when I saw Rupert Shovel I said you know my husband, is I think he is having you know, some problems and then from what I told him he said “yes I think you know your husband could do with some you know, with some treatment because of his very disruptive up” – well his childhood is awful I mean when you think what has happened to a small child who came as a nine year old boy –

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I: The trauma

PP: The trauma of that you know and he said "yes I think your husband could probably benefit". And so I suggested it to my husband and then he said to me I can't take him on as a patient he also saw patients privately and because he said I know you and it wouldn't be fair because you know I would rather he went to see a colleague maybe of mine or one of my colleagues because then it is totally impartial because I know you and therefore I, I would rather leave it. So I said okay fair enough. So I suggested that to my husband and he went to see, and see he went to see somebody up in Hampstead and he went for two sessions then. And I now think that he probably felt that the ground was getting too hot under his feet. You know and he just backed out and said I don't want it I'm perfectly all right, perfectly normal. And then later on I did hear from Rupert Shovel that he said it's a shame that he didn't continue with it because you know he is actually able to do the treatment but obviously you can't force an adult.

I: Hmm.

PP: And I think that, but that is now in the past you know but I think-

I: So you've both had some kind experience of therapy before the idea of –

PP: Oh yes, very, very much so you know we had an idea and I knew it would help and I was sure it would be very painful because you know that is not something that you go in lightly and especially not with these sort of background and you sort of start raking up all this and so on and having to come to terms with it. But, if you do it with an expert eventually, you can never forget it but then you can sort of give it a place in your life and you can carry on with that. I mean it's like somebody dying as well er, my dad died and I as devastated because I couldn't go to the funeral it was two weeks before Joseph was born and because I had a fairly poor gynaecological er history my specialist said I don't want you to and I don't think the airline company would taken me to go cos it was two weeks before he was due. But erm, I, I, I do find that you know, you give it a place in your life I, I, resented the fact that suddenly my Father just wasn't there from one day to the next wasn't there and he died quite young and I was then already living in England here. And now I sometimes when I see my children I think "oh it's a shame Dad couldn't see that you know" like one of my son's is mad
about football and my father was very much involved in football as well and I think it would have been nice if he could… and then but that is the sort of thing. I’ve given it a place. My Dad has died but then he died, well, an early death which is a bit unnatural but basically you know, under normal circumstances, but –

I: You can still carry him with you and it would be nice if he could see your children but it’s not continued grieving.

PP: Yes that’s right. Yes it is not that I still mourn. I sometimes think “oh dad would have liked that” that sort of thing I have but I have been able to give that a place the same as the death of my Mother she died in 89 and sometimes I think I wish I hadn’t done one or two things because I was a teenager and was a bit of a stinker so I think “I wish I hadn’t done that”. Cos then when you have your own kids you suddenly realise ho ha it’s not so easy to raise children and you know, they can be a little bit of handful. And I think I had been a little bit unfair and I wish I could tell her that “mum I do realise and sorry I was such a stinker when I was a teenager” so yes that sort of thing but I mean I am not constantly sort of being deeply depressed. And my husband never had that opportunity and there was that opportunity possibly there through therapy had he continued but perhaps he would have given that very, very important part of his life, he was very affected by, a place in his life. Not forget about it but in fact you know it was a part of his history but carry on forward. And I think he was quite often very depressive. But I was always hoping that the experts would be able to solve sort of making things-

I: Hmm

PP: And that is why time, and time again I said “okay let’s go for it again” and then we did and then also when Sophie Trixie said I personally felt oh it’s never been very much good and things haven’t really improved is there any point? But then I thought I don’t want to be the one whose a spoil sport so then that’s why I said “okay let’s go in for it” and that’s how we then ended up.

I: So did Sophie Trixie explain the structure of what it would be like?

PP: Er, she did. And it was certainly also explained to us when we got there you know because I mean er, you know she came to see him basically because of the connection with the Alzheimer well, at that time it wasn’t definitely established
that it was Alzheimer's but memory problems and then
certainly explained it to us, you know, what, what the whole
structure was going to be and so on and so on and so forth. So
yes, yes they did they did that. There was certainly not a lack
of them explaining to us what would be involved you know.

I: Okay so that is about your expectations. So the next section
I want to ask you about your first impressions of the therapist
and the team. What were your initial impressions, in your first
session, of the therapist?

PP: Umm, well I thought it was fine because also it was the
first time after quite a gap because at the, no at the Tree Hill
they already had this sort of mirror thing but this was a little
bit more sophisticated. And then also at the Tree Hill clinic
we had only just two people – one therapist went behind the
sort of the, you know one way mirror and then the other one
did questions and then later on they switched over and then
eventually something together. Whereas here it was a little bit
more, there was a team because they were usually, well there
was er, the one person asking the questions up front and then
there were one, two three, usually in the other room. So that
was a bit different that there were many more people involved
and one was a man as well and er, and er then of course this
whole thing with the camera and that sort of stuff that was a
little bit but erm...

I: That was a little bit?

PP: Well it was a little bit different in the fact that it was
technically a little bit different with the cameras there you
know.

I: What did that feel like for you?

PP: Er, well well it didn’t worry me really, no. I don’t know
whether it worried my husband but it didn’t worry really, no it
didn’t, it didn’t worry me and I knew that this was an extra aid
to ah. Because very often I think as well, that probably erm,
ah, body language is important as well-

I: Hmm.

PP: and I suppose that that catches it on camera and later on
perhaps if the therapist then discuss what has been going on
during the session and then they sort of, you know they can
still see because presumably they taped it on video as well I
don’t know, I don’t know whether they do that. So it’s
probably very helpful as well to sort of see well you know our
body language is constantly fidgeting or, you know, doing this or that and the other and so it, I just see it as an extra thing that can only be a positive help

I: hmm.

PP: It doesn't worry I mean I, em, cos they asked whether we minded and you know, I said "no it didn't matter" and my husband didn't have a problem with that either so...pause

I: And the therapist that was in the room with you was it a lady or a woman er a man!
(Both laughing)

PP: Yes, it, it was a lady, yeah.

I: And what were your first impressions of, of her?

PP: Erm, (pause) you see that's again the sort of thing within me erm...(pause). I know that they have to be impartial so they can't sort of being all very much (laughing demonstrating facial expressions) on their face I work best with a person, you know, when she or he is angry I can see it.

I: On their face?

PP: On their faces and when they are happy and so on and they, but I can also see that they can't afford to be like that because they can't sort of, if I say something funny or something silly or something that they laugh at or you know, because then I would also lose confidence. So in the overall picture I think it is better if you probably have a fairly, sort of, you know, um, you are, are, a fairly um er (pause)

I: Composed? Don't give away much?

PP: Er, (pause), er up to a point quite detached you know I work quite well when people say "oh come on so and so" because of myself I'm like that and of course it's jolly unfair of me to expect and I do understand because I, I, do remember because I did go into therapy as, as well right, right, right from the beginning. Er, and er, then I sometimes thought well "doesn't this man ever er, get, say something rather than...". But I think the strength of it is the fact they are not like that. That they are not sort of saying "oh you poor thing" and so on and so forth you know and "oh that's awful" and, no! And, and –

I: So initially you felt that she didn't give away too much on her face?
PP: I found that she didn’t give, yes, yes, and, and I find it always very, er, very hard I, I, I, er (pause) at the one level rationally I realise it is ultimately for the best and it is not a good thing to have somebody there who is constantly, you know sort of with your mood or the other person’s mood you’re with, you know, er constantly, sort of, in, in line with that. Erm, but at that same time it’s something that I’m, this is basically a little bit of the um, the sort of part of my character that on the one hand I know it can’t be like that but the other hand I’m hoping might be like that – you know what I mean?

I: Ummm

PP: And it’s the same with this sort of thing as well sort of going into, er into I know that certain things will just not change but I always somehow think “well maybe perhaps you know if I, if I go into therapy it might this time work”

I: Ummm

PP: Whereas perhaps rationally I know ah, a (shaking head).

I: So you were perhaps hoping that she might a bit give more away?

PP: A bit more or a bit more or perhaps give a smile or say sort of say “oh yes, yes, yes” or that sort of thing and there was never very much much sort of, sort of, of that.

I: Hmm. So when you first met her did you think “she’s someone I could build a relationship with”? Or...

PP: Not so much with her but there was one lady there who was, usually behind the scene, and er, and and then she came er, then she came halfway through, you know, they sort of came into the room with us and then they sort of gave a resume of what had been done and so on. And there was one lady there and I, I, you know she was a little bit on the sort of, you know plump side, and she had this very reddy, smiling face and I think she was the one I would really, I felt very, I, I thought well, hmm, if you would be in that chair, like that you know (laughing).

I: So you’d have liked her to be the therapist in the room? And what was it about her that …

PP: It was just (pause). She was warm, yes, she was warm, she
was warm she was cuddly she was a little bit on the plump side you know and she was cuddly you could sort of imagine her sort of you know....pause

I: Mothering?

PP: Mothering, yes! That sort of a thing, yeah, I think so. Er, but, but the other one was perfectly all right, you know, and, and so on. But I found that almost, erm she was almost sort of a bit doing it on the intellectual side and she was leaving out any emotional side which is of course a stupid thing to say because the other lady probably had she been the therapist she would probably would have also been less sort of you know, er, lying there, but perhaps being....

I: So you thought the therapist was being intellectualising and...

PP: Um, ...

I: A little more than focussing on the emotions?

PP: Erm, I did feel at times a little bit like that, yes, I did feel like that.

I: Okay did you think your impressions of her changed over time?

PP: Pause. Er, no, er I think they changed more or less the same I think. I also realised that she was very fair, you know, she would sort of you know, take pick things up and then ask my husband you know, about things to sort of give his version and so on and so forth. So she wasn't sort of letting me sort of you know say a lot of things and my husband very often is like that if I talk, and I'm very chatty, then he quite often he sort of takes a step back but she was quite sure that he would also get his say in.

I: So she made sure you both were heard?

PP: That there was balance. Yes, it was very balanced, so she, she did do that. Yes, yes.

I: And how do you think your husband viewed the therapist do you think he saw her in the same way? Or...

PP: Erm, (pause). Well he's always been very sceptical because he always found well you know it's all right but it's not going to do an awful lot of good he didn't really think an
awful lot and he primarily went a. because he respected Sophie Trixie very, very, again because she was Jewish and I think he always has that little sort of thing and it’s or something I find this as well – maybe it’s understandable maybe or, although I don’t personally feel ah, somebody is more competent just because they’re Dutch and I’m Dutch but he always, sort of has this sort of a thing that if somebody is Jewish then it must be all right. And she turned out to be Jewish I mean she wasn’t sort of saying she was Jewish

I: Umm hmm.

PP: But we sort of realised that she was Jewish anyway. And he had an enormous faith in her and he was very upset that she actually had to then leave because she was changing jobs and we then had somebody else who was always very nice but he already felt, well you know, and so on. (coughs) And I think also he, he took it on because sophie did say you know “I think I would like to recommend you both to family therapy I think you could both benefit from that.

I: Hmm.

PP: And this is she started the whole process, you know set it all in motion. And so he went along because she had said that and he had an enormous respect for her and enormous faith in her that she, you know, she was, you know because he had already been seeing her lots of times because of the suspected Alzheimer’s and so on. Er, and so that he did, er he did that and er, he went along and he does all also very often he finds less so now but in the past erm, maybe because he himself through circumstances didn’t have a formal education he does respect women who are quite clever.

I: Hmm.

PP: You know and he, and I mean his first thing always I found I sometimes called him an intellectual snob and I will say to him cos he would say “oh she’s very intelligent, she’s very bright” and then I would say “does that matter that she’s intelligent, that she’s a warm person, that she’s a good friend and mother or whatever” you know. I would say “why do you always judge people on their intellectual capacities” you know.

I: Hmm.

PP: But er, and this is another point that I sometimes say “well is it important?” I mean well people for what they are...
I: So with the therapist in the room you said she was, it seemed like she was working on intellect

PP: Yes

I: Did, did you think that might have worked for your husband?

PP: I think it did work for my husband because he probably respected that you know that she was, that she was, that you know, she was quite, that she was clever, she came across to him as very clever and so on and and must be capable. Whereas he thinks, for instance, the, the erm, because we had Sophie Trixie first and then, then when we had to go for various scans and then also the tests and so on that er she did she is a lot younger and he has no faith basically in her you know, sort of er, I mean, I don’t know whether...

I: The lady that was doing the scans?

PP: Well the lady who recommended he do the scans the, the Consultant, erm, Psychiatrist who took over actually from Sophie Trixie.

I: Oh right.

PP: Erm, you know and so he had to go and see her then at well, yeah he had to go for two scans MRI and CT scan and then also she did some tests with him and er, he sort of you know sort of derided that he sort of derided and “she was asking what borough do I live and so on and so well they’re stupid questions” and that sort of thing and he won’t take on board that this is sense behind certain questions

I: Hmm

PP: Which may think utterly stupid you know, and so on. And also because she, well, I don’t think she’s that young I think she’s probably around thirty-eight, forty but he thinks she’s twenty-five and he says “well she’s young she doesn’t know what she’s doing” and he has very little confidence in her.

I: so the therapist in the room –

PP: Yeah.

I: Do you think her age might have had an impact...
PP: Erm a little bit I think but I think she was probably about sort of in her thirties probably maybe even slightly older difficult to say with women nowadays um, I think also because she was, she came across as being very efficient and very sort of that sort of I think appealed to him.

I: So you think your husband might of, sort of, seen her as credible?

PP: Yes. Yes, I think, yes, I think he did yes, he did and also the fact that also I think, and that I can understand as well, erm, because before we had always teams of women only whereas this time although the therapist in the room with us most of the time was a woman in the group of the other three there was a man. And I think he liked that as well because I think possibly as a man you can feel well, you know... I: Unbalanced with all these women?

PP: Well, imbalance and that they'll see it all from a women's point of view and you know, they'll see things a little bit more differently than a man and so on and so forth. And I think he probably felt that, that was sort of you know something against erm, not against him per se, but something that a bit of an imbalance there so I think he was rather pleased that there was a man there someone who could sort of give a man's interpretation of what he had viewed and heard you know when we were talking to the therapist.

I: And do you think your husband's view of the therapist changed over time – over the course of therapy?

PP: No I don't think so because he never really said very much I mean ah, at one time we would afterwards but you see I think that where the Alzheimer's comes in as well. Because things are very, you know instantaneous and moment, moment, moment things and ten minutes later he may have forgotten or already lost what happened ten minutes before.

I: hmm.

PP: And whereas on previous occasions when we went for therapy we quite often afterwards would talk together and sort of go over what we had discussed and so on and so on and sort of have our own little sort of you know – and that never happened the last time at this clinic and I don't think that has anything to do with at this clinic the way they did it I think that is purely because my husband just simply, already had put it you know away, or had forgotten about it.
I: Hmm.

PP: That I think basically is I think a contributory factor that we never really sort of afterwards talked very much about it.

I: So you think that might have contributed to the outcome of the therapy?

PP: Er, I think as well, yes, yes, and that’s why also I had my reservations about going into therapy the last time because I knew how forgetful he was and you see he is still, he has always been very er very able to ah express himself his language is still very good, only now is he forgetting names of things you know, and he says oh “what do you call that again?” But he can, still he is still capable of talking, always has been he could actually for a long time, when I met him he was a lot older than I am and I was an eighteen year old little green girl coming from Holland you know just from high school meeting him. So, I took everything in lock stock and barrel because he is, he is educated although his education was of course, very, very sort of you know he has educated he is educated he is well read he has read a lot. And I looked up at this much older man with all these friends that were much older than I was and I took everything in lock stock and barrel because I thought “well he must know it all!” but of course then I became a little bit older and started doing various things and I thought “hey just a minute you know” and then I sometimes would question what he would say and that of course is also another thing which he didn’t like. I mean if I were to just take everything on board lock stock and barrel then it would be fine I would have had a blissfully happy marriage but you see you, you yourself develop as well and then of course when you have children

I: Hmm, Hmm

PP: Sometimes you have to stand up for your children you know whether it is in the playground and you see that your little Johnny never gets a go on the slide you stand and you say “this little boy of mine wants a little turn” and this sort of so you become a little bit more, you know you, you, do-

I: you develop as a person?

PP: You develop as a person. And, and that again was something that my husband found, I think, rather hard er, to, to take. But also, you know and erm, at times we would actually, we would then afterwards we would discuss things as well but this now, you see doesn’t, doesn’t happen anymore
you see because his memory just, it’s just not what it was but he can still a lot of people who meet him for the first time now, you know, probably don’t cotton on that he’s got Alzheimer’s and, and because he can still talk quite a lot you know. They may sometimes think that he has sort of said but then again you lose yourself as well and sometimes you know if somebody says something to you and then you think five minutes later you think “oh my God what did they say?”

I: So he’ll come across as very competent?

PP: He comes still across very, and I think that was why also I think he quite often I think fools still not deliberately because don’t get me wrong it’s just the impression he conveys because he’s always been very capable of talking and so on and sidetracking as well you know. He used to sidetrack a lot and if anything perhaps didn’t suit him he could go on because as Sophie Trixie again told him once she said “you know really Mike”- she called him by his first name of course she said “Mike you know you want to go to Wimbledon via Edinburgh” and that’s exactly my husband-

I: laughs
PP: up to you know, because he is like that he won’t shhh go like that.

I: So what were your initial impressions of the team?

PP: Of the team? Oh fine, lovely I liked them.

I: You didn’t feel, you felt, what felt that they were what did you think that they were trying to do?

PP: Erm, I, I think er (pause) well they were obviously first of all I, I knew that they would obviously try and help us perhaps to sort of you know see things perhaps in a slightly different light or you know, sort of make it part of certain things that they are not necessarily... I think they were trying to give us I think also confidence in ourselves and also, and also to see the other person’s point of view quite a bit as well.

I: How did you think they enabled that?

PP: By always then when (pause) er right at the beginning er, well then again it was the therapist first because we would always start with her first. She would say something and then quite often I would start the whole thing well she would sort of say well, whatever, and then I would something that particularly that had happened during the week I would sort of
bring that up. And then she would let me have my say and then she would ask Mike you know about his, his sort of view. And then she would put a few questions which then made you think yes, I have looked at it perhaps too much my way and I think their prime aim was I think possibly for us to have more of an understanding of the other person’s situation. And I think both Mike and myself I think have maybe an inability that rationally we can at that particular moment have a feeling and once or twice you know, we, we cried there because emotions coming suddenly up.

I: Hmm.

PP: And so on and yet somewhere along the line and either an inability or a deliberate not wishing to take that further I think the problem lies probably with us rather than that I would say they’re inefficient or anything cos I wouldn’t like to say that at all.

I: So emotion would come to the surface but you wouldn’t want to take it...

PP: I think that we did not really as some the emotion came to the surface and you would get an insight in the emotional feeling of the other well, this is how I perceived it, I don’t know whether my husband necessarily felt it in the same way but then, I, I really and then at times I thought yes you know you really have to allow for the fact that it isn’t just because you can easily er, accept things and you’re more flexible it doesn’t mean to say that the other person you know, doesn’t have feelings either.

I: Hmm.

PP: That there is also a feeling but it comes across in a different way. And at certain moments and that, it did and I think that was probably the whole purpose as well that, that of therapy that you try and see the other person and why the other person has done or said certain things. And, and I think that is probably what they tried to do er, I’m sure it was what they tried to do

I: Hmm.

PP: To sort of help us to sort of see each other in slightly different lights and not always in this set way that either of us we would you know have reached.

I: It sounds like to an extent you did start to see each other’s emotions.
PP: Yes, yes, we did start to see them but then somewhere along the line coming back home again that sort of completely dissipated again. That there was nothing else to sort of maybe there was deep, deep inside and, and again this time I can only talk for myself you know, and I sometimes now have moments that I feel extremely sorry for my husband and I can just suddenly sit on the train and like, the other day when I came back on Wednesday from the theatre and I was going back from Ridgere to oh, well wherever, you know to here. And er, suddenly, I my thought, because it was quite a – I saw the deep blue sea play which is very much about feelings and, and relationships and so on. And I was sitting on the train thinking about it then all of a sudden for no reason at all I just thought of Mike my you know, my husband, and, and then I thought yes and then a wave of feeling that came over me it was very emotional and I thought well I must, I must try and try and try. But then I come home again and then he says something which irritates or something like that and the whole thing is gone then you see? It’s not a lasting feeling.

I: So the reality doesn’t-

PP: Interferes with

I: Interferes with what you think is a good intention behind it.

PP: Yeah, something like that and I think probably that it might also be the same with my husband that perhaps um reality takes over again and you know, um that’s it. But, as I say I can’t speak for him and he is also a man that who he doesn’t easily come across with his emotions because sometimes - he has a very, very, good friend who he knows for a long time also Jewish and a refugee as well and then sometimes when I say, and they meet, and they met fairly regularly not so much now because he has moved had a very difficult time him and his wife the move and this and that. But then I thought this is a male sort of thing that men perhaps don’t talk much about their emotions because sometimes I’ll say did you ask him about his health “oh that’s something personal oh I wouldn’t ask him” and I think you know, and this again and the first thing, this again, we, we function at a totally different level I mean I if somebody says to me “I’m not feeling very well” or “my leg is hurting” then the next time when I see them again I say “how is your leg today”-

I: hmm.

PP: Which to me is natural because that’s breeding I think.
I: Because it would seem to you to be uncaring to not ask – but your husband thinks it would be being rude to ask?

PP: He thinks either it is rude, but also when he had, because he had a wonderful er, er, manageress in the shop she was you know the last few years she was running it. A wonderful person and thank, we sold the shop to her, while so she took it over anyway, so she's there now still but now it's her business. And, erm, I remember and she was wonderful because she was really, really very good and my husband realised it and appreciated it. But she had once or twice because she had two kiddies and so on and she was there full time and once or twice she just basically had the flu and just couldn't so he sent her home. So he told me, “today I've had a very busy day because mary wasn't in the shop today because I had to send her home or she didn't come in because she was really very ill, very ill. So the next day I would ask him how mary was feeling and he didn't ask I said so you didn’t ask if she was feeling better then. And he said no because if ask her and she says I’m still not feeling very well he said then I might feel obliged to have to send her home and then I would have to do the work myself. Now this is a way of thinking of rationalising that to me is so foreign and there are lots of things like that. You see, and then, when he is together with Barry as well he says I won’t ask that’s his business, I won’t ask. Barry has had cancer he’s had prostate cancer, he’s had, he's had heart bypass things and I say sometimes when he’s seen Barry and I say, well “how is Barry today?” You know “does he have to still go back for checkups?” “Oh I don’t know because I don’t ask that sort of thing because it’s personal”. He, he almost feels that he doesn’t want the person to become (inaudible) and as I if somebody’s had a triple heart bypass and all sorts of you know, real health problems and Barry has had them, I’m surprised he’s still alive, you know, then I want to know if it’s a good friend I ask, you know, I wanna know! And although I know I can’t change the situation and at the moment the situation is still very bad I can only sympathise and I certainly can’t change it but I still would like to know and I wouldn’t feel well, I mean obviously you’re not sort of going to ask too intimate a question either I mean there are things between a husband and wife you know, and you’re not going to sort of start probing like that let me tell you something. I mean but it’s a person’s health...

I: So what was it like for you both being in therapy together?

PP: Well, as I say er, we, we, we did find out that we’re not quite...well I found out about my husband that he did have
feelings but he simply just only there could sort of, you know, come out with them a little bit more.

I: Why do you think that was? What was different about that environment, that, do you think that made that possible?

PP: I really don’t know. I really don’t know. I suppose it was the skill of the erm, of the therapist in order to bring this out and get him to sort of say things, you know that he would not come out with to me, basically. And I maybe, I don’t know, maybe my inability to work on that back home again, I, I, I, don’t know. And perhaps I should have faced facts and not sort of lived in cloud cuckoo land that perhaps one day it would still, it would, would be better, you know, and erm perhaps had thought and acted on and what, what last night I said to Julie, actually, I said some of it probably part of the problem is that perhaps when I did realise things were not going right that perhaps I should have said look let’s part. But then I thought well, these children, we have sent them into this world they didn’t ask and basically you know, apart from the major sort of things, well the things on Sundays and so on and so forth, during the week when of course my husband wouldn’t come home till eight o’clock and would leave in the morning at about eight. So, basically we were there and we were and of course this is also another thing my husband always tells me – I’ve stolen the children away from him that is an expression that a therapist in the Tree Hill clinic used. She said “so you Mr. Wood”- she still called him Mr. Wood then it was in those days before we, sort of, you know and she said “so you Mr. Wood you think your wife has stolen, has,” and she used the expression “has stolen your children away from you?” and so he said “yes I feel that because the children are sort of all hers because they sort of always come to her first”. Now I don’t find that unusual at all because if I am with the children such a lot and my husband is not there then obviously when they come in from school and they have a problem they come to me and they are not going to wait till nine o’clock when my husband has got a moment to listen to them. And I find it a normal sort of thing I don’t find that, that, you know that I’m, and I, I can’t see how somebody could really see this as stealing away. But he pouched on that word and then every time “the children are yours, you’ve stolen them away from me” you know “there always with you” and so on and so forth. And, then, you know, again, and this I did bring and this did come out as well, well in one of the very first sessions at –

I: At this time?

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PP: At the clinic as well that he said well “you know my wife has stolen the children, my wife and the children, you know that’s just one unit, you know and I’m on the outside”. But (pause) I guess if he feels it like that, that’s an honest feeling then as well even though I feel that it’s confused but, it’s still his feeling if that’s the way he feels and, and I quite often used to say to him “but this is not true I mean we’re doing things here” and sometimes you know quite often at the table he, you know was the bantering going on, I mean five kids and, you know and a lot of things going on. And then he would say, and eat his food and pretend as if he wasn’t part of it. Well, and quite often as well, it’s in all sort of things it’s the atten – now again, it’s probably to do with his background because he didn’t get the attention when he was a child because, you know, he, he was one of a hundred boys. But, for instance, if you speak to him, you know, he, he will lots – and now sometimes I do go away because I, I can’t take it and I just sort of pack up and start washing up. But, for instance, if you talk to him he wouldn’t like it if at the same time you did a bit of washing up even when you were talking about other, you know, trivial sorts of things “can you please sit down and listen to me” you had to actually sit in front of and listen-

I: Full attention?

PP: He wanted the attention, the attention. Whereas I sometimes can quite happily in the kitchen, quite often do this, you listen to your kids and at the same time you need to wash up you know you need to do a few things at, you just use your hands and you may have to use your brain for that. But that he found always very, very hard and you know you really had to sort of sit down and sit and talk and “let me speak, let me talk, can I finish my sentence and so on, can I finish this and that” and then, you know, it’s all these things these very sort of rigid things. (Pause). I’m sure inside his personality is a very, very sensitive guy that’s maybe perhaps why I felt I had to hold on because I feel inside him there was this little, sensitive, little boy who from circumstance –

I: And that’s what gave you hope?

PP: And that’s also I think what gave me the hope well yes because there was sometimes things you know that I thought – I mean now I’m getting full of emotion because sometimes I think on occasion he will come out with things and I then I think yes but you have got all these feelings and why did you fucking well hide them! (crying). I’m sorry I’m getting emotional about this now because…I think, bloody great…anyway…
I: So you saw a lot of potential in him?

PP: I saw the potential in him and I wanted to go on and maybe I made a mistake and maybe I should have said "look it will never work out" but perhaps I should of but then I thought the upheaval of the children changing school probably changing houses and so on and so forth and the problem’s between us and not the children and we were, we were managing. So I thought stick it out and wait until they were, I remember often the magic 2000 I thought well in the year 2000 maybe I'll, I'll, I'll will leave because then Adam our youngest is twenty he’s probably, he probably might not even be living at home he'll be studying. Basically, you know, you know, perhaps he won't leave and then it won’t matter so much and because I wanted this to be, to remain the family home also because the children don't have any family in this country you know we have lots of friends because that again we’ve cultivated because we had no family. But I thought this is always the point that, I mean, family is very, I mean Christmas's here, apart from the fact that he well that he was very often anti christmassy thing, you know it's a big family gathering, birthdays still as well and the children still like to come back and Julie has been here, she had a little holiday she has been here for a week, you know and in between sometimes when the kids are having changing apartments and you know they can only move in, in six weeks time

I: Hmm

PP: but they have to vacate where they are now. They come back here lock, stock and barrel stuff in the garage and so on. It’s all and I feel as long as possible I would like to keep this because as long as I can nurture that when we are gone they still know I fought hard for that family so that if ever I need, they are in need of somebody you know, or somebody, not on a long term basis but, that's where I can go to you know to those people were without any questions sort of saying, and you know. And I will say the relationship between all the five kids is wonderful it's really wonderful the way also now all rally around and sort of take things off me, you know, one takes my husband swimming –

I: You have given them emotional security to feel this is the place they can come back to?

PP: Yes, yes, and I have always and that’s why I didn’t and I thought well you know, basically, you know its okay, its okay. But I remember I had this magic 2000 in my mind and I
always thought well, and then of course in 2000 my husband retired and then, memory problems started coming and you know, because I already suspected a long, long time before then that there were problems there because I used to work for quite a while, I used to work in France and because I, I studied French at university as a mature student when the children were sort of, you know, I’d given them and I did a degree course at UCL. So, erm, and then for my spoken French I felt that I wasn’t getting enough at university so basically I found a job in France during the summer months for about four or six weeks well, usually about four or five, and then I had to speak French all the time that was in holiday homes for the elderly and handicapped. And, French people of course you know and they worked a lot with voluntary workers doing sort of daily bits and pieces and this is what I, I volunteered for and they took me on and I’ve done this now for the past twelve years since 1992 no, longer than that actually. In 1992 I started but now I have to stop because I can’t be away from my husband for that long anymore. But I did it and of course then I, I, there were always in the group of people, there were always one or two people who in some sort of stages of Alzheimer’s you know, but there the organisations thought that they could still benefit from a fortnight holiday somewhat. So I already recognised some of the symptoms there and I said to the children it’s just not a normal forgetfulness, you know and er, I think I can see Alzheimer's and his sister in Australia had already then having signs of Alzheimer’s and now being like a complete like a vegetable basically. I said I have a feeling he’s got Alzheimer’s and unfortunately I was proven right because eventually then I did manage to persuade him to go and see his GP about it you know, and he said “oh this is ridiculous” I said go and see your GP because nowadays they have drugs available to help you a little bit and so on and so forth. And then he went and then of course the whole thing started with emotions and so on and so forth. But, um yes, it’s and still there I still have, and I couldn’t leave him now you know and, and I still, I still you know, have bouts of feelings and I still want to make the most of perhaps the next couple of years as well but it’s nothing to do with the therapy. And it’s basically erm, you know while he’s still con, I mean he may forget things but I want to do certain things with him now and we’re going to Holland er you know for a weeks holiday not to visit family but, to (inaudible) I’ve booked another holiday and I asked him what he’d like to do and so, and when you take him away from here, you know, from the whole situation and no phone calls and no things that he doesn’t understand but then that is wonderful and we have some very, some very lovely, lovely times. And so whilst he’s still capable of enjoying them even...
though a week later he may have forgotten that we went to Holland, you know, he will still whilst he's there enjoy things-

I: Enjoy things

PP: Enjoy and this is what I would like to do as long as it is possible and, and so on. And, and maybe this is also again because I always sort of hoped that whilst they, perhaps, you know and that's why I sort of plunge to these sort of things again but although on the one hand I think well it's been a failure this therapy the last time it didn't really lead to anything afterwards sort of ssssh back to square one again very quickly erm let's just give it another try, you know. But, erm, I had my doubts as more serious doubts and I did say to Sophie Trixie well basically I can't really see an awful lot of benefit but if there is a chance of some improvement I will still try it and, you know, and that's why we went into therapy.

I: Did you feel you could say everything you wanted to?

PP: Yes. I did. But, no, the last time I was already limited then because I couldn't ru-, when I heard my husband say a few things which I knew were just not correct because of his memory, I felt I couldn't interrupt the people and say it's totally it wrong, you don't remember that. I couldn't rub it in. So I think, again, through my fault nothing to do with the therapist or the therapy there, I feel that possibly also I might have nipped things in the bud because I felt I can't, I can't, I just felt well if that's the way you feel it, if that's the way you see. Well I actually know. I mean feelings you can't say, I can't say-

I: hmm

PP: That was the wrong feeling because you didn't feel like that because if he did then he did and I, then I have to take it on board. But when I knew in fact that he was relating events and bits and pieces which I knew just were, just not right or some of them didn't even happen (sighs) I sometimes thought say now when he says something and I hear him say things and I think oh God I know it doesn't serve a purpose anymore and I don't want to shame him. And the other day I felt, very, very and we were with a couple and they are not in a very happy marriage either and er, and then in front of us, and my husband picked it up you see just because he has Alzheimer's it doesn't mean to say he is not sensitive to a lot of things still. Erm, you know and he picked it up and she said in front of the two of us because we had gone over there for a meal and she said to her husband "oh this is absolute rubbish you are talking
you are absolute you know, you can’t, rubbish, rubbish” and she was really sort of really shaming him in front and I felt belittled and you know I really felt like, saying you know, how can you do that? And, later on my husband said to me I mean he said you know “she’s quite a strong, sort of powerful woman isn’t she” and I said well you know the situation I think she gets a bit frustrated at times, you know, sort of. But he had picked it up as well and, and this is something that I can’t do, I can’t sort of you know, really, show him up, I can’t do that it doesn’t make me Mother Theresa believe me because I’m a bitch sometimes as well, I may, I sort of within private and sometimes I’m so frustrated and, and I shout and I holler as well so don’t get me wrong. You know the picture you see here, is not, you know, the full me.

I: Today.

PP: No, no, no it’s not I’m very volatile as well and I’m very much a person you know I say it and that’s finished now I know that’s an easy thing to say because afterwards what you say lingers quite often with the other person so you may say “well I’ve got it off my chest and now, you know we’ll start again from square one it’s not always like that. And so yes, I’m also the way I react although I might say well it’s better to get everything of your chest it’s not always the best thing to do but there are moments definitely that I think well I can’t do that because that would really shame somebody and I know how I would feel if somebody really showed me up in front of somebody else, you know, I...

I: Do you think your husband felt able to say everything he wanted to kind of thing?

PP: (Pause). I think he probably, because he is, or has become, such an insular person I think he probably at times perhaps also perhaps didn’t say exactly – I don’t think he ever came possibly completely clear about his, his feelings because he also felt well, what’s the point or I don’t want to embarrass her or something like that. Er, I think that at times he possibly did er, did, I think he held back in expressing what he really feels, felt.

I: It seems like there was kind of a hope to change but also a kind of a holding back of is it worth what we might have to go through to make the change in front of these other people?

PP: Er, yes, possibly yes. (Pause). I don’t really know. It’s weird because I’m a very practical person and if I see a problem I try to solve it and then it is solved but it isn’t like
that with therapy, you know you can’t sort of say well you
know this is like that and if you do that the whole thing is, is,
is changed and will be changed for the rest because of course
that is the way you have changed it. Erm, no it’s, it’s, it’s,
no it’s not like that. It’s always the sort of thing on the one
hand you want to and at the same time you always seem to not
want to act on what is coming out. I, I, I often wonder as to
what is it that we haven’t benefited where, where a lot of
people they go in and things are a hell of a lot better. Why
not, why is that not with us? And, I really don’t know (pause).
I really don’t know. Or is it perhaps because both of us don’t
want to perhaps we want to stay in our little sort of corner, of,
of, of you know, of, of feelings or whatever. Erm, and maybe
because we felt that if we really do let go and make ourselves
more vulnerable vis a vis the other person that we are, are
frightened and of course now I really have to be realistic as
well with somebody that has got Alzheimer’s there really isn’t
much of a hope now anymore, you know. And, again, then I
resent that perhaps in the past we didn’t make more of an
effort to build on what had been started in therapy whereas
now I’ve felt the last time, certainly, because my husband
sometimes, you know, half an hour later forgetting what has
been discussed...

I: A lost opportunity?

PP: We lost an opportunity. And then I feel, sometimes you
know yes it’s probably yes, it probably was a missed
opportunity which earlier on in therapy when my husband’s
Alzheimer’s maybe it was already in the very early stages, I
don’t know, but possibly not, erm, we could have done you
know something a little bit more positive which would have
been a little bit more longer lasting and probably would not
have left, felt, or have led to us going to Springfield the last
time because Sophie Trixie thought that there might be some
kind of benefit. I don’t know there are sometimes questions I
ask myself sometimes and then I don’t get the answer and I
also know that it’s a lost opportunity because I just don’t think
basically my husband would be able to act on a lot of things.
So that’s why I feel now I, I try to control myself by not
reacting because a lot of his behaviour now was already
behaviour in the past and sometimes, I do, and that’s why I
think I’m a little bit more sort of, ah, recipherous in my
reactions to him as an Alzheimer patient now because some of
the behaviour he displays now but to a stronger degree, he
already displayed also over the years and sometimes I think
“now are you doing this because you know this is just a
continuation of what you were before is it because now you
really sometimes don’t know what you are saying or what you
are doing?” So I have this sort of doubt in my mind that, er, as well, you know what is it – is it the Alzheimer’s that you’re like that so sometimes I err on the wrong side and then I, I sort of think, you know this is you know, because you’re just being bloody minded and so on and then I get cross and then react er which I then you know, regret afterwards but now I gradually, and the children as well, they are much better, er, er, I mean as Julie said to me last night when we were talking she said well ah, I, I used to be very angry with Dad and of course our youngest son is, was very angry with his Father particularly about the religious side, he’s always got a religious, he’s always as dramatic as my husband is about religion he’s anti-religion, you know. Um and so, and, and so and Julie said well Adam and I, we are now, she said I see erm Dad just as an elderly man who is ill and she said I just don’t see him very much as my Father. Sad.

I: Hmm. So it’s quite a big transition for everyone.

PP: Yeah it’s a big thing and I also now feel that don’t argue anymore because it upsets him. I can’t logically try and explain things to him anymore so I now very often I just say “yeah”, “no” or I pick up my washing up or, or you know and I still listen to him but I just don’t pay an awful lot attention to somethings because I don’t want to get involved in an argument because unfortunately now his logic is gone and what are you going to do? – I mean it’s almost like arguing with a child of one I mean you can talk to them about philosophy but if the child doesn’t even know what you’re talking about it’s pointless, you know? Just, so I, I feel that more so, and then, then of course it’s part of the onset you lose them, the person very much as a, er a partner you know because whereas in the past we could quite often – well we can we could always discuss things not on an emotional level but, on things we could have, I mean I could talk to him for hours, on books, erm on the theatre, or on, well on, on, well his politics and I’m not that interested in politics. And that’s wonderful but that’s not always what I want from, from a partner you know, I want to talk about other things. And then of course, very often, then you come out with differences of opinion. Now I’m not saying that I’m not opinionated because I’m also very opinionated myself you probably sort of you know, realise. So there’s two very strong personalities going like that as well erm if I basically in our marriage had always said “oh yes” and so on and had gone along the way I was when I was eighteen when I first met him of course I was a stranger to this country, I didn’t speak the language that well and so on and so forth. So with everything he said I went along with for a long time and of course as long
as I do that our relationship would be blissfully happy you know, it could always be on a very nice living situation.

I: It's not realistic?

PP: No, but it is not realistic. And for me to talk always about politics, well politics is less so now, but, you know to talk about always about the theatre, or to talk always about things, no I sometimes want to talk about, you know...

I: Day-to-day emotions?

PP: Day to day emotions and that's where I find various people vary there, we look at things in a different way and then I think "well, what's the point?" And so, now, you know I do less of the things because I think what's the point in arguing? So, yes, to come back to your question again I think, I think sometimes, er I would not in, in therapy the sessions, want to correct because I felt embarrassed about embarrassing him so probably it was a slight, well probably dishonesty on, on, on my part er, when I knew that he was saying certain things which I knew, well, it wasn't, you know, like that but I thought, well what's the point in starting an argument...but I didn't so that was... Basically I will say that, I, well perhaps that's the reason why you go to therapy because the problem is yours not the therapists problem (laughing) but er, I think part of the fact that I feel that it hasn't done an awful lot for us is basically I think our inability to take it onto the next step I think.

I: And what do you think the next step would be being able to talk about the same things in therapy at home?

PP: Yeah, at home, more so at home and then take it from there and try to sort of, er, erm, and sort you know live, live a little bit more and have that more, you know a moment then to think "hey just a minute, you know in the past we always used to sort of say something and then have an argument let's now just take one step back for a moment and see, just a minute is there something in what the other person said and see the other's point of view". And I think we very quickly slip back into the old routine.

I: Okay so now there's some final questions about how you think therapy has affected you or not- and your husband. So did you notice any changes in you or your husband during the time that you were attending therapy?
PP: Er, not so much the last time again, but I have to ascribe it to Alzheimer’s but, er, you want the twice before yes, it, it did make a difference.

I: But at the clinic you think at the time...

PP: No and I do think it is because we were dealing with someone who was basically forgetting an awful lot.

I: And you said that going there and talking sometimes, talking about what might have happened that week, did that, does that...

PP: Yeah but you see very often my husband couldn’t even remember the things that had happened.

I: Hmm. So even thought you got the chance to talk about it would it be frustrating that he-

PP: For him, because it was talking about something that “oh, yes, vaguely” but forgets.

I: Hmm. So for you, you couldn’t have a discussion with him afterwards and you felt that didn’t-

PP: No, no because, it was basically something that happened. Vaguely he would remember that there had been an argument but he had already forgotten what it was all about well, so what can you do with someone who honestly doesn’t remember?

I: Hmm. And was there anything that the therapist said that you, personally, might have found helpful or see things in a different way, or....

PP: Erm. Well yes, because there once or twice some things would come out and he would say and I would think “oh I didn’t realise that you had actually felt like that”, yes, you know, yes, there were moments that I thought yes something had come out that probably on my own I wouldn’t have discovered and er, that, that is helpful. And also I think it has, I think the overall outcome of the therapy for me is that I still have this residue of feelings for him, and, and, at times, well I said once to Sophie Trixie sometimes I just feel pity for him and I said and I feel it is such a negative erm, ah, erm, its such an almost a shame because if you only sort of accept the person out of pity.. I mean if I knew that somebody accepted me only out of pity I would feel, I was less than a person because you know, all the talking well actually, and so
therefore I feel that possibly other people if they were aware of it they would feel the same way. So I said to Sophie Trixie as well I said well all I feel for him now is really a great deal of pity because I don’t wish this sort of thing, if it is Alzheimer’s, at the time it wasn’t – it hadn’t been established, erm, I feel that, you know, it’s it’s a shame that I can only sort of, that I do things for him and I feel some things out of pity. But she said it is still an emotion you know and she said don’t sort of look at it as if it is completely negative. But I felt that it was a fairly negative emotion but I think the pockets of, of feeling that I have for him, and which then sometimes you know come to the fore are probably also as a result of therapy because in therapy I have been able to see other sides of him which I haven’t been able to see of him at home. So I have been able to sort of take that on board and to store it somewhere then occasionally it sort of surfaces, you know, so that is a positive thing about therapy.

I: Erm, were there any aspects of it that you found might have been unhelpful?

PP: (Pause). No, I don’t think so, no.

I: Nothing that you thought oh, I’m not sure about that, or I don’t like that, or-

PP: No, no, no. One thing I always feel just when you feel you are onto something and you want to go into more depth and it’s time to stop. But then I found, but then sometimes I feel that I wish therapy could sort of be a day (laughing) you can...I mean obviously I would be knackered at the end of the day, but could be a day but I always feel that you know, all of a sudden, - and I know it’s got to be done because you’re not the only client and basically there’s a limit to what people can take as well. But sometimes I always feel that then she’ll say well, we just sort of already started and then the exchange of the groups came in that the others came into the room and I knew that already half of the time had gone and there was a big clock there anyway so erm, so you were aware of the time. And then you knew just gradually...and also then I think probably I felt at the times possibly as well it’s nearly finishing time, you know, nearly throwing out time so I’d better not start anything at all because basically you know, five minutes in you’ve got to leave.

I: And did you feel able the next week to come back, to the issues, the next time, that you went that were important that had come up?
PP: Sometimes but sometimes then something had then happened then during the week which I thought was more important and then I would bring that up. Or, ah, you know or the therapist would ask a question and then sometimes my husband would bring up something first. I mean most of the time I would bring, start it off and then she would listen to me kind of thing. But then sometimes she would say “oh well last week you said something like that” and then she would actually refer to something like that and we would sort of go back to it. Ahm, but this is always I found a little bit irritable, but then again that’s the way the system works I mean I can’t, I can’t change that and I’m sure it can’t be changed because you know, you cannot have a whole day of therapy and really unload the whole lot, you know.

I: So did you ever feel like sometimes things could get lost?

PP: Yes, I did feel that yes. I feel that there is a pity that there is a time limit on it but that it’s absolutely essential that there is a time limit on it and maybe also that there is on a time limit that you can sort of leave something with something not fully sort of thrashed out and then it gives you sometime, something at home to work on you see?

I: Hmm.

PP: So possibly it has that. And at times it did work like that in certainly the beginning, the very first time in our earlier years you know, we quite often would, actually, talk about what had been discussed and sort of, you know, give each other the opportunity of seeing the other point of view, or that there is another way of looking at things, or doing things and so on and so forth. Ah, but then now of course with, completely then we would come in the car, back into the car and then we I would drive away from and then he would say “oh what are you going to do now or what are you going to do..” and basically this we were and to this very second then and there wasn’t really an awful lot of feedback ....

I: You couldn’t process together what had happened. Did you manage to make some time for yourself to think over what had happened?

PP: Er, sometimes I, I, I did yes I did have time. And other times I thought okay well you know, just like that and things were left. But then again, I’m sure it’s not, you know, you can’t blame the therapy. But I do think it’s a pity. But perhaps there’s a reason for that as well that you actually only give a client a maximum of an hour or whatever it is time
limited because then it will give them perhaps a chance at home, to sort of, you know, embroider further on the theme that you have actually started.

I: And did you find the reflecting team helpful?

PP: Yes I did, yes. Because it was good for a feedback and I quite often, you found a slight difference, although each one picked up on something that had particularly struck him or her during the, during the session and I found that often. And sometimes I would then when they went back again for the final part then perhaps sometimes I would pick up something that one of them had said and said well I would like to sort of well I would like to say I'm touched by that or I whatever, you know. I, I found that, that also gave an opportunity of again, sort of, you know, again to feedback and then you could embroider on that and sort of, carry on, on that.

I: So they might pick up on something that perhaps you hadn't noticed as much and then it enabled you to go in that direction a bit more with that particular thought?

PP: Yeah, yeah, yeah.

I: So now that it's finished do you think anything is different now as a consequence of that therapy at ?

PP: No.

I: No.

PP: No, no I don’t. But again I have to say I think that is not because the therapy as such and the way it is conducted there is at fault but I think it is because my husband has got Alzheimer’s and things have changed so dramatically and he has actually gone down quite a bit and that’s part of the reason.

I: Is there anything you’d like to add that we haven’t addressed about the last therapy and your thoughts and feelings about it?

-(pause). Er, I don’t really think so no. (Pause). No. It is just that now, well the only thing is that this time er, will go in for er, some counselling because they, well the person involved with it she sent me various options that I have and I won’t go in straight away now as next week I am going to New Zealand and my younger son is going to stay with my husband and so therefore I can go to New Zealand for two weeks. So it’s no good starting something which I then have to interrupt
anyway. So I will take it up. And that’s purely, erm, so I will
take it up because it will give me an opportunity sometimes,
just to simply just talk to somebody, you know, just talk. Not
necessarily for therapy but just to talk. But I think er, family
therapy I, I would say definitely now no I would definitely
that is the one thing I have left therapy with. So maybe now I
have come down to earth a little bit more and I am facing facts
a little bit more for what they are and I feel that as far as I can
see there is no purpose being served anymore for us now to
take up an offer of family therapy but again, it is because now
I feel we have now reached a point that you know, it would be
a one sided thing because my husband doesn’t remember
enough for it to be really of any value.

I: Okay, thank you very much.

PP: That’s all right.

I: For sharing your experience I have learnt a lot from hearing
how people have experienced it to help my own practice to
think about what it’s like. I would just like to find a bit about
what it was like participating in the interview. So what was it
like for you talking about your experience of therapy?

PP: For you now, the interview now?

I: Yes.

PP: I felt it was good and I apologise for the fact that in a way
I have sort of side tracked as well because in a way I’ve sort of
gone in giving a lot of the background history which I think
possibly you might not need...

I: I think it’s important to give the context to really
understand.

PP: Yes, yes, but sometimes I thought really I must stop now
because, you know basically you have gone away from the
question and then you may notice that I said “to come back to
your question” because I was aware that you asked me a
question and then I also a little, bit, you know I went to
Wimbledon via Edinburgh –

(Both laugh)

PP: And then I thought this is probably not the purpose of why
you’re coming here.

I: It helped me understand what led you to going to therapy.
PP: Possibly I sometimes thought if I can just briefly sketch a bit of an outline how sort of things might have come about you know, it might be a bit helpful, but, again, erm, I didn't want to use you as a therapy session basically and I felt awe, when I got a bit emotional you are sliding into a bit of a therapy session now and that of course, is not the purpose because you basically want to find out basically what my experience was of the er, er, what our feelings are about our experiences of therapy.

I: I guess it is bringing up feelings, so it is understandable –

PP: Well yes, I spose it is so. I thought so basically ah, ah cut it short now because this is probably not what, what you are after and so come back to, to the question. So, I felt a little bit that perhaps that I perhaps over stepped the mark a little bit.

I: Not at all you really helped me understand your journey to therapy and what it was like for you. Erm, have you got any feedback you would like to give me about the interview questions if you thought “oh what’s that about” or “you could have asked more about this?”.

PP: No, no, no. Because I know not enough about, you know, what your guidelines are, obviously you told me a little bit but then again I'm not in the full picture so I really don’t feel that I want to sort of say she could have asked me this or that because maybe you’ve had a briefing or you’ve been told...

I: Do you think you got to talk about most of the areas of therapy that were important for you?

PP: Yes I think so. You sort of asked about emotions how it felt, why, things afterwards, and so on what did I feel about the therapist and so on. So all sort of things and areas you wanted to find out a little bit more. Er, you may have left some out I don’t know but then again I don’t know, you know what your overall briefing was.

I: But just to tap in with your kind of experience of therapy do you think you were able to convey what it was like for you?

PP: Yes, yes, I think so.

I: Okay so erm, I have some supportive telephone numbers that we give to people for participating in the interview so if you felt for example distressed or if you wanted to talk to someone else there is a list of numbers you might want to use.
PP: Ah yes.

I: We always advise that if you need to contact your GP.
PP: Ah yes of course I would, yes, yes.

I: And I’ve got a card and a voucher to say thank you for participating today.

PP: Ahh how sweet thank you very much, thank you.
I: Thank you.

PP: And a voucher that’s not necessary.
I: Marks and spencer voucher.

PP: Oh my goodness me that is oh - how very kind.
I: Its a swipe card and there is twenty pounds on it.

PP: Oh that’s very kind. Really so kind
Appendix M
Copy of interview schedule for Consultant Systemic Psychotherapist/clinic director
Interview schedule to be conducted with Consultant Psychotherapist

Thank you for agreeing to participate in this interview. As you are aware I am conducting a research project exploring how older adults experience family therapy. I would like to find out how you perceive older adult family therapy may be experienced and find out a little more about the clinic here in order to contextualise the therapy received.

(A) Firstly, I would like to ask you about your understanding of what older adults and their families come to expect of family therapy.

1. In what way do you think that older adults and their families are prepared for what to expect before attending the older adult family therapy clinic here at the clinic?

Prompt: What is your understanding of who explains the purpose of coming to family therapy to older adults and their families before they attend their initial session?

2. Who usually suggests family therapy to older adult clients?

Supplementary question: Why do you think they suggest it?

3. How do families respond to being offered family therapy?

4. For what kind of work do most older adults referred to the clinic come for?

Prompt: What type of referrals (issues) are referred to this clinic for this client group?

Do you discuss with family’s how they have come to be in family therapy?

5. Do you think that family members generally have differing understandings of why they are referred to therapy?
6. What do you think family members initial impressions of the family therapist are?

7. Do you think that individual family members hold divergent views regarding the family therapist?

8. Do you think that their impressions of the family therapist changes over time?  
   Supplementary question: If yes, how do you think this process occurs?

9. What do you think family members initial impressions of the team are?

10. Do you think family members hold divergent views regarding the team?

11. Do you think their views change over time?

12. How do you think family members feel being in therapy together?

13. Do you think that family members feel able to say everything they want to in therapy?

14. What kind of changes do you think family members notice in themselves and in each other when attending therapy?

15. What do you think family members think contributes towards changes that occur during the time that they were attending therapy?
Prompt: Do you think they are aware of anything that the therapist does or says to bring about change?

16. What aspects of therapy do you think that family members might find unhelpful?  
Prompt: Is there anything that you think that family members may not like about therapy or that they may feel makes things more problematic for their family?

17. If family members do find anything unhelpful in therapy, do you find that they are able to address it within therapy?  
Prompt: Do you think family members feel able to let the therapist know what they think about therapy sessions as they progress?

18. Do you think that family members find the reflecting team helpful?  
Prompt: How do you think that the thoughts shared by the team help families?

19. How do you think therapy affects family members' lives once it has been completed?

20. What do you think that family members perceive as the most significant contributor to change in therapy?

21. Do you think any changes brought about by therapy are what family members expected before they started therapy?

22. Is there anything that you would like to add that we haven’t addressed?
Appendix N

Copy of interview with Consultant Systemic Psychotherapist/clinic director
I: So as you know I'm um conducting a research project about older adults and their experiences of family therapy.

C: Yes.

I: So I'd like to find out how you perceive older adult family therapy may be experienced by the clients coming here

C: Okay.

I: And have this conversation to kind of contextualise what does go on at the clinic.

C: Okay.

I: Okay so it's kind of trying to map on what you hope happens to clients as well but not as specifically as the individual therapists.

C: Okay.

I: So the first set of questions I would like to ask you about your understanding of what older adults and their families come to expect of family therapy.

C: Okay

I: So looking a bit at expectations beforehand.

C: Before they come. And you're talking to me as the Director of the Clinic. Okay.

I: Okay.

C: And er live supervisor of the older adult team.

I: Okay.

C: Okay.

I: So who usually suggests family therapy to older adult clients?

C: Erm, well we would get referrals from the community mental health team primarily but also from GPs but I think erm that er recently it's er reached my attention really that not
enough people know, and I think periodically we have to sort of advertise the team. So we’ve just written, or I’ve just written to erm to all of the potential referrers again because I think it’s important to keep doing that.

I: And how far out does the cmht’s cover is it just wally hall or –

C: No it’s the whole trust so it’s um (lists all boroughs in trust).

I: So there’s potentially quite a lot-

C: There’s yeah. I’m not quite sure about the older adults but the population, the demographics of the five boroughs I think is nearing, nearing a million and Wally hall itself has a population I think of a quarter of a million so erm...

I: And why do you think people suggest family therapy to older adults – the people that might make the referral?

C: Okay. Well, I suspect it comes er two ways really. There may be something about, that, the older adult or their partner or carer’s think that something has changed in that older adult but they might not necessarily so, that so something’s changed essentially I think makes the difference erm about why now – which is always an interesting systemic question why are people referred now. And I can think of, for example, there is a couple we’re working with at the moment where both the couple have had depression. But the man has had chronic depression over many, many years but the reason for the referral was that he now has bowel cancer, so that, that was the change really. That I think meant that, that there was a referral um to this service. To, it’s almost as if there was an opportunity to try and get something clearer or about the family relationships.

I: And do you think there is a difference between the referrals made to this clinic older adults than to um cos you’ve got an adult mental health clinic as well.

C: Well all of our work here is adult mental health so it’s not just one clinic – it’s that’s what we do and um, no I think the referrals are very much the same, um, they are the same sorts of issues it’s just people are older, that’s all it means so there’s still the issues of depression and um I mean I guess obviously psychosis is not the same way obviously, but maybe some bipolar and the er, and I think often the onset of dementia. Sometimes that’s known about and people are wanting to try
and find a different way forward as a couple because often dementia really interferes with how couples are together. And erm, people often want to find a way forward. And also we’ve had occasions where there has been referrals where there has been the onset of dementia it hasn’t been understood as that and people have just thought maybe seeing someone changing because of retirement or because of those sorts of things and actually because we have a multidisciplinary team erm often those things are picked up and often we can refer on to the appropriate services.

I: So there can be changes that are noticed that are to do with a stage of life as well?

C: Because of dementia you mean?

I: Erm well kind of different stage of life issues perhaps in some cases to the adult mental health clinic?

C: Yes, but, but, yes absolutely. Yes, on the whole to me systemically they are the same. Because what, what, you know if you take a life cycle framework and therefore transitional framework it almost doesn’t matter, what the tr- I know it does for the person themselves, but professionally I don’t think it matters what the transition is it’s just that any transition at any part of our lives actually brings with it changes.

I: Umm.

C: And erm and I guess some changes, you know some families find it enormously difficult to allow their kids to go to school and um there are other families at different developmental stages um find it more complicated, and er and I think there are very few people who manage er dementia because it is such a difficult – because that person changes really.

I: Yeah. And because - it’s all about changes just at different stages of your life-

C: Yeah.

I: And we were talking about people knowing about the older adult clinic do you think that’s why the referrals you know that the referrals are less – well if there’s are the same issues – but? – why do you think that people aren’t making to this-
C: Well I think there is, I think it has just very recently been understood that there is a general lack of psychological provision for older adults erm and I don’t know whether that is because traditionally psycho- if you take a psychoanalytic approach that there was this idea that people development slowed down and then stops and that people become very sort of solidified in who and how they are. But I think, so that sort of psychoanalytic understanding erm seems to me to have infiltrated other sorts of psychological approaches whether I think systemically we would think you know in terms of life cycle that there are always changes because it’s how we er how we change and adapt to influences in our lives.

I: And do you think those kind of beliefs might have infiltrated the people that you would like to be making referrals.

C: Possibly, possibly, yeah.

I: Okay and in what do you think the older adults and their family members prepared for what to expect before they come?

C: Erm, well we send the same sorts of letters about to everybody and which essentially er, explains something about the clinic and we always send our leaflet out and the first appointment always the identified patient erm, is offered the opportunity to define their own system. So to bring with them whoever they would like to bring. And erm, but I guess what we don’t do a lot of – we talk about the team in the letter, but we don’t really talk a lot about the team and the screen. And I think there are different schools of thought about that. I, I suppose I tend to think erm, that it's better for people to have an experience of it and to get them to talk it through and then make a decision if this is for them because I think sometimes, because it's a different way of working, and I think if it's just explained coldly or in a letter without somebody, a therapy, who feels comfortable with that way of working, doing the explanation I think it can, it can seem as if it is going to be interrogatory er and I hope that's it’s not but-yeah.

I: And so you mentioned about the letter do you know anything about the person who referred it, the actual people that might make the referral might explain do you get any information about that?

C: No, no, I mean we will ask in the first session erm but also I don’t want to make a decision about the referrer because it’s not up to them to tell people how we work um it’s for us I
think so I don’t want to sort of set up something that somebody else should have told somebody something you know otherwise you are setting up a negative to start with.

I: Yeah. Ummm. So you might have a more general conversation about how did you understand coming here?

C: Yes um but um but even then I think sometimes that’s quite, it’s difficult for people. So I think what one has to do is um, talk about the team and the screen in, in everyday language and for people to come and meet the team um first off come and see where, you know behind the screen and so that that family feels that the team is their team

I: Umm.

C: and so the therapist is their therapist but the team is their team too. And that there isn’t a split so all of these people are working on their behalf erm –

I: So they’re part of a system together?

C: Absolutely, and that the family have a lived experience of that.

I: And how do you think erm families respond to be offered family therapy?

C: Erm, well the er, complicated really isn’t it because I think for some people. And it’s very interesting I had a phone call this morning from somebody who had seen our website and actually really wanted to be referred because she thought that this was exactly what she wanted. So I think there will be a mix

I: Umm.

C: For some people it will be yes, exactly what they wanted, for other people particularly perhaps for people who have had, pardon me, very complex histories, might think er that some how either they are going to be blamed or their families are going to be blamed. And but I think there is such, such a mixture of responses really.

I: Yeah. And so I guess we’ve talked a bit about what, about what kind of work that a lot of older adults come – we’ve kind of talked about the issue of the referrals erm but kind of what does the clinic hope to offer – which is quite general but thinking about kind of with the referrals that you get for this
client group and I guess thinking about the models really that you might use with family therapy.

C: Umm, hmm. Umm, hmm. What was the question again sorry?

I: Just thinking about what the clinic hopes to offer?

C: Er, I think a containing environment where er people are able to er to talk about whatever they choose to um and they are listened to and respected and that different views can be valued so that there isn’t er, you know for example, there isn’t a family view. There are a number of people in the family all of whom may have a different view and it’s the job of the therapist to actually to elicit or to allow people to feel comfortable enough that those views can be talked about and other people, other members of the family can hear maybe, other peoples’ er opinions. Er, and often the sort of issues want to talk about, if they talk about them at home they end up either in argument or someone feeling hurt. So it’s with a third and with a team I think sometimes people can take different conversations further and find a resolution for them.

I: So it's offering a safe space for communication and to think about how you do communicate and hear-

C: And that we work strengths and resources so that we see families as allies that they’re the people who have strengths and resources, for, for all of us really.

I: And how long might, might a family be seen for, what’s available?

C: Well, er I mean all of that’s negotiated with the family. But in our leaflet we sort of say 6-8 sessions but also I guess in our own heads we probably think a maximum of 18 sessions. So anything really from 6-18 sessions just depending what the issues are and what the, what gets negotiated.

I: And how frequently would a family be seen?

C: Well at the beginning of the work, because to form some attachment you know we really go with sort of the John Byng-Hall er, sort of attachment model of family therapy in the sense that at the beginning of the work you’ll probably be meeting fortnightly possibly even weekly but more rarely than that so that the family engage with the therapist and the team.
After sort of a few sessions of fortnightly you can probably go down to three weekly then monthly.

I: And what’s the idea with um leaving more space between –

C: Because that’s, that’s the sort of that’s the traditional sort of systemic idea that when you’re working with, when you’re working with a family most change happens outside of the sessions. So you actually need to have a bit of time to allow those changes to take place.

I: Okay and do you think we were talking about the routes to the referral and kind of the family members’ perceptions. And I was wondering do you think that family members when they come here they express different reasons –

C: For, for coming here?

I: For why they’ve arrived in therapy?

C: Er, yes I mean most people come I guess because they would have been used to being in the NHS so we’ll see probably the identified patient as being the reason they come. But if you then sort of talk about you know are there other concerns or other issues that people want to work on or think about then you get a more of an array of issues really you know because for example you can get that somebody that wants to come because I don’t know, their husband is depressed and then when you ask them how does this impact on you, you get a different sort of different description.

I: I guess expectations and what people understand about the referral and what they hope for might gradually come out, not just at the beginning but through out-

C: Oh, absolutely, absolutely. Yeah I view it always as a process it’s not linear you know that you can move backwards and forwards into the sort of process of therapy.

I: And I guess I was thinking about the building of the attachment, the secure base as they’re beginning to trust you they might be able to I’m not the identified patient but I’ve got –

C: Oh absolutely, absolutely and I think I really have learnt over time not to become too intrusive at the beginning and that even if you have a hypothesis about something you might want to start testing it out gently but actually if you just leave something and people thinking it’s important they’ll tell you.
But they’ll tell you through the trust of the relationship. And I think sometimes if we go too quick to, to something er people feel worried and possibly don’t come back.

I: So they might not feel safe?

C: They don’t feel safe.

I: So now thinking about the initial impressions of the therapist and team. How do you think family members do respond when they meet the person in the room initially – the therapist in the room with them?

C: Erm, well I hope they think people are friendly and going to listen to them that’s what I would hope for.

I: And is there a kind of a particular way of being that you hope that therapists are?

C: Erm, welcoming and erm available to listen to people, don’t over talk but also don’t just sit there so being a blank screen. So it’s, it’s sort of er, er I guess as warm and engaging as people need you to be really.

I: So being very responsive to the family, to individual families.

C: Yes, yeah.

I: And do you think that individual family members, can have you experienced when individual family members experienced the therapist very differently and is that been something that has been able to be-

C: I would hope not because er because one of the I suppose tenants I suppose of family therapy that I really hold dear is neutrality and I would hope that a family would leave not feeling that that the therapist was more on one person’s side than another.

I: So that kind of people feel listened to equally?

C: Everyone feels listened to yes, and respected.

I: And do you think that family members impressions of their therapist change over time and have you been able to observe that happening as yourself as a therapist?
C: I think possibly, I think people erm can er I suppose the model of therapy I would use is that if you sort of join in a respectful way that over time you, you are allowed to offer more challenge so you can offer more challenging questions erm, and so people I would hope still see you as somebody useful but er, somebody who is able to offer them new ideas. So that might, that might change over time. And sometimes if you, you know, there are occasions where er for whatever reason people may feel that you have got it wrong or they may feel that you’re, you know whatever people visit therapists with they will visit family therapists with as well whatever the transferenceal issues are. Um you know, I mean as I’ve got older, I, I know that I’m probably seen in a more possibly more maternal way than I would have been seen maybe ten even you know and certainly twenty years ago. So it’s just sort of what you take on, what sort of role.

I: Umm and is something that you encourage-

C: You know even grandparents.

I: Therapists to kind of bring to supervision?

C: Yes, yeah if you feel you are becoming too whatever you feel you’re becoming too...

I: And I guess that’s just make me think about endings as well and how like cos we were talking about a safe base for therapy.

C: Yes, yes, yeah. Well I think endings are very important and er that depending on how long you’ve seen people that there’s generally a point in the therapy where you somebody starts to say let’s just review this work and um and then you can think you know what er, how many more sessions do you think you need. And so you’re, you’re just sort of building in endings and, and to try and work to the families agenda really. Because often what’s really nice when therapy works well is that there is um, that, that families and the therapists will probably feel I don’t know about three more sessions or we were wondering that ourselves – and you know that there’s a sort of congruence really, coherence.

I: So between the team and the family.

C: And the family, yes.

I: Okay, and how about the initial impressions of the team you’ve talked about taking the family behind and meeting the
people behind the team. But how do families in this particular clinic generally respond?

C: Erm, well I think generally families are very polite so it’s very difficult to know I think really. I would hope by the time they’ve had the first reflection that they experience people being, er, having something to say er, something which is positive but also something, something new as well. And, er, and again over time as well I think the team connect and say more challenging things too. Um, but again still in a respectful, using a positive sort of framework.

I: And, and how is the kind of the team explained initially?

C: Erm that more heads are better than one.

I: And is kind of is it initially set up that they are definitely going to be behind the mirror or is it sometimes negotiated that they might be in the room all the way through or-?

C: Er, we try and set it up that people are behind the mirror because it’s the model and I think it works but on the other hand you know there’s no point setting up something which is rigid that families not going to want. So, sometimes we will be in the room but actually once people once they’ve heard the first reflection and they’ve met the team generally, I think feel okay, there will always be families that don’t like it at all.

I: So the experience of seeing it in action can make it less of a threat?

C: Yeah, yeah. Because I think that sometimes people thought that they’re sort of almost like a panel who were going to sort of do some sort of judgement or criticism of them. Or essentially you know popular culture is erm you know police series are forensics that are psychologists (laughing)

I: Umm.

C: When people are behind a screen and people are being grilled.

I: Yeah.

C: So-

I: So they might use their frame of reference from the media to try and work out-
C: Absolutely, absolutely.

I: And you said that more heads are better than one.

C: Um hmm.

I: What else might you hope that, that the team with that kind of thinking about having a diversity of perspectives-

C: Well I just see, because I think that if you say too much more you get into, you get into something that the therapy is more about, you know if you have a therapy that takes longer to explain what you’re doing than the session what (laughing) what’s the point really?!

I: Hmm.

C: So I tend to say er, that you know sometimes when we’re working with the family that one person just can’t take it all in and we don’t want to miss what people are saying and er, so we work with a team because we think that more heads are better than one.

I: Yeah and what are your hopes, of, of the team. Kind of that’s what you, I know that’s what you explain to the family but do you have any kind of other hopes that-

C: Yeah that er, that they will be there working and that they will be thinking and thinking about the relationships between the family and relationship between the therapist and the family and erm, and particularly if there are particular sorts of issues that for whatever reason maybe the therapist has not heard or hasn’t attended to maybe you know you can ring in and suggest that people might go a certain way or..

I: And us of the telephone.

C: And the use of the telephone.

I: And I just wondered, having been part of a reflecting team, what that is like for the therapist and the family.

C: Well it all depends how it gets set up. As a therapist I get really fed up if people don’t ring me in because I think what are you there for you might as well have I might as well have just sit here on me own! But that’s because I think I’m very used to it, I really er enjoy working as a team, er I always use the teams ideas because I think that they are seeing something that I haven’t and erm, I so I and then I think if I’m
comfortable with it the families comfortable with it. If the therapist somehow sees it as an intrusion so will the family but then I think there's something often transferential about that. That you know sort of the closed group that can't, nobody else can be let in.

I: So that might be taken to supervision and thought about with the team?

C: Yeah, yeah.

I: As well. And so we've thought about the reflecting team and that the families perception of it might change over time as well erm, do you think that family members feel able to say mostly what they want to be able to say in therapy?

C: Er,

I: I mean obviously that is difficult to know from the other side of it-

C: I think, I think it's very hard to know. Erm, because people are always about not upsetting people or not wanting to say something which is going to make things difficult at home or so how do you either know really?

I: Hmm.

C: And but I hope that people experience enough usefulness over time to, to think that they could probably bring difficult issues and erm that we would find a way of helping people talk together about them erm without people leaving the room or having to get so angry that it's overwhelming.

I: Yeah.

C: I think that's the job of therapy really.

I: Hmm. And I guess because you said about expectations - it's not linear - Kind of new things come up it's possible to review within the work.

C: Yes, absolutely, absolutely.

I: Okay. So now moving on to thinking about how you hope about how therapy does work with families and what the outcome of therapy is. So what kind of changes do you think family members might notice in themselves and each other when attending therapy?
C: Erm I hope that they might experience erm, that they could listen to people in a different way because sometimes even though people recount the same stories and you say to people “did you know that?” and they say “yes” but then sometimes they might say “but I haven’t heard it quite like, said like that before”.

I: And how do you think that, that is facilitated?

C: Because I think that the therapist of a team will probably pay attention to things and, er they maybe highlight a certain aspect of a story or erm, it’s like all of us if we hear the same thing, we, we tend to just er place it into our, into our framework of understanding but I guess what family therapy tries to do is create an environment where things might be heard a little bit differently. Erm, so for example, the, the, the, a, couple who the, the wife wanted, they were an African Caribbean family and the wife wanted to move back to I think it was Antigua and her husband didn’t. And er, what became clear was that the husband had um, er, dementia and was actually worried about moving out of his, what he knew. But because he didn’t know he had dementia and his wife didn’t know he had dementia she was just seeing him as being, as reneging on, on the agreement they had made when they first came here and she was feeling terribly angry and let down by him. And I think what we were able to do is that through the work she understood more that actually he had, I mean we referred him on and continued working and when it was confirmed that he had, erm you know a diagnosis of Alzheimer’s, that she was able to understand his behaviour in a different way-

I: Hmm.

C: And it wasn’t that he was just um reneging on their deal that they made when they married that this was something else. And so they made some sort of agreement that maybe whilst he was still well enough that she could go for longer periods of time to Antigua cos their daughter lived there. But, you know and how he would need to be cared for in her absence. So it just negotiated a different sort of understanding really.

I: Hmm.

C: And, and took, the you know that sort of personal hurt out of it because it contextualised it and the context was the context of um onset of Alzheimer’s.
I: And the importance I guess was being able to recognise that with the different members of the team you have as well that might enable that.

C: Yes.

I: And I guess having that safe base to think about what might be going on

C: Going on, yes.

I: And communication being so important –

C: Absolutely.

I: And how you can hear

C: Absolutely. And so neither of them you know, were obviously neither of them were at fault.

I: Hmm.

C: Whereas when they were at home talking about it they were really getting into battle.

I: It was quite polarised?

C: Very polarised and for the first time ever in their relationship there had been an incident of domestic violence and he had pushed her and she had immediately called the police because it was so unlike – and that was the reason for the referral. So in a sense there was something that was so unusual about his behaviour erm and he was such a gentlemanly person that you can understand how it would be such a shock.

I: A shock. Okay. And what do you think –

C: Oh it’s eleven.

I: Sorry.

C: Oh I am due to do something how much longer

I: There isn’t much longer

C: Can I just negotiate with a colleague hang on

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I: So what do you think that family members might think is happening that might be affecting the changes – do you think that they’re aware or?

C: Well I think what’s very interesting is when people feed back to you, and then I think yes, we’ve done it really when people say what I like coming about here is that you hear different points of view and er that they like being able to hear each other’s points of view without things ending in rows but they can also hear different points of view from the team and I think that’s an important aspect.

I: So it’s kind of what they hear if they’re able to hear it and that might allow them to –

C: Do something differently. Or more benign – because if you actually have a different view that somebody is doing something not to you erm because of what they feel about you which is negative, but actually they are doing something because of something else, like this man with Alzheimer’s, obviously his wish not to go to the Caribbean. His wife was attributing to their relationship and what he felt about her-

I: Hmm.

C: Whereas actually it was something other. And so it allows more empathy um so if you contextualise something it often takes away the blame –

I: Hmm.

C: And you know and often it goes alongside mental health issues there’s often sort of blame, shame and guilt really and if you can alleviate some of those feelings a little um I think it creates a different environment that people can have relationships within.

I: And that actually just triggered a thought in my head about care staff sometimes and where there are people presenting with challenging behaviour and when it’s contextualised that can help them develop empathy for the person that they’re experiencing violent behaviour from. It just made me wonder if, if there is work that goes on from here, for example, sort of consultation work or on the wards?

C: Well we do some er, I would like to do more of that but for reasons I don’t quite understand, maybe it’s because we
haven’t been overt enough about it erm, I mean there is some responses around that but not as much as I’d like and I suppose some of it I wonder is because I do wonder that, that the NHS is such a hierarchical organisation that it is very easy. I know, I’ll just give an example, in another part of the trust people tried to set up erm some er family work in one of the wards. But they didn’t include the nursing staff in setting up and of course, lo and behold, the project failed of course it does, because people feel, you know the nursing staff are there day in day out doing this work and there are these people who are just swanning in and erm, so it sets up a very difficult dynamic. So er, and I think a lot of that has happened it seems to me and so there’s a big history to try and erm, so I think sometimes er-

I: So a systemic therapist is quite well placed to understand what that must be like for the nurses – these other experts, thinking their experts coming in and we’re here everyday.

C: Everyday, yes. So if you and I mean we have set up the ward clinics with older adults and have really very much included nursing staff and I hope, touch wood, that you know that that will go on because the nursing staff are, are involved in it as equal members of the team. So er, those things are very complex I think.

I: Yeah. And I’m just wondering if, if you’re talking about when erm, clients that come here feedback to you about what they find helpful here and different perspectives and having the context erm, wondering if, if you are aware of, have heard from clients, or perhaps have hypotheses about perhaps what they might find less helpful or difficult about coming here?

C: Well I would imagine the same things, I would imagine that it’s the other side of the coin. Erm, a. you have to come to a special place you know this just doesn’t happen in people’s own home’s – it could do but there’s just not enough of us to, to do it it’s not about the model –

I: So there’s a limit on resources?

C: Yeah, there’s a limit on resources. Erm, I mean I’m always happy to do a one off in somebody’s home I’ve never been asked even though I’ve said that to many people if they were interested. And erm, but we couldn’t do more. So there’s that so people have to get here. Erm, people who would not come into erm a psychiatric hospital for a service. And I guess also the model er for some people we will never hear if they don’t like it even though you try and set something up which
hopefully allows people to talk about things they don’t like
nevertheless there will be always be people who it doesn’t
work for

I: Hmm.

C: Or it doesn’t fit er, they don’t like it, it’s too intrusive.
And you don’t always know who those are. And the other
thing is what you never know, particularly people who just
come once – which I have to say happens very rarely – erm,
but if people did come just once and didn’t come back you
also don’t know if people have got something from here.

I: Hmm.

C: Erm but.

I: So that might be an interesting thing to find out as well –
what it was that stopped them

C: Yeah

I: And it could be something not related to the clinic.

C: Oh absolutely.

I: And it just made me think then if it’s possible, or if this
happens within the work that something about what we’re not
hearing or what’s difficult to say

C: Hmm.

I: If that is a part of –

C: Yes, yes, we do try and say that if there is something that
er, I mean certainly in the reflections that’s always built in that
reflections are just ideas, we try and say that all of the, you
know often to remind people they’re just ideas, that they’re
not true um that you might –

I: So very postmodernist?

C: That you might agree – well yes it’s a post modern
structure of course erm, the, the, the whole I think the whole
clinic works in a postmodernist way because it does work with
different views and that’s exactly how it’s set up

I: Yeah.
C: You know that the models are post-Milan the models that we use are dialogic they are all post-modern um even the structural work is post-structural so it's all post-modern er, theoretical perspectives that we use and the importance of, of different perspectives and um, allowing subjugated discourses to be heard erm I thinks a very important part of the work. So, so the reflections are always that these are just ideas that we have and it's just as important or maybe just as useful to disagree with them as it is to agree with them and you might not even want to express your ideas which is fine.

I: Umm.

C: So.

I: I was thinking then while you were talking about that about some of the background reading I've been doing for my project about kind of marginalisation of older adults, older adults being marginalised

C: Yeah, yeah.

I: And I wonder if that does, if that is something that does get picked up on cos sometimes working with older adults there can be ageism within families themselves and beliefs about aging.

C: Umm. Umm. Possibly but I don’t know I mean it’s interesting that you say that and we might have had a hypothesis erm I mean I was just thinking of where we were working with one couple where there was elder abuse actually from the daughter who had a psychiatric illness. Um and maybe there was something there, and she became very protective of her daughter um, but so it all, you know it had to be deconstructed and, and then I think we, I think essentially the other children, older adults came into play much more but maybe some of their erm, positioning at first was something about, a little bit of ageism about their mother and, yeah.

I: So that, that can be a part of the work kind of deconstruction and –

C: Yes, it is, yes it does and so we, and I guess what deconstruction does is not really accept anything at face value so you’re trying to, er,

I: Get understanding and contextualise it?
C: Yes, er and I guess that’s the challenge of family therapy, of systemic therapy is to do that so that the timing is right that you don’t do that – because if you do it too quickly it can become intrusive. Have you ever read – it’s one of my favourite books “the time of times”?

I: No.

C: By erm, it’s, you might find it interesting. It talks about time in therapy erm it’s by Louis G. Boscolo and Paulo Bertrando and they’re Boscolo is one of the Milan group.

I: I wouldn’t mind having a look at that.

C: Yeah do it’s lovely. Yeah.

I: And do you think that that family members’ afterwards find the team helpful?

C: Yes.

I: So when they feedback is it kind of a general – because you mentioned that family members you get feedback is that kind of ongoing in therapy or at the end, or do they give you written-

C: Er, no it, it’s the feedback to the reflecting team cos theirs is always that bit there’s the reflecting team and then you always ask the family for any thoughts that they have.

I: So it’s inbuilt, it’s a continuing dialogue?

C: Absolutely, absolutely

I: Between the two.

C: Absolutely it’s part of the structure. And we do at the end of the work always send out erm, er a sort of some outcome measures to people too.

I: To see how it goes, so it’s continuously audited?

C: Yes.

I: Erm and how do you think erm therapy here affects family members lives once it’s been completed. What do you think they take away?
C: Well I would hope some sort of continuation of er cos once you’ve started to hear and understand somebody a bit differently it’s hard to go back on that.

I: Umm.

C: So, hopefully just a more empathic position er, about other people in the family I guess. And particularly if there’s mental health issues that, that erm, more of I guess an externalisation of the symptoms that they’re not that person.

I: So I guess the sort of framework that you’re using is looking is an ongoing conversation that doesn’t finish when the therapy finishes it continues

C: Yeah, yeah it continues.

I: Outside of therapy. And I guess difficulty might arise when family members have an idea that something will be finished with therapy, they’ve got an outcome in their head of what they wanted to achieve?

C: Well I would hope because that’s why at the beginning of the work we do say what are people’s aims what are their goals for coming here and, and that you would hopefully be working, checking with them about where things were er in their aims for therapy and er, so you’re not here to solve everything in everybody’s’ lives it’s not personal development therapy. It’s, it’s you know you sort of have your referral. So there is the reason the referrer referred and then you have the family and there is the reason the family referred – sometimes they will be the same and sometimes they will be different. But you’ve already got some construction of goals and aims for the work which is not about make this family you know a happy family.

I: And I guess that will be a big part of the work with the family understanding what can be done?

C: What can be done and this is what we’re working to yeah.

I: And I guess that can take a while to negotiate?

C: It generally takes a couple of sessions to negotiate what are the goals what are the aims for the work.

I: And um do you think that the changes generally brought about kind of staying this conversation is kind of what the family members expected?
C: Sometimes, it's sometimes different and it's sometimes er what people haven't necessarily expected is that there may be changes between the identified patient and themselves but what people have not necessarily expected is that there will be changes with other family members too um so it sort of the systemic impact I guess of working with a family.

I: And that kind of takes it towards the end of the interview.

C: Okay.

I: So I just wondered if there was anything that you would like to add that we haven't addressed? Erm, because there are obviously a lot of issues – it is a mind field!

C: Yes, er I don't think so but, but I do think maybe it is something about the, the capacity for, for people to change throughout our lives and um, and that you know even with awful things like the onset of dementia that there is something that can be done which is positive and helpful and allows people maybe to have useful time together and enjoyable times and not maybe to just dwell on the negatives of diagnosis.

I: There's something important there about an instillation of hope

C: Absolutely.

I: And that being carried with the team and the therapist.

C: Yes, yes.

I: Kind of sharing with the family.

C: Hope and something about maybe for people with dementia maybe you live in the here and now a bit more.

I: Hmm.

C: Um so er, you may want to do more of stuff you enjoy together because there may come a time when that doesn't happen. So if people like going on holidays we generally try to encourage people to go on holidays

I: Yeah.

C: Just, just that sort of thing so just think in the moment kind of thing yes.
I: So is there a lot of work around kind of thinking about bereavement?

C: No.

I: No. Which is interesting because with the client group you would think that there are multiple losses not just of people but of homes and abilities?

C: Sometimes but we only talk about what people would want to talk about.

I: Yeah.

C: I mean it was very interesting you see because I think sometimes as experts we can take those experiences but actually those losses (one side of tape finished)

I: You were speaking about losses.

C: but I think it’s important that sort of taking an expert position that we don’t take expert positions from that. We learnt a lot from this couple, this Afro-Caribbean couple because actually this man had experienced er, he had come to this country with something like six friends and they were mates through thick and thin and he had lost all of them and we wanted to, sort of talk a lot about those losses really. And he was very good, he did say at one time yes I have had those losses and yes I was sad however there are still these other issues.

I: Umm.

C: And it was really good cos he was saying yes I know that and erm however, that’s not the total explanation of what’s happening and I really admired him for that really

I: Ummm.

C: And I think we can very easily get caught up in our own hypothesis and that no matter when we’re desperately trying not to but even so our own prejudices and assumptive frameworks can come to the fore. And yes, there is loss, but that may not be what people are wanting to talk about. And for us not to somehow-

I: To say you have to talk about it cos that’s what we thinks going on?
C: Absolutely.
I: Okay.
C: Yep.
I: Thank you.
C: Okay Jane that was very interesting thank you.
Dear ,

Thank you for participating in my research project about family members' experiences of family therapy. Your time was very much appreciated.

I am writing to you now, as discussed, to share with you the findings of the study. Six family members participated in total. Unfortunately not all individual experiences of therapy can be presented in the findings but instead the three main themes identified aim to show something of the essence of the experience of family therapy that was shared across the participants in the study. Three overall themes were identified: ambivalence about engaging with therapy, facilitative aspects of therapy, and constraints to change.

I have enclosed a feedback form and a stamped addressed envelope for you to give me written feedback but you are under no obligation to do so. Alternatively, you can email me on to give me your feedback. If you asked me to telephone you in relation to the findings I will call you one week after posting this letter.

Best wishes and thank you again for your valuable time.

Jane Major
Trainee Clinical Psychologist.
Findings:
From the interviews with family members who had participated in family therapy three overall themes were identified that were largely shared.

1. Ambivalence about therapy
Family members appeared to hold opposing feelings about engaging with therapy. These opposing feelings included both the possible benefits and possible costs of engaging with therapy. These feelings of ambivalence seemed to be present within individual family members and within family sub-systems (e.g. where one family member might be hopeful about engaging with therapy and another family member might feel more doubtful about the benefits of doing so). It seemed that some family members had particular thoughts about what might be beneficial and difficult about accessing therapy.

Potential costs identified with accessing family therapy included that it could be potentially stigmatising, that it might not be beneficial and that it might not be a safe environment. Concerns about stigma included that work colleagues might find out and that people might assume that having therapy meant there was a problem. Some family members drew upon their previous experiences of therapy and also wondered if therapy might not be effective. Fears about family therapy not being a safe environment included that questions might that be intrusive and there was uncertainty about what other family members might want to talk about.

The potential benefits of engaging with therapy were specific to the difficulties identified by family members that they wanted support with. For many family members it seemed that changes in family circumstances had occurred. For some participants it seemed that there had been a dip in their ability to cope at the time of referral to therapy and it was hoped that coming to therapy might help them adjust and discuss difficulties. The majority of family members expressed hope about what therapy might facilitate. In particular all family members appeared to hope that family therapy might increase understanding between family members.

2. Facilitative aspects of therapy
Family members identified what aspects of therapy they thought had been helpful. For some family members, but not all, this included the relationship with the therapist in the room. This seemed particularly beneficial when the therapist was perceived as caring, competent, friendly and open.

However, for some family members that did not experience this with the therapist in the room, it seemed that they could relate to members of the team. The “reflecting team” was also identified by family members as a beneficial aspect of therapy. In particular family members referred to the benefits of being able to receive feedback that included different points of view. In addition, it seemed that hearing what the team had to say in an indirect manner was particularly effective for some participants. If the team had a diverse membership including men and women this was considered especially helpful. It was suggested that it could be beneficial for the team to consist of a more diverse age group.
Non-specific elements of therapy were also considered by some family members to be helpful. This included having a space to talk to one another, to listen and for some to gain a different understanding about other family members’ feelings and their own feelings. It seemed that gathering as a family for some participants was symbolic that the family itself was trying to work together.

3. Constraints to change
All family members discussed aspects of therapy that may have made it more difficult for them to benefit from the experience on this occasion.

For some family members this included difficulties negotiating the tasks of therapy between the team and the family. For some this included what might be worked on and discussed in therapy, and where change might be possible, in addition to experiencing difficulty negotiating when therapy might end.

Time constraints on therapy were noted by all participants. Time constraints were defined as including both the number of sessions, the time of day sessions were held (for example if held during work hours), and the timing of therapy in relation to family members mental health. Some family members felt that not enough sessions were offered given the amount of time family members had been coping with their difficulties. The timing of sessions, in relation to working hours, could make it very difficult for all family members to attend. When all family members were not able to attend this led to participants questioning if this was really “family therapy”? Some family members questioned the benefits of having therapy when one member of the family was particularly unwell and wondered if it would be possible to have it when family members were in better health. However, there were diverse opinions about this.

Some family members expressed that there were limitations to the extent to which they felt safe within the therapeutic environment. For example, some family members wondered if it would be possible for individual family members, or certain sections of the family, to meet with the therapist to discuss certain issues. It was thought that perhaps these issues might be too difficult to discuss in front of all family members. In particular several family members noted the long break between sessions. Some family members spoke about not knowing what to do in this break and wondered what might happen if the family went into crisis.
Should you wish to do so please complete this feedback form after you have read the findings of the study.

1. Was there anything in the findings that you felt was especially representative of your experience of therapy?

2. Was there anything in the findings that surprised you or you disagreed with in relation to your experience of family therapy?

3. Do you have any comments on the interpretation of the themes?

4. Are there any comments you would like to make in general or in relation to your involvement with the research?