An Exploratory Study of a Reflecting Team's Influence on the Family Meaning System in The Self-Harm Intervention Family Therapy (SHIFT) Trial

Christina Marie Iantha Barker

Submitted in accordance with the requirements for the degree of

Doctor of Clinical Psychology (D. Clin. Psychol.)

The University of Leeds

School of Medicine

Academic Unit of Psychiatry and Behavioural Sciences

August 2016

The candidate confirms that the work submitted is his/her own and that appropriate credit has been given where reference has been made to the work of others

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

ACKNOWLEDGEMENTS

ABSTRACT

Introduction: The study aimed to explore a Reflecting Teams (RT) influence on the family meaning system in The Self-Harm Intervention Family Therapy (SHIFT) Trial where the referral problem is adolescent self-harm.

Method: A multiple case study design was undertaken to examine the practice and influence of a RT across three different families by comparison of the pre and post RT dialogues and the discursive strategies utilised by the RT. An original analytical strategy was implemented, derived from Discursive Psychology, the pragmatic application of Positioning Theory and the Semantic Polarities Model, to capture subtle shifts within the family meaning system from recorded family therapy sessions.

Results: The RT was instrumental in guiding and reinforcing the therapist's influence; acting as a consultative team, a supervisory resource and a collaborative partner. The RT influenced change across cases through a range of discursive strategies: collaborative co-positioning of the family and therapy team, adopting an expert position regarding the management of risks and areas of continuing concern and also emphasising and reinforcing family strengths, progress, and resilience. Findings suggest that the RT may have a differential influence depending on the stage and context of therapy.

Discussion: These novel findings are discussed in the context of existing literature and the specific contribution of the current study regarding adaptations to RT practice in response to the management of risk and stage of therapy. Limitations of the current research design are indicated with recommendations for future research.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE: INTRODUCTION

Aims of the Study

The current research seeks to explore the influence of a Reflecting Team (RT) on the process of meaning-making in family therapy, taking place within the Self-Harm Intervention Family Therapy (SHIFT) Trial, where the referral problem is that of adolescent self-harm. RT approaches originate, and are integral to, the practice of family therapy. The RT process involves a team of observers who watch the therapist interviewing the family from behind a one-way mirror, or alternatively from within the therapy room (Janowsky, Dickerson, & Zimmerman, 1995). As the RT members listen to the interview, they formulate ideas which they think may be helpful to the family (Andersen, 1987). The RT members subsequently have a conversation together about what they observed, to which the family is an audience. This process is intended to generate a range of different perspectives and provides the opportunity for the family to reflect on the possibilities and alternative perspectives offered by the RT. Theoretical and practical explanations of RT processes exist, however, there is a dearth of empirical research that explores the RT process in practice.

The use of RTs is demanding of professional resources, hence the approach has significant cost implications. It is therefore essential that efficacy and process studies begin to be undertaken if the continued use and expense of the RT approach is to be justified, particularly in austere times. The current research will seek to begin to inform this gap in the research literature by undertaking process research specific to RT practice.

To contextualise the research I will first give an indication of my own position within the evolution of the current study. Following this, I will present a brief history of family therapy, the use of teams and the RT. I will then move on to discuss the current literature on RTs and will provide a summary of key findings from the existing research.

Declaration of Interest

As a child I was keen to get my voice and opinion heard but frequently experienced feelings of powerlessness in this regard when discussing issues with adults in positions of authority. I also witnessed many adults disrespecting children and young people and misusing their positions of power. My personal experiences led me to go on to work extensively with young people in various settings. As an adult, I feel a sense of responsibility to promote and encourage the voices and experiences of young people. I undertook a timely piece of research for my Master's thesis in 2008 'Exploring the Emotional Experiences of Young People on Antisocial Behaviour Orders (ASBOs)' (unpublished) whilst also working at the Youth Offending Team (YOT).

Since then I have been fortunate enough to work with a number of influential family therapists. During this time I have witnessed and experienced the value of utilising reflective practices in family therapy sessions and also as a technique for facilitating case and service related discussions within teams. It is a combination of these experiences which provided the initial impetus to extend my studies and undertake the current research.

I am a white British female in my early thirties and from a working class background. However, through entrepreneurship, my immediate family are now more representative of the lower middle class and I have been fortunate enough to be the first generation to undertake postgraduate education. Studying throughout my early adulthood has maintained my dependent position as a 'learner'. Within my immediate family my primary role is that of a daughter, and I do not have direct parenting experience. During the process of undertaking the current research, I recognise that I may have been more prone to recognise and relate to the roles and perspectives of the adolescents as opposed to those of the parents.

Throughout my career, I have worked extensively with children, adolescents, and their families in a variety of roles and contexts. This includes; working with children and parents involved in parenting assessments, child protection proceedings, youth justice settings, looked after children (LAC) and carers, in addition to mental health services in community, inpatient and secure establishments. This work has involved promoting early attachment relationships, advocating for, challenging, and supporting children and parents/carers, delivering parenting programmes, and undertaking intensive therapeutic work.

Over the duration of the analysis, I drew upon my range of experiences to facilitate a more balanced interpretation of the data. This included closer consideration of the parent's positions, perspectives, stressors and strains, in addition to those of the adolescents. A quotation by Liddle represented my reflexivity in this regard; "One should assume that parents have tried their best to deal with the difficult challenges presented by their children, and further, one should be sensitive to the many personal and extrafamilial developmental and contextual pressures faced by many of the parents" (Liddle, 1995, p.46).

Background to Family Therapy and Reflective Practices

"The whole is greater than the sum of its parts" (Aristotle, 384-322 BC).

Developers of the SHIFT manual indicate that they were influenced by Milan systemic family therapy, Post-Milan and Narrative models (Boston, Eisler, & Cottrell, 2009). The orientation of family therapy in the current study integrates theoretical principles and techniques from The Milan team, Solution Focused and Narrative Therapies; this includes attention to dialogue, narratives and the use of language, collaborative working, highlighting the family's strengths and possibilities in addition to the systemic management of risk (Boston et al., 2009). I will provide an overview of the history and development of family therapy here with reference to the theoretical principles and approaches relevant to therapeutic practice within SHIFT.

Family therapy emerged in 1950s America which followed a shift in the attribution of problems from intrapersonal to interpersonal (Carr, 2006). This interpersonal, relational perspective of problems was in contrast to the dominant psychoanalytical framework that prevailed at the time (Anderson & Goolishian, 1988). Family therapy has at its core the intention of engaging with the whole family to improve their interactions, communication, relationship patterns and their capacity for problem solving (Cottrell & Boston, 2002). Early Systemic Family Therapy (SFT) moved the focus of pathology from the individual to the family system to avoid blaming the individual. Later developments of family therapy moved to consider the influence of broader contextual factors to avoid reinforcing disabling, and blaming family narratives (Hoffman, 1985; Mirkin, 1990).

Observation was central to the development of family therapy theory (Whitaker & Keith, 1981). Through a combination of therapy teaching, training, and research at The Mental Research Institute (MRI) of Palo Alto, California, therapist-researcher teams typically observed the therapy

system which provided some of the early foundations of family therapy theory (Gehart, 2014). Gregory Bateson (1972) and colleagues contributed to the early development of systemic therapy theory through their work on general systems theory and cybernetics (described later) at the MRI (Cottrell & Boston, 2002). Stemming from biological theories, general systems theory emphasises the interconnectedness of living organisms and is concerned with the coordination of parts and processes within the system (Von Bertalanffy, 1972). A system is defined as "an organised whole that is comprised of parts that are interdependent or interrelated" (p. 134, Weakland, Fisch, Watzlawick, & Bodin, 1974). Applied to the family system, this involves the social interaction, communication patterns and relationships between individual family members to consider the interconnected functioning of the family unit as a whole.

In line with the modernist and structural ideologies that prevailed at the time of family therapies emergence, structural family therapy was one of the earliest models (Boston, 2000). This included the work of Salvador Minuchin and colleagues at the Philadelphia Child Guidance Center (Minuchin, 1974) and later developments from the work of the Milan team in Italy which I will go on to discuss (Selvini, Boscolo, Cecchin, and Prata, 1980). Minuchin founded structural family therapy in response to Don Jackson's (1956) concept of family homeostasis which refers to the maintenance of equilibrium within the family (Minuchin & Laplin, 2011). Structural family therapy adopted a political stance and an interventionist approach that challenged the typical psychoanalytical way of working with children and adolescents. By considering the sociopolitical and economic context of the family, Minuchin's (1974) approach was intended to be more helpful for families faced with poverty and disadvantage. At the time, Minuchin considered the Hispanic families he was working with to be highly reactive and unreflective (Minuchin & Laplin, 2011). Minuchin also drew upon his experience of boundaries, hierarchy and power that operated within his family of origin (Minuchin, 2012). In response to these influences, structural family therapy was generally active and directive as opposed to reflective, with an emphasis on the hierarchical nature of families, power dynamics, alignments and coalitions (Minuchin, 2012; Minuchin & Laplin, 2011). The therapist also recognised their influence on the process of therapy and change within the system thus being open to changing one's way of interacting, for example, taking a 'one-down' position to reduce resistance and enable change (Minuchin & Laplin, 2011).

The Milan team made significant contributions to the development of systemic practice (Campbell, 2003; Hoffman, 1985). Originally the Milan team implemented techniques consistent with first

and second order cybernetics (described later), however, the Milan team went on to develop their work in line with social constructionist and post-modernist influences (Gehart, 2014). Their early work focused on observable behavioural sequences and interactional patterns (Hoffman, 1985). The "circular questioning technique" was developed and intended to provide feedback to the system, creating new connections thus generating a difference within that system (Campbell, 2003). This incorporated Bateson's (1972) idea that the introduction of a 'difference', such as the therapist introducing the family to a new perspective, brings challenge to the consistency of the family system to initiate change. In line with the early modernist origins, the therapist takes a position of neutrality and is considered to be a knowledgeable expert to advise the family system. Selvini and associates conceptualise neutrality as the "specific pragmatic effect" (1980, p.9) of the therapist's behaviour on the family as opposed to an intrapsychic disposition. Neutrality results from the therapist's shifting and successive alliances and curiosities regarding each member of the family system, with no one alliance being stronger than another (Miermont, 1995).

Solution focused brief therapy (SFBT) also arose in the 1970s from the work of Steve de Shazer, Insoo Kim Berg and colleagues at the Brief Family Therapy Center, Milwaukee, Wisconsin (de Shazer et al., 1986; de Shazer, Dolan, Korman, McCollum, Trepper, & Berg, 2007). SFBT was developed pragmatically through close observation of positive changes which became apparent during family therapy in addition to the influences of Watzlawick, Weakland and Fish (1974) at the MRI and aspects of Buddhist philosophy (de Shazer et al., 2007). While the developers of SFBT claim the approach is not theoretical, the approach appears consistent with cybernetics and positive feedback loops in line with the desired change. Key principles of the approach include looking for exceptions to problems, and recognition that the language of solutions is different from the language of problems (de Shazer et al., 2007). A focus on emphasising, reinforcing and congratulating exceptions, strengths and solutions facilitates a future which is more focused upon overcoming the problem (Trepper et al., 2008). The therapist is active in creating change, however, rather than explicitly directing or instructing the family, the therapist leads "from one step behind" (Cantwell & Holmes, 1994, p.17-26) as one "taps on the shoulder" (Berg & Dolan, 2001, p.3) of the individual or family member enabling them to consider a different direction (cited in de Shazer et al., 2007, p.4).

A paradigm shift occurred in the 1980s resulting in the progression of systemic theory from first order to second order cybernetics (Boston, 2000). Cybernetic theory suggests that systems have

homeostatic, self-regulating properties operating through closed controlled feedback loops which maintain the status-quo (Gehart, 2013). In contrast to first order cybernetics, second order cybernetics place an emphasis on the individual mental constructs of the observer, which brings awareness to the therapist's objective view and the lens through which they perceive the world (Hoffman, 1985). From a second order cybernetics epistemology, the therapist was considered to be a participant-observer, embedded within the therapist-family system (Bateson, 1972). Central characteristics of a second order family therapy involve the inclusion of an observing system, a collaborative structure, establishing a context for change, circular assessment of the problem and a non-pejorative, non-judgmental and non- instrumentalist approach (Hoffman, 1985).

Influenced by social constructionism and the post-modern movement, developments in the field of family therapy eventually moved away from perceiving the family as a cybernetic system to that of a meaning-making system consisting of a "series of interconnected *relationships* which generate *meaning"* (Campbell, 2003, p.17). From this standpoint, therapy was viewed as a "conversational domain" in which all participants were part of an "evolving meaning system" (Hoffman, 1985, p.387). This resulted in a reformulation of the problem, moving away from the idea that this was in some way an aspect of the family system but rather being an aspect of the 'ecology of ideas' that are held within the broader context (Bogdan, 1984; Hoffman, 1985). From this position, the therapist was an observing system whilst also playing an active role in the co-creation and construction of meaning within the therapeutic system to which they formed an essential part (Bogdan, 1984; Hoffman, 1985). Following the post-modern movement, the concept of 'self' also became transient, open to construction and changeable (Boston, 2000).

Such developments in family therapy emerged in response to the "linguistic turn", a movement amongst philosophers, the social sciences and humanities which involved a shift in focus to consider the "meta-level" of language as symbolic as opposed to an objective representation of reality (Besley, 2002). The "narrative turn" was part of this post-modern movement; this led to the emergence of narrative therapy which originated from the work of White and Epston (1990). Narrative therapy places an emphasis on the use of language and meaning (White, 2012), and incorporates the ideas of Bateson (1972), Bruner (1986) and Foucault (1982). Bateson's (1972) concept of creating difference within the system is evident in the elicitation of 'alternative stories' and contrasting current problems with preferred future self-positions (Sluzki, 1992). This comparison of past and future positions provides an opportunity and opening for change within

the system (Beaudoin, 2008). Bruner's (1986, 1997) influence is apparent in the perception of narratives being 'constitutive' of the world. Consistent with social constructionist theory, narratives are understood as creative of identities and problems as opposed to being representations of one's reality (Carr, 1998; White & Epston, 1990). Foucault's (1982) influence is apparent in the recognition of dominant discourses and socio-cultural norms on the shaping and emergence of narratives, with the resulting subjugation of others. Challenging oppression and encouraging the consideration of subjugated narratives is central to narrative therapies which take a socio-political stance towards the conceptualisation of problems (Monk & Gehart, 2003).

In contrast to strategic approaches, the "collaborative co-authoring position central to narrative practice is neither a one-up expert position nor a one-down strategic position" (Carr, 1998, p.22; White, 1995). Fundamental to narrative therapy is the idea that therapeutic change occurs as a result of therapeutic conversations in which meaning is co-constructed; identifying strengths and re-authoring problem saturated narratives is considered central to change (O'Connor, Meakes, Pickering, & Schuman, 1997). Following narrative therapy sessions, therapeutic letters provide an informal method of reviewing and providing feedback to reinforce the client's progress (Hoffman, Hinkle, & Kress, 2010; White & Epston, 1990). Externalisation is also a key strategy which associates problems with dominant societal discourse as opposed to being internal characteristics located within the person (White & Epston, 1990). Externalisation provides an opportunity for family members to take a different perspective in response to problem events which minimises blame and leads to an increased sense of personal agency (Tomm, 1989).

Applied to family therapy with adolescents engaged in self-harm and their families (such as that undertaken within the current study), the act of self-harm is conceptualised as a method of communication which has developed in response to an interplay of interconnected factors (Boston, 2009). "Rather than focus on the causal explanation of individual problems... SFT is concerned with the way these problems will have become embedded in the matrix of family and wider social relationships, the felt experiences and the meanings and narratives that have become attached to and shape these difficulties" (Boston et al., 2009, p.11).

History and Development of the Reflecting Team

"The development of reflecting processes… have provided… essential tools for giving expression to our therapeutic stances, ways of conversing, and emphasis on listening, which makes the therapeutic relationship more horizontal and democratic" (Garcia & Guevara, 2007, p.73). "This configuration of the therapeutic setting is itself congruent with the conception of human dilemmas as multifaceted phenomena whose meanings are always constructed by those who observe" (Grandesso, 1996, p.306).

The use of an observing team is typical in family therapy, however, as the RT enter and contribute within the therapy room, the RT have the potential to be directly influential on the process of therapy (Grandesso, 1996). In addition to the use of the RT in family therapy, RTs have been adapted and utilised creatively in a range of contexts and settings including conversations between individuals, groups, networks, and as a method for mediation (see Anderson & Jensen, 2007). The RT has also become an established method within some counsellor-therapy training courses (Biever & Gardner, 1995; Chang, 2010; Cox, Bañez, Hawley, & Mostade, 2003; Griffith, 1999; Landis & Young, 1994; Paré, 1999; Shurts et al., 2006) and within supervision (Prest, Darden, & Keller, 1990; Reichelt & Skjerve, 2013; Stinchfield, Hill, & Kleist, 2007). To capture the various formats and applications of the RT, this approach has been referred to more broadly as a "reflective process" (Hoffman, 2007). However, for the purposes of the current study, this literature review will focus on the history and use of RT practices within family therapy.

In comparison to traditional psychodynamic approaches to therapy, early family therapy was less private and boundaried as it was common to incorporate methods of external observation in order to develop and influence therapeutic practice (Minuchin & Fishman, 1981). "The ensuing shift in focus from the unconsciously linked free associative thoughts of the individual patient to the apparently observable family interactions, made the subject matter of therapy open to scrutiny in a way that traditional approaches to psychotherapy were not" (Eisler, Dare, & Szmukler, 1988, p.47). Direct observations of family therapy and family interactions therefore commonly took place as a method for research, therapeutic training (Gehart, 2014) and for rebalancing the 'enmeshed' therapist (Minuchin & Fishman, 1981).

Observing teams were utilised by a number of family oriented therapists (Papp, 1980; Andersen 1987; White & Epston, 1990). A number of different styles and approaches to RT practice have

emerged over the past thirty years (Andersen, 1987, 1991; Friedman, 1995; White 1995). In 1980, Papp published work on the use of a consultative team to the therapy room known as "The Greek Chorus". This team generally operated from behind a one-way mirror, observing and passing messages through into the therapy room (see figure 1). These messages had the intention of influencing therapy in various ways including; supportive messages of praise for the family, "public opinion polls" predicting the family's likelihood of change, surprising or confusing the family, or "splitting" the system by disagreeing with the therapist (Papp, 1980).
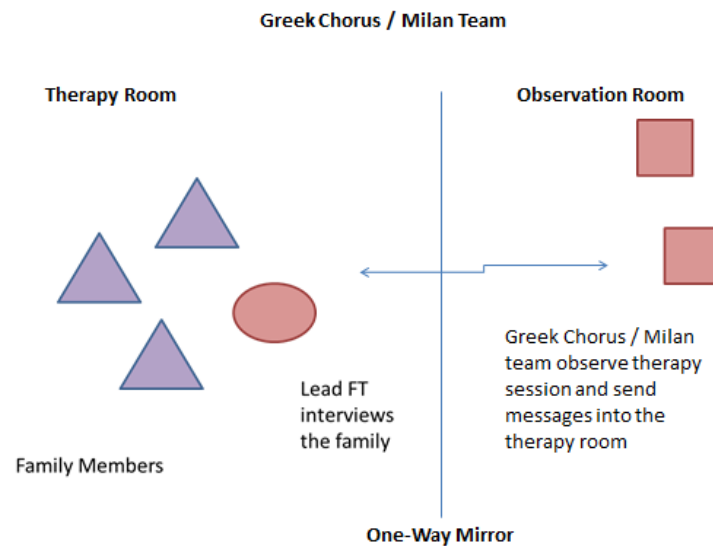
Figure 1: Configuration of the Greek Chorus & the Milan Team

In response to complex and 'resistant' families (Sheinberg, 1985), Papp and her colleagues went on to introduce the idea of involving the consultative team in a "Strategic Debate" (see figure 2, p16; Sheinberg, 1985). In contrast to The Greek Chorus, the Strategic Debate included the team in the therapy room, entering from behind the one-way mirror to openly initiate a debate. This debate was considered 'strategic' as it intentionally replicated the dilemma and positions taken up by members of the family. Through this process, covert family relational patterns and associated symptoms were intended to become more overt, increasing the family's awareness of the systemic nature of the 'problem'. From this 'meta' position, the family were considered to be more able to contribute to resolving the family dilemma (Sheinberg, 1985).

STRATEGIC DEBATE: STAGE ONE

Therapy Room   Observation Room

The consultative team
observe the therapy session
from behind the one way
mirror taking note of the
family dilemma

One-Way Mirror

STRATEGIC DEBATE: STAGE TWO

Therapy Room   Observation Room

The consultative team engage
enter the therapy room to
engage in a 'Strategic Debate' –
intentionally replicating the
family dilemma

One-Way Mirror

Figure 2: Stages and configuration of the Strategic Debate

The Milan team

The Milan approach made use of a team of Psychiatrists and Psychoanalysts including Selvini
Palazzoli, Luigi Boscolo, Gianfranco Cecchim and Giuliana Prata at the Centro per lo Studio della
Famiglia, Italy (Selvini et al., 1980; Tomm, 1984). Due to their professions, the Milan team, were
heavily influenced by Italian medicine and psychoanalysis and, as a result, were positioned as the
'expert' consulting system intended as a supervisory resource for the therapist (Treacher, 1988;
Mitchell, Rhodes, Wallis, & Wilson, 2014). Families were perceived to change as a result of direct
intervention from the team, with adaptations to one part of the family system viewed as having

implications for the whole family (Tomm, 1984). The lead therapist referred to as a 'conductor', consulted with the team outside of the therapy room to provide an alternative perspective or formulation which could be selectively incorporated into their intervention with the family. The team's hypothesis regarding family alliances, myths and communication patterns informed the therapist's approach as they returned to deliver a message designed to create a high impact jolt to rearrange the family system (Gehart, 2013). This was a non-blaming message with a positive connotation, with the therapist offering hypotheses regarding the dilemma of each family member and why it might be difficult for them to change (Hoffman, 1985).

Andersen's development of the RT

Tom Andersen (1987) and colleagues reported first utilising the RT in 1985. They reported stepping in to assist a therapist who was repeatedly drawn into the family's pessimism. When the therapist did not succeed in facilitating a shift in the family's positioning, Andersen and colleagues offered to change the arrangement of the therapy session. The team went into the therapy session from behind the one-way mirror and reflected on what they had observed. As such, the family were able to take a reflective 'meta' position, as they listened to the different perspectives and ideas offered by the team. The therapist was also able to pick up on the ideas and themes offered by the team. Following this, discussions between the therapist and family members were more optimistic. New understandings, meanings and possibilities were seen to be created by the inclusion of the observing system in the therapy room who effectively 'tuned into' the 'stuck' family system (Andersen, 1991). This practice marked the beginning of what is now known as the RT.

In developing the RT, Andersen was largely influenced by postmodern approaches to family therapy, social constructionism and hermeneutics (Bateson, 1972; Hoffman, 1985). Andersen's development of the RT moved away from the previous expert positioning of the Milan team, instead opting for a position of neutrality and collaboration to 'demystify' the consultation process and provide greater transparency (Andersen, 1987; 1991). Andersen was not comfortable with observers discussing the family, 'behind it's back', as it were, and subsequently introduced the concept of sharing reflections directly with the family, making these ideas visible, timely and relevant to the family's discussions (Andersen, 1987; 1991). Family members were then able to hear and consider all perspectives offered by the RT. Andersen's positioning of the RT provided a more empathic, non-pathologising and relational approach; he perceived this to be a way of

thinking and collaborating with the family as opposed to being a specific technique or intervention to be applied (Friedman, 1995; Mitchell et al., 2014).

The main aim of Andersen's RT is to "free the stuck system by offering a range of alternative perspectives which will challenge and broaden unrestricted thinking" (Parker & O'Reilly, 2013, p.176). The 'non-expert' positioning of the observing system acknowledged the existence of multiple alternative realities and was consistent with the prevailing social constructionist ideas of the time (Anderson & Goolishian, 1992). Andersen's use of the team differed from the strategic debate as he incorporated the thinking of Maturana & Varela (1987) to include the idea that there could not be any 'instructive interaction' to the closed conserving system but rather, where conditions allow, the system could be perturbed by external influences (Hoffman, 1985). Where conditions of safety are established, and individuals are able to maintain their integrity, through the exchange of ideas, it is possible for the family to be influenced within the range of their individual repertoire to thus expand the system of available meanings (Andersen, 1991).

Maturana's concepts of no 'instructive interaction' and the need to maintain integrity within the system were also in line with Bateson's concept of 'a difference that makes a difference' (1972, p.453). Andersen (1991) interpreted this difference as something 'unusual' and different enough to be noticed by the family system but not too unusual in order to bring about change. Andersen applied these concepts of subtle differences which brought about 'perturbations' to the family system through small shifts in the use of language. He interpreted helpful influences as those which bring about new perspectives, ideas and possibilities for progress and evolution of the system (Andersen, 1991). In contrast, unhelpful influences involve attempts to impose fixed, restricted ideas and perspectives to the system which impede possibilities, progress and development (Andersen, 1991).

In contrast to the subjective monological perspective provided by a single therapist, the inclusion of a RT introduces an intersubjective dialogical perspective which leads to the development of new meanings (Grandesso, 1996). The RT raise questions regarding areas of interests and ideas that arose to them as they listened to the therapy from behind a one-way mirror (Eubanks, 2002). Through the reflecting process, multiple perspectives and ideas are shared with the intention of facilitating a shift within the family meaning system (Andersen, 1991; Zevallos & Chong, 2007). Central to this process is the "multiverse" concept which extends the idea of there being one

universal truth by acknowledging that many alternative realities and understandings of phenomena co-exist (Andersen, 1991). The family are then able to continue discussions about ideas and themes that they found helpful by selecting from those offered by the RT, which in turn frees up the previously stuck system (Andersen, 1991; Friedman, 1995).

Typically reflective conversations are non-blaming and attend to significant themes, dilemmas and positive developments within the family narratives (Friedman, 1995). Instead of being judgemental and directive, 'either-or' positions are promoted, "we stop saying what people should do and think, and then alternatives popped up almost by themselves… for example… we said, 'in addition to how you are thinking, we have thought' and 'in addition to doing what you've been doing, you could also consider'" (Andersen & Jensen, 2007, p.158). This process moved away from the polarisation of perspectives to recognise the multiplicity of potential viewpoints which co-exist. Andersen believed that through a cyclical process of exchange between the family and the RT, alternative explanations and conceptualisations of the family's problems would emerge (Andersen, 1987; 1991). This exchange is intended to expand the 'ecology of ideas' (Bogdan, 1984) within the reflexive space between the family and the RT (Andersen, 1987) and thus to the evolution of the meaning system (Hoffman, 1985).

"The reflective setting provides a liberating opportunity to talk to each other without having to prove who is right or wrong. Instead of deciding how things should be, talking about how things are and how this affects all concerned creates a new understanding of oneself and others. These discussions, added to what's already known, make everyone more capable of dealing with their dilemmas… It also makes a big difference… if you see yourself as a professional who creates an atmosphere for conversation and communication among all parties who comprise the problem defined system" (Kjellberg, Edwardsson, Niemela, & Oberg, 1995, p.61).

As opposed to paraphrasing or restating what had been said, the term 'reflecting team' drew on the French word réflexion which means that "something heard is taken in and thought about before a response is given" (Andersen, 1991, p.12). The listening position of the non-speaker is said to enable a focus on the ideas and perspectives of the RT. It is hoped that this provides an opportunity for some small shifts or adaptations to the listener's inner dialogue which opens up the possibility for new external dialogues and changes in the meanings, understandings, and interpretations of the system (Andersen, 1991). 'Outer' dialogues involve a continual exchange of

ideas between people in conversation which parallel the 'inner' dialogues occurring within the individual as they make sense and meaning from the outer dialogue (Andersen, 1991). The potential for change to one's internal dialogue arises in response to the penetrative words of another (Bakhtin & Emerson, 1984). The shaping of one's sense of self and identity is also developed through this process; "when the language changed, each person's way of viewing things changed too. Attitudes changed" (Wagner, 2007, p. 101).

Andersen highlighted the importance of "speaking less and listening more" (Andersen & Jensen, 2007, p.158). Through the listening process and being 'with' the other person and their spoken word, a collaborative experience of shared meaning-making unfolds (Wagner, 2007). Ideas are offered in a non-threatening, tolerable manner (Andersen, 1987; 1991). Andersen also takes a responsive approach to the family, considering their readiness for therapeutic intervention and the most appropriate method for opening up new possibilities and alternatives which are compatible with the family's existing constructs (Andersen, 1991). The transparent, open and honest nature of Andersen's practice is also hypothesised as leading to an improvement in therapeutic relations; empowering families to be active in the therapeutic process and enabling them to accept or reject the ideas posed by the RT (Andersen, 1991; Friedman, 1995). It is proposed that members of the team were also more self-reflective and openly influential on the process of meaning-making by being in the room, which was in contrast to the earlier work of the Milan team who remained behind the one-way mirror (Andersen, 1991; Friedman, 1995). Andersen's RT overcame the hierarchical, expert position of prior interactions with the family, bringing an opportunity for movement in the dynamics of the integrated family and therapist system (Friedman, 1995).

The RT was not intended as an intervention that would be rigidly adhered to; rather it was a philosophy which intended to positively influence practice by promoting transparency and reducing the hierarchy (Andersen, 1991). Despite this intention, Andersen did propose guidelines on how to embark upon the RT process in practice (1987, 1991). These guidelines consider how the RT is introduced and the family's choice as to how or whether the RT will contribute, for example, whether the RT will join the family in the therapy room or provide reflections from behind the one-way mirror. Andersen's guidelines also establish boundaries for the intended format, contribution and style of the RT, including non-instructive and 'intuitive' questions which 'flow' from families 'openings', with members elaborating on issues understood to be of most

significance to the family's dilemma. Reflections are also intended to "'be speculative and tentative as opposed to being pronouncements, interpretations or supervisory remarks" (Andersen 1987, 1991). Cautionary notes and guidelines for reflective processes include Anderson's assertion that, "the team must remain positive, discreet, respectful, sensitive, imaginative and creatively free" (Anderson, 1987, p.9). He also emphasises the need to be responsive, adapting the style and content of questions posed to the family in order to expand their descriptions and explanations whilst also allowing them to maintain their integrity.

Additional guidelines are proposed for the use of RT's within various contexts (Lax 1995; Paré, 1999; Janowsky, Dickerson, & Zimmerman, 1995). For the purpose of clarity, brevity and standardisation, key features of these guidelines can be conceptualised as follows:

1. Enable family members to take a listening position by offering reflections through conversation between RT members and avoiding direct communication.
2. Offer speculations in a tentative and curious manner from a position of 'not knowing'.
3. Promote inclusion and collaboration by ensuring all members of the family are included in the reflections.
4. Be sensitive and responsive to the family's verbal and non-verbal communication; to emulate their pace, rhythm and style and monitor their readiness for ideas.
5. Use the family members own words to convey an empathic understanding of their position and/or rephrase their story to offer a different interpretation.
6. Offer a manageable range of multiple viewpoints and alternative perspectives by noticing exceptions to problem narratives, being cautious not to overwhelm the family.
7. Establish a sense of hope by offering thoughtful, respectful and helpful reflections.
8. Minimise the expert-patient hierarchy by offering meaningful reflections and promote transparency by linking comments to personal experiences.

Current reflecting practices are informed by the ideas of both Tom Andersen and Michael White (1995, 2004), both of whom utilised teams with the intention of overcoming the power differential between clients and therapists. However, differences are apparent in the way in which White and Andersen framed reflections and their team compositions. I will now move on to provide an overview of White's use of teams and reflective practices during the process of therapy before going on to outline research on RTs.
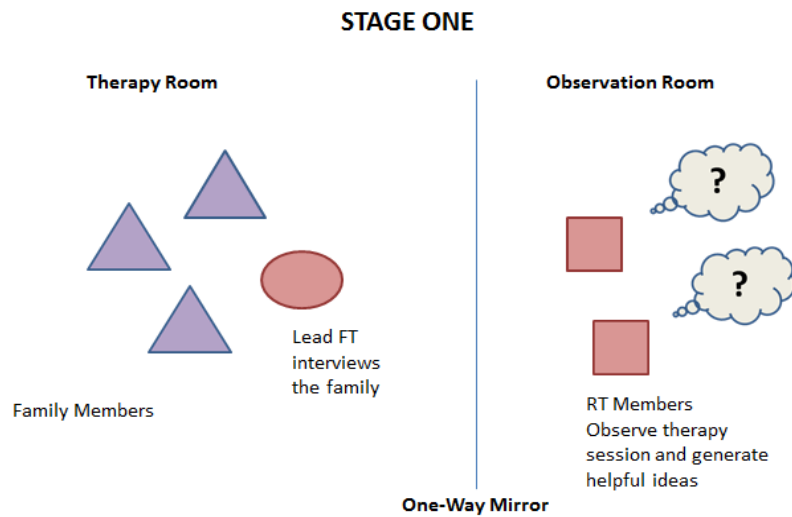
Outsider Witness Practices – The Reflecting Team as a Definitional Ceremony

For some, the autonomy and anonymity of the Milan team had raised political and ethical concerns (White, 1995). The Milan method was also reported to be difficult to implement in practice (Seikkula & Olson, 2003). In contrast to the Milan team and Anderson's use of the RT which are generally made up of therapists, White's practices involve significant members of the client's network including friends, family members, teachers, and colleagues being present in the therapy session to reflect on what they hear of the client's situation (White, 1995, 2004). The intention is that these outsider witnesses provide an audience to the client's new narrative which facilitates the translation and continuation of this narrative into everyday life (Walther & Fox, 2012). White and Epston (1990) adapted the RT in their use of 'outsider witness' practices and 'definitional ceremonies' for the re-authoring of lives and the re-defining of oneself within narrative orientated therapies (White, 1995, 2004).

In contrast to previous uses of a team in therapy, outsider witnesses may consist of non-therapists and the members provide a personal connection by describing how their experiences resonate with those of the family (Lax, 1995). According to Myerhoff, "definitional ceremonies deal with the problems of invisibility and marginality; they are strategies that provide opportunities for being seen and in one's own terms, garnering witnesses to one's worth, vitality and being" (1986, p.267). Ceremonies consist of four parts, opening with the therapist meeting and interviewing the family and the team bearing witness to the discussions. The therapist and the family then become the audience as they switch places with the team who interview one another and reflect on what they heard in part one. Subsequently, the therapist re-interviews the family with the team again observing the discussion. Finally, the therapist, team and family join a discussion together in order to debrief (White, 1995). Team members are asked to introduce themselves and acknowledge all members of the family in their reflections. They may also respond to what they perceive to be 'preferred developments' that is 'sparkling moments, exceptions, unique outcomes, or contradictions' to elicit alternative stories. The team are discouraged from strategising, problem-solving, teaching, role-modelling, perturbing or advising. The use of tentative language such as 'possibly' and 'maybe', in addition to deconstructing statements by reference to therapists own personal lives is also encouraged to avoid statements of truth or certainty (White, 1995).

The Reflecting Team in practice

An outline of the typical stages and configuration of the RT process in family therapy is presented in Figure 3. Within stage one, the lead therapist interviews the family while the RT observe the session from behind the one-way mirror (Janowsky, Dickerson, & Zimmerman, 1995). As the RT members listen to the interview, they formulate their ideas independently and generate ideas they think may be helpful to the family (Andersen, 1987). Within stage two, the RT join the family and lead therapist in the therapy room. Here, the RT have a conversation together about what they observed to which the family is an audience. Following their conversation, the RT leave the therapy room and return to the observation room for stage three. This third and final stage provides the opportunity for the family to reflect on the possibilities and alternative perspectives generated by the RT.

STAGE ONE

Therapy Room   Observation Room

Lead FT interviews the family

Family Members

RT Members Observe therapy session and generate helpful ideas

One-Way Mirror

STAGE TWO

Therapy Room   Observation Room

RT Members join the therapy
session and share their ideas
by reflecting together on
what they observed

One-Way Mirror

STAGE THREE

Therapy Room   Observation Room

Family are given an
opportunity to reflect on
the RT's ideas

RT observe the
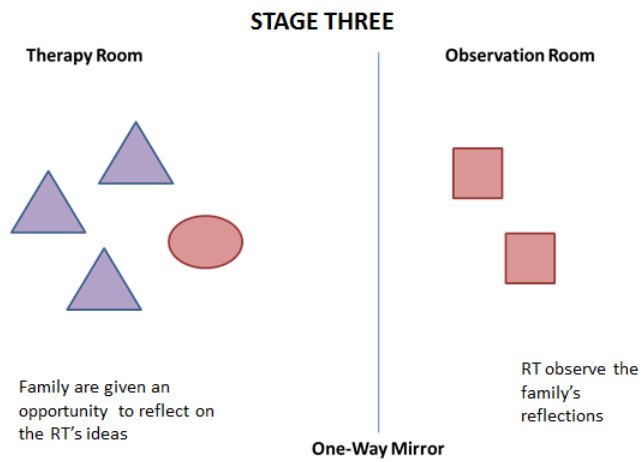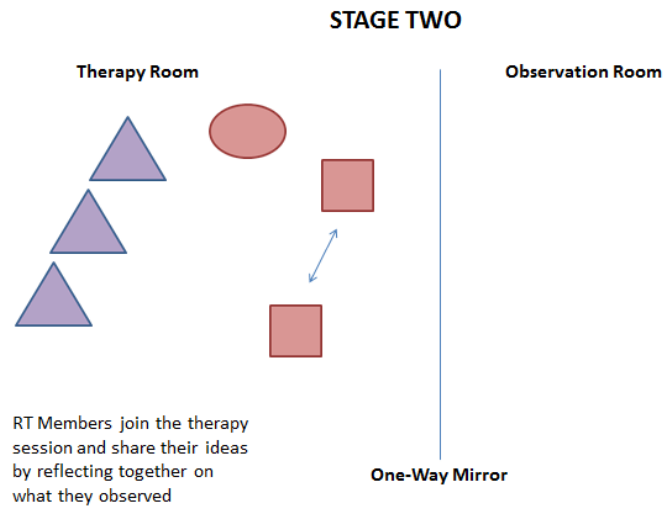family's
reflections

One-Way Mirror

Figure 3: Stages and configuration of the RT process

Research on Reflecting Teams

> "How many sessions worth of good therapy is a good RT discussion?...
>
> An average of 4.7" (White, 1995, p.195).

Michael White's remark, while not apparently intended to be factual and scientific, suggests that he thought the RT had the potential to be more effective and influential than therapy alone. Nevertheless, he did not undertake any research to justify this position and in addition, there is currently very little empirical research or evidence available to support, or refute White's claim (Brownlee, Vis, & Mckenna, 2009; Pender & Stinchfield, 2012; Willott, Hatton, & Oyebode, 2012). This dearth of research significantly limits our understanding of the RTs therapeutic potential and influence in practice.

A comprehensive search was undertaken in order to identify existing research on RTs. A number of theoretical, descriptive and retrospective studies were identified across various cultures and contexts (see search strategy - Appendix A), however, only five peer-reviewed empirical studies of RT practice within family therapy were located (Griffith et al., 1992; Höger, Temme, Reiter, & Steiner, 1994; Mitchell et al., 2014; Parker & O'Reilly, 2013; Smith, Sells, Pereira, Todahl, & Papagiannis, 1995). As it was not feasible to review all of the identified studies in detail here, I will provide an overview of those papers considered to be of direct relevance to the current research. Namely, the empirical studies of RT practice in family therapy and the key theoretical papers.

Review of Existing Empirical Research

The earliest available empirical study was undertaken by Griffith et al., (1992). This study investigated the use of RT practice in consultation clinics for non-psychiatric psycho-somatic complaints with the families of twelve patients referred by physicians in the United States of America. Therapeutic engagement for this population is considered problematic as there is potential for non-medical therapeutic interventions to feel blaming, particularly during initial consultation (Griffith & Griffith, 1992; Griffith et al., 1992). Using the structural analysis of social behaviour scale (SASB) prior to, and after RT consultations, the study indicated promising results with a shift in communication patterns across consultations from controlling, monitoring, blaming and belittling in the pre-RT discussions, to trusting, relying, comforting and nurturing in the post-RT discussions (Griffith et al., 1992). Findings from the Griffith et al., (1992) study indicated the potential for RT consultations to facilitate the therapeutic alliance in a complex family setting.

However, as this research is focused on initial consultations with families presenting with psychosomatic complaints, it is not clear whether these findings translate to family therapy with different populations and clinical presentations.

In subsequent years, Höger, Temme, Reiter, and Steiner (1994) combined data from two exploratory studies of the RT; The Göttingen study in Germany (Höger, Temme, & Geiken, 1994) and The Vienna study in Austria (Reiter, Steiner, Ahlers, Vogel, & Wagner, 1993). The families in these studies presented with many different problems. Details of these studies have not been accessed directly as they were published in German as opposed to English language. Höger, Temme, Reiter, & Steiner (1994) provide a comparative overview of these studies in English.

The patients in the Göttingen study (Höger, Temme, & Geiken, 1994) were children and adolescents with emotional, conduct or psychosomatic difficulties. A range of measures were utilised including observations of process issues occurring during the initial therapy sessions that were rated on a five-point Likert scale. Observer ratings considered contributions from the RT and the families' responses. In addition, 76% of families completed follow up questionnaires approximately fifteen months after completion of the original study. Three of the twenty-five respondents did not attribute changes to RT intervention and so were not included in the findings.

The Vienna study (Reiter et al., 1993) included a wide age range of index patients with a variety of presenting problems; this included children, adolescents, adults with emotional, conduct, psychotic, substance misuse and marital problems. As the Vienna study was primarily a clinical evaluation study it included a measure of therapist perception of therapy and follow up interviews with fifty percent of the families following treatment termination. Both of these data sources considered input from the RT.

Findings of the Göttingen and Vienna studies were combined to include a total of fifty-nine families (Höger, Temme, Reiter, & Steiner, 1994). The vast majority (approximately 80%) provided positive feedback, with two thirds reporting symptom improvement, including those who terminated therapy after only one session. There was also a positive correlation between RT input and family outcomes, with more favourable results being associated with the multiple perspectives introduced to therapy. This finding indicates a positive impact from the RT. In contrast, families who were seeking a more directive and advisory intervention reported

dissatisfaction with the RT approach and did not return to therapy (Höger, Temme, Reiter, & Steiner, 1994). Results of the study suggested that the RT had a differential impact on families dependent on the clients' characteristics, with more positive results indicated where the family experienced emotional difficulties as opposed to psychosomatic complaints or severe mental health diagnoses (Höger, Temme, Reiter, & Steiner, 1994). Suggestion is put forth for the use of directive approaches similar to strategic and Milan techniques to be more effective for certain difficulties (Höger, Temme, Reiter, & Steiner, 1994). The most appropriate therapeutic approaches may therefore be partially determined by the nature of the presenting problem(s).

The Göttingen and Vienna studies outlined by Höger, Temme, Reiter, & Steiner (1994) suggest that the RT is a valuable resource. The combination of data from the different sources also strengthens these findings. However, the 'RT therapy' undertaken in the Göttingen and Vienna studies was delivered by a Psychologist and Psychiatrist and it is unclear whether the therapists and RT members were fully qualified family therapists. A strength of the Göttingen study was the use of direct observational data of the RT in action. However, these observations were rated on a Likert scale as opposed to being a rigorous qualitative account of the specific way in which the RT were influential. Both the Göttingen and Vienna studies are therefore unable to provide specific information regarding the influence of particular aspects of RT treatment. Further in-depth analysis of the dialogues and strategies utilised by the RT within family therapy is therefore warranted. Such research will enable an improved understanding of the subtle and specific ways in which the RT influence the family meaning system in family therapy.

Over the period 1992-1995 Smith and colleagues carried out six qualitative research studies exploring RT practice in the United States of America. One of these studies (Smith et al., 1995) combined qualitative and innovative process research methodologies in an attempt to progress theoretical knowledge and understanding of RT processes in practice. This involved ethnographic video assisted Interpersonal Process Recall Interviews (IPR) with both clients and therapists (Greenberg, 1991; Smith et al., 1995). A comparative analysis of data transcripts was undertaken of interviews which related to therapists and clients experiences of therapeutic activity at time points prior to, during and after the RT (Smith et al., 1995). Four conditions for effective RT practice relating to client characteristics, RT characteristics, and the therapeutic relationship were recommended (Smith et al., 1995). These were client readiness, trust, a sense of collaboration and the credibility of the team.

The two most recent empirical studies of RT practice in family therapy are those by Parker and O'Reilly (2013) in the United Kingdom (UK), and Mitchell et al., (2014) in Australia. Parker and O'Reilly (2013) adopted a qualitative language-based analytical approach of therapeutic activity to inform clinical practice. This involved identifying the therapist's "performative actions" and "conversational strategies" (Parker & O'Reilly, 2013, p.176) to indicate how the therapist managed specific aspect of the session. Three specific aims were investigated; the therapist's departure from the therapy room, therapeutic rupture, and the incorporation of feedback from the RT (Parker & O'Reilly, 2013). Similar to past research (Lever & Gmeiner, 2000), this study highlighted the importance of preparing the family for therapy, particularly in relation to the purpose of the RT and the therapist's departure from the therapy room to consult with the RT.

The format of the RT within Parker and O'Reilly's (2013) study appears consistent with that of the Milan approach as the therapist leaves the room to consult with the team and directs the family to undertake specific tasks on their departure. While the study claims to inform the use of RTs within clinical practice, it does not directly analyse the actions or language used by the RT. The authors note that "a stronger empirical evidence base regarding the use of RTs in family therapy is essential to inform best practice" (Parker & O'Reilly, 2013, p.177). In the absence of direct observational studies of RT process in clinical practice, it is essential that further research is undertaken with a specific focus on the RT in action.

Mitchell, et al. (2014) undertook a qualitative study to explore and compare the emotional experiences of 15 families following input from either a Milan oriented team (Selvini et al., 1980) or Andersen's (1991) team approach during an initial therapy session. Both approaches involved eliciting feedback from the families following input from the team (Mitchell et al., 2014). In addition to generating a range of alternative perspectives, families indicated that the team approach provided them with a feeling that they had been understood and a sense of hope for the future (Mitchell et al., 2014). Families reported feelings of anxiety as regards therapy being an unfamiliar experience and more specifically in relation to the use of a RT (Mitchell et al., 2014). RT intervention raised specific concerns for some families who expressed feeling disrupted by telephone communications and being judged by the team. This experience also led family members to question the experience of the therapists' (Mitchell et al., 2014). The therapy teams in Mitchell et al.'s (2014) study were also comprised of clinical psychology trainees as opposed to

accredited family therapists; the therapist's knowledge and expertise is a factor worthy of further consideration.

Therapeutic Techniques and Team Composition

Smith and associates undertook two qualitative studies to establish both therapist and client perceptions of the RT process over the course of therapy to generate new hypotheses about RT techniques in clinical practice (Sells, Smith, Coe, Yoshioka & Robbins, 1994; Smith et al., 1994). The researchers included a number of strategies to verify their interpretations, including second ratings and subsequent interviews with family and team members to check and expand upon their interpretations. The research highlighted the potential for the RT to enhance therapeutic practice by supporting and easing therapists' anxieties in addition to the importance of having a mixed gendered team, to offer the family a balance of male and female perspectives (Sells et al., 1994; Smith et al., 1994). The timing of the RT, clarity of therapeutic goals and problem definition were also seen to be important to the family (Sells, 1994; Smith et al. 1994).

Egeli, Brar, Larsen and Yohani (2014) utilised video assisted IPR with three couples in an exploratory case study approach to investigate experiences of hope in anticipation, participation and debriefing stages of the RT. The study identified specific therapeutic techniques which relate to instilling hope, this includes 'identifying strengths', 'normalising difficulties', 'presenting inspiring possibilities', 'support' and 'highlighting personal growth'. Particularly important is the observation that rapport with the therapist and progress in therapy are important for engagement with, and perception of, the RT. Characteristics of the RT were also suggested as being important such as having a mixed gender composition as well as the perceived skill, experience and alliance of the RT members (Egeli et al., 2013; Sparks, Ariel, Coffey & Tabachnik, 2011).

As past research suggests that the process of reflective practice may be influenced by the gender of the RT and the gender of the client, (Egeli et al., 2013; Fishel, Ablon, & Craver, 2010; Sells et al., 1994, Smith et al., 1994), it will therefore be important to carefully consider the gender balance of the RT, plus the gender of the index patient and characteristics of the families included in the current research.

Therapeutic Relationship

Smith, Winton and Yoshioka (1992) observed RTs in practice and subsequently interviewed members of the RT. This research highlighted the need for the family to have some understanding of the RT process, and the importance of the therapeutic relationship between client and therapist for the RT process to be effective. Similarly, research undertaken by Smith, Sells and colleagues (1994) emphasises the importance of the relationship between the client, therapist and RT in influencing the client's receptivity to the RT reflections (Sells, Smith, Coe, Yoshioka & Robbins, 1994; Smith, Sells & Clevenger, 1994; Smith et al., 1995). Smith et al. (1994) also note the RT was not effective in the initial sessions, and it was helpful for the family to meet the team. These claims have been supported by further research (Fishel et al., 2005; Pender & Stinchfield, 2012, 2014).

Parker and O'Reilly (2013) discuss the potential benefits of utilising a trusted RT who may pick up on family issues and mitigate against the risk of a ruptured therapeutic alliance. The opposite is also possible whereby a RT could contribute towards a problematic therapeutic alliance to perpetuate and compound families' feelings of being disrespected, invalidated or misunderstood (Mitchell et al., 2014). It is therefore suggested that the RT should only be utilised when trust and safety has been established within the therapy room (Mitchell et al., 2014).

Within a multiple case study by Lever and Gmeiner (2000), families reported experiencing the RT as helpful but also disruptive and intrusive at times as they experienced feeling attacked, belittled and undermined by the team. Evidence of this potentially detrimental impact was related to the RT's style of reflecting and their use of language (Lever & Gmeiner, 2000). The authors also suggest that this may have been due to the family being uninformed and unprepared for the family therapy approach. In addition, reflections from the team were consistent with the therapist's line of thought and thus were not connected to the family stories which heightened a sense of disconnection within the therapy room (Lever & Gmeiner, 2000). Similar to the study by Parker & O'Reilly (2013), this research highlights the importance of the family being thoroughly informed about and consulted on the approach to therapy and the introduction of the team. Lever and Gmeiner (2000) also suggest that it may be more suitable to introduce the team once a therapeutic relationship has been established.

The findings from Lever and Gmeiner (2000) should be considered in the context of the research which focused specifically on families who had found therapy useful and had subsequently disengaged from therapy. It appears that these complications may have arisen due to complexities within the dynamics of the therapy team as some of the therapists were inexperienced and unfamiliar with the theoretical principles and practice of family therapy. The lead therapists were also team leaders which introduced at power dynamic to the therapy room. These factors raised anxieties and compromised the family therapy being practised in the study. Similar to Mitchell et al.'s (2014) study, this finding highlights the importance of the therapy team and their central influence on therapeutic practice.

Research Synthesis

In summary, previous research suggests that the RT has the potential to influence the family and therapeutic process in a number of ways being at times both helpful and unhelpful. Reflections from the team have the potential to be overwhelming, with families reporting difficulties in retaining all of the information (Mitchell et al., 2014). RT practices can be anxiety provoking for families, particularly during initial therapy sessions (Lever & Gmeiner, 2000; Mitchell et al., 2014). Others found the RT process strange, artificial and unhelpful (Lever & Gmeiner, 2000; O'Connor et al., 1997; O'Connor, Davis, Meakes, Pickering, & Schuman, 2004). In contrast to the potentially detrimental effects, the RT has the potential to influence the family in a more positive and productive way. Some report the RT being helpful for generating a range of alternative perspectives, hope for the future and supporting the family to feel heard (Mitchell et al., 2014). Some family members also report that the RT's presence changes their conversational dynamics as they are less inclined to interrupt, talk over one another or enter into conflict (Mitchell et al., 2014). Families also report appreciating the teamwork approach and the RT's recognition of family change and acknowledgement of their successes (O'Connor et al., 1997).

Research also suggests that the composition and organisation of the RT may impact on their efficacy, for example, the Family Therapist's departure from the session to consult with the team (which is typical of a Milan approach) can be disruptive to both the flow of therapeutic conversations and the therapeutic relationship (Parker & O'Reilly, 2013). A central concern for successful RT intervention is therefore the initial framing and organisation of the session in order to prepare families and manage their expectations (Parker & O'Reilly, 2013).

The current research literature suggests a number of factors related to the family and RT have the potential to impact on the RT process and subsequent outcomes. Such factors include the gender composition of the team, therapeutic techniques and process issues such as the timing and clarity of reflections, the focus of the session, the problem definition and also the nature of the clinical problem.

Rationale for Current Research

Over the past decade, family therapy has established itself as an empirically supported therapeutic approach for a diverse range of presentations (Asen, 2002; Carr, 2000a, 2000b; Cottrell & Boston, 2002; Shadish & Baldwin, 2003; Sprenkle, 2002; Stratton, 2010). However, there is a need for further efficacy and process research, specifically in relation to RT practice (Brownlee, et al., 2009; Pender & Stinchfield, 2012; Willott et al., 2012). In order for such practices to continue, it will be essential for researchers and practitioners to establish whether the RT is effective, and the means by which it is, or is not effective. It is important to consider whether the theoretical concepts underpinning the RT translate into clinical practice. The first step in progressing research towards this aim is to focus specifically on the RT process in action so as to differentiate the impact of the RT from other therapeutic and extra therapeutic factors.

To build upon past research findings, a small scale multiple case study will be undertaken which directly explores the specific therapeutic strategies and influence of the RT on the family meaning system through the use of direct observational data. Family therapy recordings provide an ideal opportunity for observing the co-construction and negotiation of meaning-making taking place during therapeutic practice. Similar to the study by Parker and O'Reilly (2013), the current research will utilise a language-based qualitative approach to examine the discursive strategies utilised by the RT from transcripts of recorded therapy sessions. Particular attention will be upon the effects of the RT on the unfolding narratives and positioning of family members through detailed analysis of therapeutic dialogues. This will incorporate positioning theory, positioning analysis (PA) (Bamberg 1999, 2004, 2008; Bamberg & Georgeakopoulos, 2008; Harré & Moghaddam, 2003; Harré, Moghaddam, Cairnie, Rothbart & Sabat, 2009) and the Semantic Polarities model (Campbell & Grønbæk, 2006) to explore the influence of the RT on the family meaning system. The analysis will identify potential shifts in the family meaning system by tracking positions within the family narratives. In order to establish the RT influence, three phases of the therapy session will be examined; the initial phase of the session (pre RT), reflections from the RT,

and the final phase of the session (post RT). This three phased analysis will capture nuances of RT dialogue and any related shifts within the family meaning system.

Research Questions

The current research will explore the influence of the RT on the co-construction of meaning-making with families in therapy with particular attention to;

1. How family members construct and position themselves in relation to one another and the problems brought to therapy.
2. The storylines and positions developed by the RT.
3. The discursive strategies utilised by the RT.
4. The impact the RT has on subsequent family discussions.

Research question three was not in the original research proposal, however, during the analysis, the importance of considering the use of language and specific dialogical strategies utilised by the RT became apparent. Similar to research on consultation processes (Nolan & Moreland, 2014) the identification of such language devices, which I will refer to as 'discursive strategies', will be central to understanding therapeutic change processes as they occur in response to RT intervention. Within the current study, discursive strategies include the words and language manoeuvres used by the RT which are intended to bring about change to the discursive construction of events unfolding within the dialogue (Allen & Faigley, 1995).

CHAPTER TWO: METHODOLOGICAL CONSIDERATIONS

Overview

To contextualise the research, I will begin by providing details of the SHIFT trial and some background on the epidemiology of adolescent self-harm. I will go on to provide the theoretical rationale for selecting the chosen methodology with discussion of alternative methodologies that were considered. Details of the methodological procedures will be provided in the method chapter which follows.

The Self-Harm Intervention Family Therapy - SHIFT Trial

The SHIFT Trial was a randomised controlled trial (RCT) of family therapy compared with treatment as usual (generic CAMHS interventions) for adolescents aged 11 to 17 years who had engaged in more than one episode of self-harm. The trial intended to recruit 832 participants across the three sites in Yorkshire, Greater Manchester and London. Families were offered up to 8 therapy sessions over a period of 6 months with the frequency of the appointments decreasing over this period and a review taking place during session 4. The initial findings of the SHIFT trial are due for publication in 2016 and are intended to provide a "well-powered evaluation of the clinical and cost effectiveness of family therapy for young people who have self-harmed" (Wright-Hughes et al., 2015, p.2).

Within the SHIFT trial, Family Therapists were utilising an adapted version of the Leeds Family Therapy Manual (LFTRC Manual) which was developed with funding from the Medical Research Council to support family therapy trials (Boston et al., 2009). Family therapy intervention on the SHIFT project was based on the original LFTRC Manual of Systemic Family Therapy developed at Leeds Family Therapy and Research Centre (Pote, Stratton, Cottrell, Shapiro, & Boston, 2000, 2003). The original systemic family therapy manual incorporated techniques from the Milan team, Solution Focused and Narrative therapies and was updated theoretically and altered to address specific issues involved in the treatment of adolescents who self-harm, and their families (Boston et al., 2009). This included specific adaptations regarding the assessment and management of risk. The SHIFT protocol detailed the nature of the study and the SHIFT Manual included guidelines for Family Therapists in their use of the RT (see Appendix B). The manual was not prescriptive

however, for the purposes of the RCT, therapists were required to demonstrate a sufficient level of adherence to these guidelines (Masterson, Barker, Jackson, & Boston, 2016).

The SHIFT trial employed qualified, systemic therapists with extensive experience in Child and Adolescent Mental Health Services (CAMHS). Therapists had also undertaken two days of training and work on a pilot case prior to delivering therapy in the RCT. Training involved an introduction to the principles of the SHIFT manual with a focus on the assessment and management of risk, working with adolescents and team building. In accordance with SHIFT protocol, the therapeutic team, i.e. the lead therapist and RT, received two hours of monthly supervision with a local expert supervisor. Supervision contained elements of adherence monitoring, therapist-selected case discussions, general case overviews, work in relation to team functioning and relationships with the trial and CAMHS teams. Therapists were required to record information regarding treatment violations and annual reviews took place to discuss team issues, cases and to support the implementation of treatment principles. These processes were crucial to the promotion of treatment integrity (Masterson et al., 2016).

The Epidemiology of Self-Harm in Adolescence

Self-harm is defined by the National Institute of Clinical Excellence (NICE, 2004) as 'self-poisoning, or injury, irrespective of the apparent purpose of the act' which includes self-inflicted harm such as self-poisoning, asphyxiation, cutting and burning. The prevalence of self-harm is higher in adolescents and young adults in comparison to other age groups (Fliege, Lee, Grimm & Klapp, 2009). Current figures also suggest gender differences. During adolescence, girls are approximately three times more likely to report self-harm than boys (O'Connor, Rasmussen, Miles & Hawton, 2009). However, these figures may be a reflection of gender differences in help-seeking behaviour in addition to current limitations in our understanding of the incidence and mode of self-harming behaviour within the male population (Robertson, Bagnall, & Walker, 2015).

The high risk of injury and death as a result of self-harming behaviour is a serious public health concern (Cooper et al., 2014). Within the adolescent population, the prevalence and severity of self-harm is also on the increase (Evans, Hawton, Rodham, & Deeks, 2005). Records from 2003 to 2013 suggest a dramatic increase in self-harm from 11,404 to 14,780 (Parliamentary Question, 2014). This is particularly concerning as self-harm is associated with an increased risk of suicide in adolescence and later life (Cooper et al., 2014; Guerreiro, et al., 2013; Owens, Horrocks & House,

2002). It is possible that the increased prevalence of self-harm is due to better diagnosis or recording procedures. Nevertheless, these figures highlight the scale of the problem. Investment towards monitoring self-harm and researching specialist interventions is warranted due to the high risk of physical injury and the associated risk of suicide. Research is required to identify interventions that improve therapeutic outcomes and reduce self-harming behaviour.

Existing research informs our current understanding of the factors associated with self-harming behaviour. These include exposure to self-harming behaviour in others (Brent & Mann, 2006), physical and sexual abuse histories (Gratz, 2003), low self-esteem (Hawton, Rodham, Evans & Weatherall, 2002), bullying (Fisher et al., 2012), and challenges regarding sexual orientation (Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003). The Child & Adolescent Self-harm in Europe study (CASE; Madge et al., 2011), a sizeable self-report study, indicated an exposure-response relationship between self-harm severity and both stressful life events, and psychological characteristics (anxiety, depression, impulsivity and low self-esteem; Madge et al., 2011). All but one of the major stressful life events were independently associated with the incidence of self-harm (Madge et al., 2011).

Self-harm is a precursor to, and consequence of, emotional distress (Klonsky, 2009; Klonsky & Glenn, 2009; Scoliers et al., 2009; Linehan, 1993). People who self-harm often report feelings of hopelessness, emptiness, isolation, and a sense of being overwhelmed by difficult feelings (Gratz, 2003; Webb, 2002). Research suggests that self-harm may function as a method for controlling or relieving such difficult feelings (Klonsky, 2009; Klonsky & Glenn, 2009; Scoliers et al., 2009). However, the act of self-harm is often associated with stigma, guilt and shame for both the adolescent and their parents who may be reluctant to discuss the issue which may perpetuate and exacerbate the problem (Young Minds, 2011).

Family dysfunction, difficult family relationships and poor parent-adolescent communication are frequently associated with self-harm during adolescence (Byrne et al., 2008, Hawton, Zahl, & Weatherall, 2003; McDonald, O'Brien, & Jackson, 2007; Tulloch, Blizzard, & Pinkus, 1997; Webb, 2002). In contrast, family cohesion, stable family relationships and open parent-adolescent communication are considered to be protective against the risk of self-harm in adolescence (Borowsky, Ireland, & Resnick, 2001; Compton, Thompson, & Kaslow, 2005; Resnick et al. 1997). Familial relationships and communication are therefore central factors involved in both the onset

and management of self-harming behaviours. Family Therapy focuses on family interactional patterns, language and communication and is therefore likely to be an ideal treatment for the prevention and management of adolescent self-harm. The epidemiology studies reviewed highlight the complexity and cumulative nature of factors associated with self-harming behaviour. While the SHIFT trial is primarily focused on the problem of self-harm, literature suggests that therapy with this population will require consideration of a range of contributing factors in addition to the act of self-harm.

Rationale for the Methodological Approach

To establish the most suitable design for the current research, a number of different methodologies were considered. Therapeutic practices can be studied by both quantitative and qualitative methodologies (Burck, 2005). Qualitative research enables in-depth analysis of variability within the therapeutic process to address questions regarding how therapy works, whereas quantitative studies address questions regarding whether the therapy works.

As indicated in the literature review, there are no RCTs or outcome studies which relate specifically to the RT. RCTs are often perceived to be the 'gold standard' for research quality standards (Stratton, 2007). However, these approaches stem from medical practices which encounter difficulties when applied to understanding the complex process of therapeutic practice with diverse populations (Stratton, 2007). The NICE (2004) guidelines used to judge research quality stem from a reductionist and positivist epistemology, and are not suitable for researching the subtleties of family therapy and RT practice (Willott et al., 2012). This is because RCTs only allow us to establish whether an intervention is effective and do not allow us to determine how or why the intervention is, or is not effective. The current focus on large scale efficacy studies has also resulted in a gap between research and therapeutic practice as outcomes from large RCTs often do not consider the adaptations of practice required with different families and contexts. However, the SHIFT trial is a manualised approach to family therapy which is applied flexibly and responsively to the needs of individual families. Qualitative case studies which enable in-depth examination of the process and adaptations of RT practice in context are therefore required.

The value of ideographic effectiveness studies which consider therapy in practice are at risk of being discredited (Sexton, 2008). The American Psychological Association proposes an alternative approach for determining what constitutes evidence in clinical practice (Levant, 2005).

Practitioners are encouraged to apply methods which best fit with the research purpose thus promoting methodological diversity. "Clinical observation (including individual case studies) and basic psychological science are valuable sources of innovations and hypotheses (the context of scientific discovery)… Single case experimental designs are particularly useful for establishing causal relationships in the context of an individual" (Levant, 2005, p.7). Small scale process research is therefore acknowledged as better situated to investigate the complexities of therapeutic practice. In order to identify what works with the diverse families and problems that are brought to therapy, it is important to focus research efforts on small scale effectiveness studies, including case studies, which can explore therapeutic mechanisms in context (Sexton, Ridley & Kleiner, 2004). Case studies and process research therefore have a central role in informing and complementing future research and practice regarding what works, and how this works by identifying underlying therapeutic processes and change mechanisms *in context* (Sexton, 2008; Stratton, 2007).

Multiple Case Study Design

A multiple case study design was considered appropriate for the current research as it facilitates the examination of a phenomenon across several linked cases within real life contexts (Stake, 2006; Yin, 2013). Case study designs enable in-depth evaluations and rich descriptions of a number of variables and conditions of relevance to the phenomena of interest (Zainal, 2007). By definition, the multiple case study includes a number of cases or 'entities' to be studied in-depth (Stake, 2006). Whilst each case is examined individually in detail, the case is not the primary focus of multiple case studies; rather, it is the common phenomenon or entity that exists across the multiple cases which is the focus of study (Stake, 2006). This approach enables a comprehensive understanding of the phenomena of interest across different contexts. As the main aim of the current research is to gain a greater understanding of the influence of a RT, the RT is therefore the phenomenon of interest which is studied across families.

The "power of case study is its attention to the local situation" (Stake, 2006, p.8). By studying the RT across different contexts of the family, adaptations to RT practice within specific family situations are highlighted by the cases. The multiple case study design also enables triangulation of data across cases to check the repeatability of observations and identify unique differences in the phenomena (Stake, 2006). The results from a multiple case study are more robust than a single case as generalisations and abstractions can be identified across cases (Merriam, 1988; Yin,

2013). Replication of the analysis across cases enables identification of the conditions under which the theory of the phenomenon is maintained (Firestone, 1993).

The primary aim of the current study is to more thoroughly understand the influence of a RT in the SHIFT trial. This will consist of a detailed descriptive account of the practice and influence of this particular RT across three cases. This research will provide evidence of a particular phenomenon existing under a set of circumstances as outlined by the context (Yin, 2013). "Generalisation of results from case studies… stems on theory rather than on populations… by replicating the case through pattern-matching, a technique linking several pieces of information from the same case to some theoretical proposition… multiple-case design enhances and supports the previous results" (Zainal, 2007, p.3). Whilst it may not be possible to scientifically generalise to wider populations (Yin, 2013), through a process of analytic generalisation, it may be possible to update the existing body of knowledge and theory of RT practice in relation to the context of the SHIFT trial and the population of adolescents who engage in self-harm. There may also be the potential to make speculative claims regarding the transferability of such findings to family therapy where there is a high risk issue under negotiation (Firestone, 1993). However, as each individual RT and therapy team is likely to have its own unique dynamics and idiosyncrasies, it is understood that further research will be required to establish how applicable the findings from the current research are to different settings.

The multiple case study approach is suitable for analysis of naturalistic data and each case study could be considered as an individual case study (Stake, 2006; Yin, 2013). Undertaking doctoral research involves multiple tasks including leading the data gathering, analysis and report writing and is therefore ideal for synthesising findings to gain the 'whole picture' across cases. The approach is guided by existing knowledge and experience of the case and phenomena under study and is 'progressively focused' i.e. that is, specific questions are asked of the data and can be adapted in accordance with the developing understanding of the case and the phenomena (Stake, 2006). Researcher reflexivity is therefore central to the process due to the subjective nature of interpretations.

My Epistemological Position
My beliefs are consistent with postmodernism, constructivist and social constructionist epistemologies and the work of Anderson & Goolishian (1988), Bakhtin (Bakhtin & Emerson,

1984), Bruner (1986, 1997), Gergen, (2001, 2009) and Shotter (1993). I perceive knowledge and understanding as primarily constructed between people and that our concept of 'truth' is governed by available language and discourse, with language being both constituted and constitutive of our individual reality. I also concur with the belief that wisdom exists beyond language, with new knowledge, creativity and insights emerging in the space beyond language and thought (Kabat-Zinn, 2003; McCrea, 2010). While not referenced directly, mindfulness practices will be utilised during the process of undertaking the current study to 'suspend' judgement, minimise bias, and creatively progress the analysis (Gale, 2010). I also acknowledge that research which focuses purely on dialogue may have some limitations, and developments in the field may move on to consider other aspects of communication (Boston, 2000). However, within the scope and boundaries of a Clinical Doctoral thesis, I have chosen to focus the current study on dialogical processes as this provides a sufficient starting point for exploring therapeutic practice and the process of meaning-making within this context.

Constructivist and social constructionist theories are central to family therapy and RT practice (Grandesso, 1996; Jenkins, 1996; McNamee & Gergen, 1992). Constructivism is a theory of knowledge which places emphasis on the individual's internal belief systems and innate ways of perceiving the environment (Hoffman, 1988). From this perspective, the Family Therapist is not considered to be a neutral observer as their individual perceptions, values and beliefs are said to influence that which is co-constructed within the therapist-family system (Boston, 2000). Social constructionist ideas which place an emphasis on the meaning-making process between people are central to the RT process whereby the sharing of alternative perspectives is intended to stimulate new perspectives and create new meanings (Anderson & Goolishian, 1988). Considered within the context of family therapy, the sharing of alternative perspectives creates a forum for joint meaning-making and the generation of new knowledge. The family and therapy system therefore becomes a mutually influencing system within which there is potential for change (Campbell, 2003).

The current research is "An Exploratory Study of a Reflecting Team's Influence on the Family Meaning System in The Self-Harm Intervention Family Therapy (SHIFT) Trial". The process of meaning-making within therapeutic practice is therefore central to the research.

"A meaning system can be seen as a group of people connected around the idea of doing something with(in) a certain situation" (Andersen, 1991, p.38). Anderson and Goolishian (1988) describe meaning-making within family therapy as taking place on two levels. The first level is reflective of systems theories as meaning is, "derived from observed patterns of social organisation" (p.3). The second is reflective of a dialogical, social constructionist stance as, "meaning and social systems are created in and through dialogue" (p.3). One's reality and meaning-making is therefore seen as being socially constructed in an 'inter-subjective experience' which is maintained through language, dialogue and discourse (Anderson & Goolishian, 1988).

"To think of therapy in terms of a conversational domain… we would no longer be focusing on the client as the unit of attention, but we would see the entire group, family plus other professionals, as a small, evolving meaning system" (Hoffman, 1985, p.387). To be in dialogue is to be involved in the construction of meaning, new possibilities and change. Within therapeutic conversations, individual ideas are exchanged, explored, contrasted and integrated to create new meanings which evolve and lead to the "dis-solving" of problems and the co-creation of new identities (Gale, 2010).

Rationale for the use of Discursive Analysis

A range of qualitative approaches were considered, and the suitability of the methodology was guided by the research questions and my social constructionist epistemological viewpoint. In line with the aims of the research, the methodology had to be compatible with family therapy theory and social constructionist principles of meaning-making and change within the process of therapeutic practice. As qualitative research methodologies, which stem from social constructionist and constructivist epistemologies developed in parallel with systemic therapies, these approaches are considered complementary to the study of systemic practice (Burck, 2005; Moon, Dillon, & Sprenkle, 1990).

Conversational Analysis (CA) is commonly used for studying family therapy Process (Strong, Busch & Couture, 2008) and was considered a potential option for exploring the RT influence. CA involves analysis of 'interpretive mechanisms' and 'linguistic resources' used by participants on a moment by moment basis (Korobov, 2001). CA also incorporates the influence of context and emerging conversations at the local level. Inferences are intended to be closely grounded in the participant's dialogue as opposed to being overly interpreted by the researcher. However, a reservation for

using CA methodology was the limited analytical potential and application of findings due to the narrow focus on the linguistic turns of the speakers (Watson, 2007). A further criticism of CA is that it fails to explain 'why' the conversation has unfolded in a particular way (Watson, 2007). In a similar way, Thematic Analysis (Braun & Clarke, 2006) was also considered but deemed unsuitable for the current research as it does not capture the transitional process of therapeutic change processes over time.

Qualitative approaches such as Discourse Analysis (DA) and Discursive Psychology (DP) assume a social constructionist stance and are therefore theoretically and epistemologically compatible with the study of psychotherapeutic processes (Avdi & Georgaca, 2007; Strong et al., 2008). In a recent study, Diorinou and Tseliou (2014) utilise DA to investigate therapeutic process in family therapy and suggest this as a suitable approach for further process research in systemic therapies. DA with a focus on discourse, language and interpersonal constructions of meaning between people was considered as a potential methodology for us in the current research. DA considers context at the socio-political level, including societal discourse (Korobov, 2001); this enables consideration of the social-cultural and political implications of meaning (Kogan, 1998; Strong et al., 2008). However, due to an over-emphasis on socio-political implications, there is a risk that DA can become ideological, unrepresentative and removed from the data (Schegloff, 1999). Due to the subjective nature of interpretations, there is also potential for researcher bias (Watson, 2007). Furthermore, there is no singular, clearly defined approach to DA and it can be challenging to grasp and systematically implement (Korobov, 2001).

Whilst both CA and DA share similar theoretical orientations, their methodological procedures appear incompatible. Considering the limitations of CA and DA, DP was deemed to be the most suitable approach for the current study as it bridges the gap between the two approaches and levels of analysis (Korobov, 2001; Zelle, 2009). DP emerged from CA, with a focus on analysing everyday interactions (Potter, 2001). DP is most suited to answering the research question as it enables detailed analysis of micro-dynamic processes, subtle changes in individual and family narratives, and the co-construction of meaning between people. This allows for the complexities of dialogue and unfolding meanings to be uncovered as they are constructed between people in the psychotherapeutic processes (Gale, 2010). DP is also consistent and compatible with a social constructionist and constructivist epistemology as it considers the interaction between social and individual meanings and how psychological phenomena are produced discursively (Wittgenstein,

1953). DP incorporates both moment to moment and contextual influences on meaning-making thus minimising the potential for subjectivity when inferring socio-cultural influences (Watson, 2007). DP was therefore utilised for the current study.

Common concepts and strategies utilised in DP analysis include interpretive repertoires, subject positions and ideological dilemmas (Edley, 2001; Harper, 2003; Willig, 2008). Interpretative repertoires are synonymous with ideologies and are considered to be the 'building blocks' of dialogue (Edley, 2001). Subject positions represent a person's representation of oneself or world view within the conversation (Edley, 2001). Ideological dilemmas are tensions that arise from incompatible interpretative repertoires and subject positions (Edley, 2001). Whilst these entities are not referred to specifically within the current study, I will consider the influence of participants' perspectives and positioning communicated within the interactions, and the resulting ideological tensions that arise and are negotiated within therapeutic dialogues. For the purposes of the current research, however, the analytical strategy is more heavily influenced by concepts from positioning theory, PA (Bamberg 1999, 2004, 2008; Bamberg & Georgeakopoulos, 2008; Harré & Moghaddam, 2003; Harré, et al., 2009) and the Semantic Polarities model (Campbell & Grønbæk, 2006).

Positioning Theory

Positioning theory was developed by Rom Harré (Davies & Harré, 1990) due to the inherent inadequacies of role theory in which roles are somewhat fixed and unchangeable in contrast to positions which are fluid and more flexible (Henriksen, 2008). Positioning theory provides a lens to explore the 'narrative construction of identities' which infold within social interaction (Bamberg & Georgakopoulou, 2008; Watson, 2007). Positioning theory also enables the analysis of complex dynamic interactional processes between people in a range of social encounters (Harré & Moghaddam, 2003). By analysis of inter-related positions, revision and change is facilitated (Henriksen, 2008). The systematic study of 'unfolding social episodes' and the creation of meanings within their social context are also made possible (Harré & Slocum, 2003).

Positioning theory explains the reciprocal process of positioning, that is, how individuals influence one another through the act of positioning (Campbell, Ayo & Grønbæk, 2009). The taking up of a position is considered to be an expression of the individual's perspective which also has a reciprocal influence on the individual's perception, beliefs and attributions (Campbell, Ayo &

Grønbæk, 2009). Interactions between people and the positions referenced in the interactions therefore determine the perceptions of self and others. As Davies and Harré indicate: "who one is, that is what sort of person one is, is always an open question with a shifting answer depending upon the positions made available within one's own and others' discursive practices, and within those practices, stories through which we make sense of our own and others' lives" (1990, p.35). It is through the application of Harré's theory of positioning that the individual conversationalist's contributions to the interactive process of meaning-making can be revealed and examined.

Positioning Analysis

PA is epistemologically compatible with the current research which explores the influence of the RT on the co-construction of meaning-making with families in therapy (Korobov, 2001). Consistent with DP, PA provides a 'middle-ground' to the theoretical tensions between CA and DA (Korobov, 2001). With reference to Critical Discourse Analysis (CDA) and CA, Korobov (2001) suggests that "Positioning Analysis offers a viable analytic way to reconcile the discrepant methodological orientations while trading on the shared theoretical convictions" (2001, p.1).

In recent years, PA has been utilised to investigate a range of sociological issues considered on local, national and global levels (Harré & Moghaddam, 2008; Harré et al., 2009; Moghaddam, Harré, & Lee, 2007). As PA focuses on both the local context and wider social influences, grounding interpretations within observations and socio-political influences on the local moral order (Korobov, 2001), it is a more applicable to the current study than CA and DA. This approach is reflective of both constructivist and social constructionist influences on the process meaning-making in conversational exchange (Bamberg, 1999). PA captures the unfolding meanings that are created between conversationalists within the immediate context of the interaction.

The Positioning Triad

The positioning triad represents the key concepts of positioning theory and positioning analysis and is often presented visually as a triangle (Harré et al., 2009). Figure 4 provides an illustrative example of the three components which are interactive, mutually determining aspects of all social interactions. These are speech acts, storylines and positions (Harré & Van Langenhove, 1999). My definition of the positioning triad concepts has been influenced by the ideas of Bamberg (2004), Bamberg & Georgeakopoulos (2008), Harré and Moghaddam (2003), and Watson (2007).

Speech acts are the utterances and words spoken by people in conversation. The speaker's use of words, tone, and intonation, signify the action orientation and influence of the speech act within the interaction including the positioning of the speaker and those referred to within the utterance. Through the use of speech acts, people position themselves and others within conversation in terms of inter-personal relationships, status, roles and associations with social groups and cultural practices (Allen & Wiles, 2013). An utterance may have a number of consequences depending on the position from which the speech act is intended and the interpretation and position of the receiver. The meanings inferred from speech acts are therefore negotiated between conversationalists from their individual positions and perspectives.

Positions are metaphorical representations of the personal attributes, rights and responsibilities of the individuals taking part in the conversation, and those persons, groups or organisations referred to within the conversation (Allen & Wiles, 2013). Positions associated with the storylines become apparent by paying attention to the person implied in the storyline which includes the use of 'I', 'we' and 'you' or named person statements in the speech acts. Storylines represent the speaker's perspective and provide the framework for identifying the underlying positions and intentions of the speech acts (Harré & Davies, 2001).

Storylines are representative of individual and family narratives or relationships and socio-cultural stories which emerge from the speech acts and positions (Bamberg & Georgeakopoulos, 2008). Harré and Davies (2001) propose that several storylines exist within an individual narrative, each organised around events, characters and moral dilemmas. A multiplicity of different interpretations and storylines of events and situations are possible and often co-exist, with an individual's interpretations, inferred positions and attributions being influenced by socio-cultural stereotypes and beliefs.
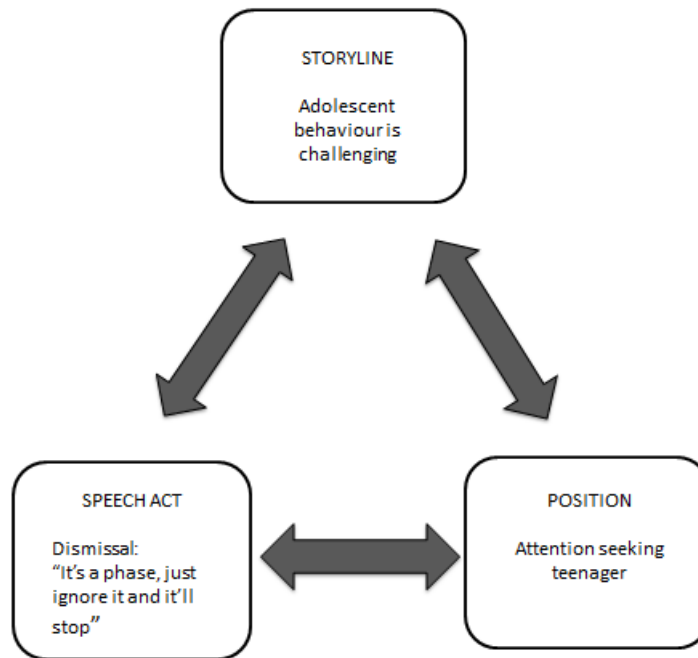
Figure 4: Example of the Positioning Triad

Within the illustrative example presented in figure 4, the storyline can be seen as influenced by developmental theory that places emphasis on emotional turbulence as inevitable within adolescence. The speech act by the parent positions the adolescent as attention seeking and therefore dismisses the adolescent and their behaviour as not to be taken seriously.

Semantic Polarities Model

The use of the positioning triad alone was not sufficient for the current study. As PA is a relatively new approach to research, the development and application of analytical tools and strategies is in its infancy. To progress the analysis, I therefore turned to the established work of Campbell and Grønbæk (2006) and their use of the Semantic Polarities model. The pragmatic use of positioning theory through the application of semantic polarities was considered directly relevant to the analytical focus of the current research.

The concept of semantic polarities was initially applied to systemic practice by Ugazio (1998; cited in Campbell & Grønbæk, 2006). The semantic polarities model was subsequently developed by David Campbell, Clinical Psychologist and Systemic Psychotherapist and colleagues at the Tavistock Clinic, London. Originally, the model was utilised to facilitate organisational consultation and complex systemic work with families (Campbell, Ayo & Grønbæk, 2009; Campbell & Grønbæk,

2006). The model was intended to be utilised as a tool or technique to be applied creatively to inform and develop systemic practices (Campbell, Ayo & Grønbæk, 2009).

The semantic polarities model is grounded in social constructionist epistemology and systemic thinking, with a focus on the conversational space, interaction and joint processes of meaning-making taking place between people within dialogues (Campbell, Ayo & Grønbæk, 2009). The model is also informed by discourse theory, semantic polarities, positioning theory and dialogue theory (Campbell & Grønbæk, 2006). Semantic Polarities are described as "the sites within discourses where meanings are negotiated" (Campbell & Grønbæk, 2006, p.5). Discourse is defined as the "institutionalised use of language" which provides a "framework for understanding" and sharing meanings which are context bound (Campbell and Grønbæk, 2006). Within discourse, a range of alternative positions are available that can be taken or ascribed to others through the process of meaning-making within the social exchange (Campbell, Ayo & Grønbæk, 2009).

The use of semantic polarities enables one to step back from the immediacy of the interaction to consider the overall process and patterns occurring in the interactions between conversationalists (Campbell & Grønbæk, 2006). Using this approach, issues of conflict or debate regarding contentious issues, or 'ideological dilemmas' in DP terms, can be captured, and alternative perspectives and positions compared. This process of comparing and contrasting the positions and perspectives offered by the conversationalists, enables the researcher to develop a greater understanding of the issues and positions under negotiation within the dialogue.

The application of positioning theory to systemic practice is simplified by use of the semantic polarities' model, providing a visual representation of positions referred to within conversation. Similar to George Kelly's (1955) personal construct grids, polarities are indicative of beliefs which sit within discourses and create positions between people. The semantic polarities model therefore represents the tensions and differing interpretations or meanings taking place within the conversation, described by Campbell and Grønbæk as "positional dissonance" (2006, p.30). Through a technique of scaling, the contrasting perspectives and positions of the individual conversationalists are placed on a semantic polarity, that is, a continuum similar to the example provided in figure 5 which follows. This continuum provides a visual aid to perceive the various positions which have been ascribed or are available within the dialogue (Campbell and Grønbæk, 2006).

Semantic pole diagrams provide a higher level of conceptualisation by comparing and contrasting the central positions and related storylines which occur within the dialogue. It is through the dissonance in positions that the negotiation of meaning occurs between conversationalists in dialogue. The negotiated meaning is represented visually on the semantic polarities continuum. For example, family members may hold different values and beliefs in relation to issues such as the best approach to parenting. Meanings about providing care and meanings about providing discipline may occur in conversation and could be placed on opposite poles to represent the two extremities of the views under discussion. The priority of 'providing care' regardless of the need for discipline would be represented at one pole; the importance of 'providing discipline' as a priority for parents above the need for care would be represented at the other pole as illustrated in figure 4. For example, one side believes that showing care is most important, the other that showing discipline is most important; positioning one as 'soft' the other as 'hard'. The discourses drawn upon in this semantic pole include the idea that children need nurturance versus children need to learn the consequences of behaviour. There is the possibility of participants in dialogue to take many intermediate positions between the 'care versus discipline' polarity to represent positions which have aspects of care and discipline such as 'love with limits'.

Care   Love with limits   Discipline
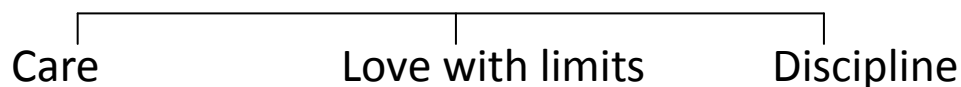
Figure 5: Example of Semantic Polarities Model

As indicated by Campbell and Grønbæk (2006); "dialogic conversation may take the individuals-in-conflict into a new median position between the two original positions. It may also allow them to reappraise the responsibilities and duties attached to their position. They may also see the connection between the two positions, which has the effect of raising meaning to a higher, more inclusive level of abstraction" (p.40). Through this creative tension, a greater level of conceptualisation is established by identifying alternative positions and available discourse. It is through this process that new narratives become available and change can occur.

As central tenets of the semantic polarities model include conversation, positioning, the process of meaning-making and change, the model was considered ideal for the current research. When

applied to the process of therapy, the model facilitates a greater understanding of the stuck system, and the relative positioning of family members (Campbell, Ayo & Grønbæk, 2009; Campbell and Grønbæk, 2006). This model allows one to explore and further understand the co-construction of meaning and the identities which are unfolding and under construction within the therapy room. Applied more specifically to the current study, the model will also enable a greater understanding of the RT's contributions and influence on the family meaning system over the duration of the selected therapy sessions by comparison of the pre and post RT dialogues.

Contemporary Research

A wealth of research is currently being undertaken across the fields of personality psychology, personal narratives and life stories, the findings of which can be summarised by six common principles (McAdams, 2008). Consistent with Narrative theory and the construction of identities through narrative, these principles include the storied self, integration, social relational aspect of stories, story transformation, the socio-cultural nature of stories and the moral positioning. As storylines are at the centre of my research, I will describe each of these principles in turn and consider their relevance to the current research.

Families engaging in therapy are likely to be discussing past experiences and future wishes which reflect aspects of their desired selves. Integration may be accomplished by constructing stories of prior incoherent and disparate collection of events across time. These stories may reflect aspects of one's characteristics and life goals in addition to transitions over time. The telling of life stories involves autobiographical reasoning and the integration of episodic experiences to establish semantic meanings. The social relational aspect of stories recognises that storying takes place in relation to another person within a social context. As indicated previously, it is therefore necessary to consider the audience as a key mediator of this storytelling process (McAdams, 2008). It is also suggested that storylines are influenced by familiar narrative patterns which are common within societies and cultures (Thorn and McLean, 2003). As a result of memory fallibilities and changes to one's life goals, priorities and social positions, there is a transformation to stories over time. Consistent with these changes, there is a comparative shift in individual storylines, some of which represent maturity, personal growth and integration (McAdams & Olson, 2010). Observed changes to the family narratives may therefore reflect such developmental and progressive shifts.

Following from the social relational aspects of stories, socio-cultural influences such as societal norms, rules and traditions provide a framework for storytelling and positioning oneself within, or in opposition to, the dominant narratives and discourse. Generally, one may anticipate differences in the narratives of individuals from Eastern societies when compared to those of Western societies reflecting more inter-dependence and individualism respectively (McAdams, 2008). As a result of social and cultural influences, stories can also be conceptualised as good or bad in relation to moral principles, values and norms of the society (McAdams, 2008). Of relevance to the current research, situated stories are said to link to one's reflective capacity, self-conceptualisation and potential for change (McLean, Pasupathi & Pals, 2007).

Background Research Informing the Current Study

During the analytical process, I read many papers on positioning theory and DA. Whilst I did not find one singular strategy or methodology to adhere to, I did source and amalgamate ideas from a range of semi-related research papers and past theses to develop a suitable research strategy (Allen, 2011; Brown, 2014; Frigerio, Montali & Fine, 2013; Ghosten, 2012; Green, 2015; Nolan & Moreland, 2014; Watson, 2007). The analysis was therefore informed by a wealth of prior research, positioning theory, semantic polarities and to some extent was also guided by intuition. Before going on to outline the methodological stages, I will provide an overview of some of the contemporary research which influenced the current study.

Positioning within Narratives

In keeping with the 'linguistic turn' and the focus on narratives, recent research has begun to look at conversational data and the 'small stories' occurring and unfolding in the moment as indicators of identity construction (Bamberg & Georgakopoulou, 2008). Stories are described as 'systems for making sense of self' and 'tools of interpretation' which provide a gateway to identity analysis. Stories provide the organizing framework, sense of continuity and meaning for the retelling, shaping, and unfolding of human lives under construction (Hoyt, 2013). By the creation of stories, there is a sense of meaning and development over time in which recent events are built upon and contrasted with historical events to create a sense of meaning within the present. Such stories also provide a foregrounding and context for how one position's the self and others and how they wish to be positioned and the direction one wishes to take in the future.

Bamberg & Georgeakopoulos (2008) provide a staged approach to undertaking small story research and identity analysis. This work builds upon their earlier work on the concept of positioning (Bamberg, 2004; Bamberg & Georgeakopoulos, 2008), which navigates between both micro and macro narratives. This involves consideration of the construction of two aspects of identity; characterisation in time and space, plus how one wants to be perceived. Small stories include narrative activities such as "the tellings of on-going events, shared events… allusions to previous tellings, deferrals of tellings, and refusals to tell" (Bamberg & Georgeakopoulos, 2008, p.5). Micro-narratives highlight the multiplicity of ways in which one positions the self, which represents the process of self under construction with recognition of discursive forces, and how one negotiates and establishes a sense of their self through dialogue (Bamberg & Georgeakopoulos, 2008). Additionally, small stories may be about 'nothing' but rather reflecting an aspect of interactional processes occurring between members of the dialogue within context.

Considering family therapy as a process of identity construction, both individual and family identities will be negotiated in the unfolding of therapeutic discussions. These interactions will involve family roles, dynamics and shared histories in addition to the influence of the therapeutic and research settings. For example, families are likely to have some anxieties regarding being observed by the RT and how they are perceived by the therapy team generally. The choice and timing of therapist and RT interventions is also likely to have some impact upon the emergence of these narratives. Similar to the intentions of Bamberg and Georgeakopoulos (2008), my interest for the current research is how family members use small stories to construct a sense of who they are within the therapy room. This includes both the situation and contextual emergence of identities in addition to the influence of the RT.

CHAPTER THREE: METHOD

Overview

To address the research questions, a qualitative analysis of therapy recordings from the SHIFT trial was carried out. The context for the current research was family therapy undertaken as part of the SHIFT Trial where the referral problem was that of adolescent self-harm. Secondary data from the SHIFT study was analysed as part of a multiple case study design using an approach informed by discursive psychology, positioning analysis and the semantic polarities model. Within this chapter, I will provide details of the research design and procedures adopted in undertaking the current study.

Data Collection

The research involved qualitative analysis of therapy sessions, with secondary data selected from the SHIFT trial. Access to data from the SHIFT trial was enabled via my research supervisor, Paula Boston, SHIFT Clinical Supervisor. Data was not collected directly for the purpose of the current research; consequently there were some limitations to the questions that could be asked of the data and no follow-up interviews were possible. As the current study utilises naturalistic observational data of one RT practising with different families in the SHIFT trial, it will provide an insight into the workings of this particular RT with these specific families at the time this therapy occurred (Potter & Hepburn, 2005).

Reflecting Team & Sample Selection

The current research provides an in-depth analysis of a RT in action. A small, purposive, illustrative sample of three sessions was therefore chosen from one therapy team to enable a comprehensive analysis of this particular RT's practice within the SHIFT trial. Illustrative samples are considered suitable for exploring a phenomenon in depth. Additionally, it is not possible to sample all combinations of factors that could be considered representative of every individual RT (Firestone, 1993). The Therapy team in the current study included one Lead Family Therapist and two further Family Therapists who formed the RT. Prior to inclusion in the current study, adherence to SHIFT's key theoretical and therapeutic principles had been established for the practice of this particular Therapy team. RT practice within the current study can therefore be considered somewhat representative of practices occurring within the wider SHIFT trial.

Each family therapy session selected can be considered an individual case study forming part of a multiple case study design which enables identification of both individuality between cases and commonality across cases (Stake, 2006). The analysis of one particular RT with different families rather than different RTs enables insight into the workings of a specific RT and the extent to which their approach, practice and influence is adapted to the different family contexts where there are a number of variables to consider. Variations in RT practice may be observed in relation to situational factors such as the stage of therapy and level of risk. As with other qualitative case studies, the findings of the current study will not be generalisable to wider contexts; one can only speculate regarding the transferability and wider implications of the findings (Stake, 2006). Nevertheless, preliminary findings from the current research will provide hypotheses to be explored in other contexts thus being a worthy starting point for further research into RT practice.

To enable comparison of RT practice across cases, the therapy recordings selected included the same therapy team. The selection was restricted to only those recordings that had been uploaded and were available for viewing. This included approximately thirty therapy session recordings from SHIFT therapy teams operating within the Yorkshire region which were screened for inclusion in the current study. Based on the research reviewed, it was important to select a RT with experience (Mitchell et al., 2014) and of mixed gender (Egeli et al., 2013; Sells et al., 1994; Smith et al., 1994; Sparks et al., 2011). As indicated in the literature review, past research suggests that the process of reflective practice may be influenced by the gender of the RT and the gender of clients (Egeli et al., 2013; Fishel, Ablon, & Craver, 2010; Sells et al., 1994, Smith et al., 1994). Recommendations and contraindications for the use of RTs include the importance of having a mixed gendered team to offer a balance of male and female perspectives and support (Sells et al., 1994; Smith et al., 1994). Based on the findings of these studies it was considered important to have a mixed gender RT.

The RT selected for inclusion in the current study was composed of one male and one female member and the lead therapist was also female. The therapy team selected had a number of therapy sessions uploaded and available for viewing which made them a suitable choice. Typical of therapists in the SHIFT trial, all members of the selected therapy team had a number of years' experience as qualified therapists with a history of working together as part of a family therapy team within a CAMHS. All members of the therapy team were White British and there were no obvious local accents noted from the recordings. A description of input from the therapy team will

be provided in the results chapter. In order to identify typical and atypical practices it will be important to consider how the particular RT operates within different contexts. To address this aim, I have provided a description of the social, cultural, situational and contextual influences observed during the therapy sessions within the results chapter.

In addition to team characteristics, gender differences in patient characteristics are indicated in the literature in terms of self-harm and help-seeking behaviour (Robertson, Bagnall, & Walker, 2015). Adolescent girls are approximately three times more likely to report self-harm than boys (O'Connor, Rasmussen, Miles & Hawton, 2009). Due to the prevalence of self-harm within the female population it was therefore decided that the current study would focus specifically on female adolescents.

The literature review indicates that familial relationships and communication are central factors involved in the onset and management of self-harming behaviours (Borowsky, et al., 2001; Byrne et al., 2008, Compton et al., 2005; Hawton et al., 2003; McDonald et al., 2007; Resnick et al. 1997; Tulloch et al., 1997; Webb, 2002). It was therefore considered important to include families with different characteristics and the sample therefore included families of different sizes and ethnic origins. Families and therapy sessions were purposively sampled for inclusion and were intentionally diverse providing an opportunity to identify how the RT operates within different family contexts. It is possible that a difference in the family's characteristics, in addition to the stage of therapy, will have an impact on the practice and influence of the RT. Therapy session were therefore chosen where there was some variation in the characteristics of the families, the nature of self-harm and the stage of therapy. Families, which I will also refer to as cases, varied in ethnicity, size, and the number of family members present, the source from which they were referred, self-harm type and the severity of self-harm episodes. There were also some notable similarities between the three families such as the birth mother and father remaining in partnership and co-habiting together as a family unit as opposed to being separated or single parent families. Despite the apparent family unity, not all family members were present in the sessions selected for the current study due to restrictions in the content of available therapy sessions.

A purposive sample of sessions from was selected from this therapy team. This process involved fast forwarding through and stopping to watch specific sections of the recordings in order to assess suitability according to the following criteria;

- Adequate data quality ensuring a reasonable level of sound quality so the therapy discussion can be heard clearly for transcription.
- Sessions which include a RT discussion taking place within the therapy room in the presence of all family members involved in that particular therapy session.
- Sufficient duration of therapeutic dialogue available both pre and post the RT to enable optimum analysis of influence (minimum 5 minutes).
- Being representative of a typical family therapy scenario. All family members to remain in the room. No role-play tasks or other non-typical therapeutic activities.

Based on findings from the literature review, it was decided that only sessions where there was likely to be an established relationship and familiarity with the RT process were included. As anxiety and uncertainty regarding the RT process were likely to be high in initial sessions, the current research excluded initial therapy sessions. A number of cases were deemed unsuitable for inclusion in the study due to problems with digitisation and insufficient time for the families to feedback to the RT. In addition, on some occasions, more creative therapy sessions took place where family members reversed roles and reflected on family dynamics which may have overly complicated the analysis. I will provide an overview of the selected families' personal profiles in Table 1 (page 56), however, the information provided is limited due to the secondary nature of the study and also to preserve participant anonymity.

Table 1: Cases Selected for Study

Family	Session	Attendees	Age of referred young person	Ethnicity	Source of referral	Self-harm type	Severity of episode
1	2 of 6 Initial stage of therapy	3 Referred female Mother Father	14 years	White British	GP	Cutting	Non hospital admission No treatment required
2	5 of 6 Final phase of therapy	2 Referred female Mother	15 years	White British	Hospital	Poisoning	General hospital admission Minimal treatment required
3	3 of 7 Mid-point of therapy	5 Referred female Twin sister Older sister Mother Father	15 years	British Indian	Hospital	Poisoning	General hospital admission Minimal treatment required

Further details of the therapy team, chosen therapy sessions, and pen portraits of the families will be provided in the results chapter.

Self-harm Descriptors

The following self-harm descriptors and details regarding the severity of self-harm were provided by the SHIFT trial. 'Poisoning' represented any instance where the young person ingested a

substance that was harmful, with the intention for harm to self. This included overdosing on over-the-counter and prescription medicines, ingesting harmful substances like bleach, and substance misuse. 'Severity of episode' was the relative magnitude of the self-harm event that prompted the referral to CAMHS. For example, superficial scratching with no/minimal required treatment indicates self-harm of low severity. 'Minimal treatment' means hospital interventions such as checking blood pressure or applying a dry dressing to a cut or burn. More severe episodes of self-harm may require more signification treatment. For example, parvolex for paracetamol, and glue, suturing or steri-strip for cuts. Potentially urgent and/or life-saving Interventions could involve ventilation, exploration of wounds under general anaesthetic, and assessment of mental state.

Ethical Issues

An application for a proportionate review was made via the Integrated Research Application System (IRAS). The application for ethical approval was reviewed by The Proportionate Review Sub-committee of the NRES Committee West Midlands - The Black Country and provided ethical approval on 7th October 2014 (see Appendix C).

Using therapeutic data which related to self-harm, it was possible that some of the research material would be of an emotive and distressing nature. In addition to the ethical issues managed centrally within the SHIFT trial, there was potential for the emotive nature of this material to impact upon members of the research team. Regular academic supervision was in place and additional support was available through the University of Leeds counselling services and The Clinical Psychology Department if necessary. It is hoped that findings from the SHIFT trial and the current research will be of benefit for future families, therapists and researchers as these studies will have implications for the design of future research and interventions.

As the current study makes use of secondary data, it was not possible to contact participants directly to ask for consent or to follow up with any further research questions. Eligibility for participation in the SHIFT trial was previously assessed by CAMHS clinicians during the initial assessment and recruitment phase of the trial. The CAMHS clinician introduced the family to the trial and provided an information sheet containing an overview of the purpose of the trial and implications for participants. Family members were able to discuss and ask questions about the trial with a health professional and the family were not required to make an immediate decision. This recruitment process enabled family members to make an informed decision to opt in or out of

the trial with no loss or negative implications for their future care with CAMHS. Written consent was obtained from both parents and children when families decided to participate. At this stage, families were then randomly allocated to one of two potential treatment groups; treatment as usual within CAMHS or family therapy as part of the SHIFT trial. Families were also given the choice as to whether they consented to their recorded data being used for future research purposes such as this study. Only those families who consented to both the shift trial and future research were considered and included in the current research.

In accordance with the Data Protection Act (1998), all data utilised for the current research was accessed via a password-protected secure drive on a specific security-enabled computer at the University of Leeds. To ensure confidentiality, the recorded therapy sessions were viewed and listened to on the secure computer in a private office using headphones. Pseudonyms were also used at the point of transcription for members of the family and therapeutic team. In addition, changes were made to data such as names of cities, schools and friends to further anonymise the data. A professional transcriber was used for some of the transcription. The transcriber signed a confidentiality agreement to confirm that all data would remain confidential. All data utilised for the research will be securely stored at The University of Leeds following completion of the study where it will subsequently be destroyed.

Transcription Process

Transcription was the first stage of analysis, with decisions about the level of detail influencing interpretation, particularly when using visual data (Norris, 2002). In the current study, it was decided to focus the analysis primarily on dialogue rather than visual data as the addition of extensive visual data was deemed to be too ambitious for this thesis. Therapy transcripts provide a construction of therapy as opposed to being the primary source of research data (Gale, 2010). It was therefore important to be involved in the transcription process, completing some scripts independently and checking the accuracy and interpretation of other transcriptions. Checking accuracy involved mapping the transcript to the audio from the recorded session. This process was essential as the subtle nuances in the therapeutic dialogue were difficult for the non-therapist transcriber to decipher but had significant implications on the inferred meaning and process of therapy. Although the level of detail and accuracy required for transcription felt pedantic, it was a helpful process as it facilitated familiarity with the therapy sessions. This also provided a preliminary phase to the analysis.

The required detail and content of the transcription was guided by the purpose of the research, avoiding the inclusion of extraneous material so as to remain as simple and easy to read as possible. The transcript aimed to include spoken dialogue, noting significant pauses and non-verbal utterances such as 'err' and 'uh-huh' so as to be representative of the dialogue and thus maintaining an element of being 'denaturalised' as opposed to being overly edited (Davidson, 2009). Focusing purely on language can limit or unintentionally skew the data leading to misinterpretations. At times it was therefore necessary to include some description of events taking place in the therapy sessions in addition to the gestures and gaze of the participants when deemed to be of importance to the flow and meaning of the conversation (Goodwin and Goodwin, 1992). Similar to the approach utilised by Potter and Wetherell (2003), Jefferson (1985) style transcription was simplified and adapted for use in the current study (see Appendix E for transcription protocol). An alphabetical code was assigned to each speaker and the pages and lines of the transcript were numbered to enable notes and data extracts to be located back to the transcripts.

Data Analysis

Analysis of therapy content and process was undertaken concurrently. In the absence of a clear systematic methodological strategy to guide the research, a variety of strategies were initially employed by a process of trial and error. Many of my earlier analytical attempts were discarded or redeveloped and refined over an extended period of analysis. The use of various analytical tools was helpful for beginning the analysis, providing a framework for further thought and the revision of key concepts. However, a more flexible intuitive process of reflection was required in order to progress the analysis. The final analysis was undertaken largely through open coding of transcripts, memo writing, transferring and clustering data into separate word documents and diagrams which I will go on to outline here. In the interest of grounding the analysis within participants' talk (Schegloff, 1997), quotations are included in the analysis and extracts of the transcript are included in the appendices (Appendix F).

Similar to Nolan and Moreland's reflections, the data analysis strategy within the current research, "whilst thorough in practice, has not been easy to put into words" (page 74, 2014).The analysis was circular, repetitive and far from linear, however for clarity, the overall process will be summarised in seven key stages. Each therapy session was initially analysed individually before

going on to undertake the cross case comparative analysis. Stages one to three involved analysis of the family dialogue in the pre and post RT discussions. Analysis of pre and post RT dialogue was analysed independently and sequentially during stages one and two, with stage three moving on to also compare pre and post RT dialogue. Stages four to seven focused specifically on the RT to determine their influence. This involved close analysis of the RT intervention with particular attention to the use of discursive strategies. Within the current study, discursive strategies included the words or linguistic devices used by the RT which intended to bring about change to the discursive construction of events unfolding within the dialogue (Allen & Faigley, 1995). I will provide details of the stages of analysis here before going on to reflect on the research process.

Analytical Stages

Stage one involved immersing myself in the data by watching the therapy session through in its entirety with the transcript in hand. I subsequently watched and listened to the therapy session again and read through the transcript noting points of interest, initial ideas and topics of conversation, potential storylines and positions which became apparent during the observation. Initial constructs and ideas were recorded on a separate word document to provide an early interpretative outline for the case (see Appendix F). Similar to the process described by Harré and Slocum (2003; p.130), the initial stage of analysis was more descriptive than analytical with no manipulation of the data taking place. Interpretations were hand written on paper copies and/or added as comment boxes to the transcript.

Stage two considered the interactional and changing nature of positions over the entire transcript, highlighting what appeared to be key issues and potential dilemmas as opposed to focussing on specific positions in isolation (consistent with the ideas of Tirado and Gálvez, 2008). Data representing key issues and dilemmas were then extracted and collated on separate word documents under headings which represented an early conceptualisation of the central dilemmas or issues under negotiation (see Appendix F). Further manipulation of the data was required to ensure that the time sequence of extractions was maintained. The relationships between family members and the progress of storylines were also traced over time to represent the flow of the unfolding therapeutic dialogue. This required the therapy session to be replayed in small 10-20 second sections whilst undertaking further detailed analysis of the transcript. Working through the transcripts line by line, I was able to code the dynamic shift in positions inferred from the speech acts on a moment by moment basis. This

process enabled the family members' relative positions and perspectives in relation to the various storylines to emerge from the data segments identified earlier (Harré & Slocum, 2003). The extraction, re-ordering and manipulation of data segments at this stage provided the initial process of refining key storylines, dilemmas and emerging positions.

Stage three involved isolation and refinement of character positions by mapping the data from stage two onto semantic pole diagrams in a manner similar to that described by Campbell and Grønbæk (2006). These diagrams provided a higher level of conceptualisation and also enabled changes from pre-post RT dialogue to be traced by comparing and contrasting the positions and storylines considered to be central to the family dilemma (see figure 6). As indicated on the diagrams within the results chapter (see figures 7-9), each end of the pole represents a construct that is under negotiation within the family meaning system and is in contrast to the other construct. During the earlier stages of the analysis it was difficult to differentiate the positions from the storylines as they often appeared interchangeable. By identifying ideological tensions and key constructs being negotiation within the family dialogues and mapping these onto semantic poles, the positioning of family members in relation to the semantic polarities became clearer. This was a reciprocal process of extraction and refinement with constructs and related positions being hand written onto post-it notes and positioned temporarily on the semantic pole at a position representative of its relation to either end of the semantic pole. These positions were subsequently moved and/or developed accordingly over an extended phase of analysis until the Semantic Position model provided an accurate representation of my interpretation of the data. This process of extracting and manipulating data into diagrams provided the final analytical framework which refined and developed earlier stages of the analysis. Over time it became apparent that there were multiple related constructs being negotiated across the therapy sessions which were combined into a two dimensional semantic polarity cross which more accurately represented the social semantic matrix of the family dialogues (see figures 7-9 in results chapter). Interpretations were than able to be coherently defined and described in the results chapter.

Parent – Daughter Relationship — Pre RT

Protective · Suffocated · Unstable — Supportive · Developing

Dependent — Parenting Discourse

Independent — Adolescence Discourse

Baby Girl — Secretive · Nurturing · Resourceful · Mature
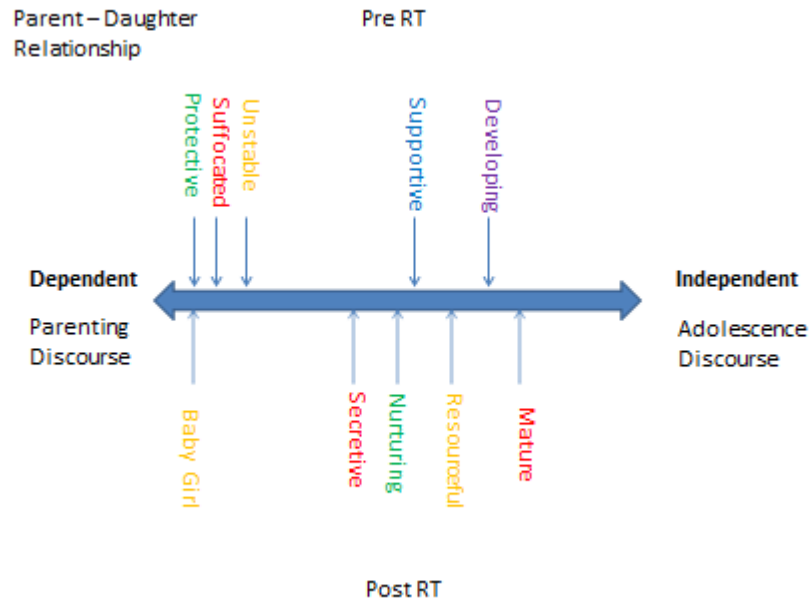
Post RT

Figure 6: Family One Initial Semantic Pole Analytical Diagram Identifying and Tracking Changes in the Pre-Post RT Dialogue

Figure 6 represents the dilemma that took place between the parents and their daughter in family one. Each individual arrow denoted on the diagram represents the family members opposing positions within the negotiation of this dilemma and was linked to the overall meaning being negotiated and co-constructed between the construct's 'dependence' and 'independence'.

Consideration of the discourse associated with the family members positioning, storylines and overall meaning system was temporarily considered at stage four to provide further depth to the analysis. However, specific analysis of discourse was not pursued further as this was not the intention of the current study which opted for a more discursive approach which complemented the research questions.

Stage four focused specifically on the influence of the RT by noting and tracing their reference to, and influence on the progress of family storylines and positions. This involved searching for reference to the family's storylines and positions within the RT dialogue. In addition, new

storylines, associated positions and inter-relationships proposed by the RT were also identified and key quotations were extracted from the transcripts to provide evidence for these interpretations.

Stage five involved closer analysis of the RT intervention with particular attention to their use of discursive strategies. This involved identifying key discursive statements, phrases or strategies used by the RT and marking these on the individual transcripts. For example, this included 'emphasising and reinforcing family strengths, progress and resilience' such as noticing positive changes, in addition to recognising and reinforcing the helpful strategies demonstrated by family members. Additionally, the RT's use of past and future tense was identified which situated problems and strengths as historical, current or future prospects. The RT's use of pronouns such as 'I' and 'we' was also identified to indicate individual or collective perspectives and the forging of alliances.

Stage six involved extracting discursive strategies utilised by the RT within individual cases which were deemed to be of relevance to the research questions and collating these into a table (see Appendix G). Commonalities were noted between different discursive strategies and where relevant, these were subsequently combined. For example, 'identifying barriers to change', 'expressing concern' and 'taking a directive, expert position regarding risk' occurred at a similar point in time for case two and were considered to be inter-related. These discursive strategies were therefore combined into one concept; 'Taking an expert position regarding areas of continuing concern'.

Stage seven involved a cross case analysis for which a conceptual list of the key discursive strategies was generated from knowledge of the overall data analysis. The relative prevalence and prominence of discursive strategies was rated for each case using numbers 3-0, representing 'high' to 'low' prevalence/prominence respectively (see Appendix H). This process facilitated identification of commonalities and atypical findings in the RT practices across cases. Common and unique discursive strategies were then presented within the cross-case comparative analysis section and used to inform the key findings.

Quality Assurance

As recommended by Elliot, Fischer, and Rennie (1999) to assure the quality of the research, I made regular reflective notes on the process of undertaking research and factors within my awareness

which may have influenced my analyses. Efforts were also made to check the credibility of the findings and interpretations. This involved peer supervision and regular formal supervision throughout the research process to ensure that a thorough methodological approach was established, and also to challenge and encourage alternative interpretations (Parker, 2004). Consideration was also made as to the relevance of these findings to the aims of the research (Potter & Wetherell, 1987). The circular and exploratory nature of data analysis resulted in further scrutiny of interpretations and re-analysis by returning to the original transcript and returning to watch sections of recordings where further clarification was needed. Analysing the activity of the RT with different families could also be considered a means of data triangulation as it was possible to compare, cross-reference and cross-examine the activity and influence of the RT across different contexts (Firestone, 1993).

Reflexivity

While it is not possible to be conscious of all influencing factors (Luft & Ingram, 1955), as a researcher, it is important to consider the influence of my own beliefs and assumptions on the process of designing and analysing the research. This includes consideration of my own position and cultural factors in relation to the research and topics which emerged within the research (Bartlett, 2008; Parker, 2004).

During the process of undertaking the research, I utilised the Social GRRAACCEESS model (Burnham, Alvis Palma & Whitehouse, 2008) to promote self-reflexivity. The acronym represents social categories of Gender, Race, Religion, Age, Ability, Class, Culture, Ethnicity, Education, Sexuality and Spirituality which are commonly used as a means for constructing identities. Being attentive to the GRRAACCEESS model encouraged me to become more mindful and aware of my position and the potential for this to influence my perceptions and interpretations.

As indicated previously, I have a personal and professional interest in the process of family therapy and RTs. During my clinical experience, I have observed and been part of RTs where I believed that this practice was helpful to the family and process of therapy. During training I have also attended some family therapy special-interest groups and completed a service evaluation project to evaluate therapist adherence and competence as part of the SHIFT trial (Masterson et al., 2016). Factors such as these have the potential to introduce bias to the current research and I have been mindful of my prior assumptions in order to challenge and minimise this impact. However, it is

acknowledged that my prior experience and knowledge of this process will have undoubtedly influenced my decision and approach to the current research. I was also aware that as a Psychologist, I hold certain beliefs and narratives regarding factors which may lead somebody to self-harm. A research diary was therefore utilised in order to remain aware of factors influencing my decisions during the process of undertaking the research.

Reflections on the Analysis

Whilst aiming to be systematic in the process of conducting the analysis, I was also aware of the need to remain analytical (Smith, Harré, & Van Langenhove, 2005). After an extended period of micro-analysis, I had to step back from the data in order to provide a conceptual account of unfolding storylines and related positions. Considering some of the common pitfalls of DA outlined by Antaki, Billig, Edwards and Potter (2003), I was able to fine-tune and present my analysis in a way which overcame many of my early analytical misconceptions.

The first of these pitfalls is "under-analysis through summary" (Antaki et al., 2003, p.12) which may involve a description or overview of common themes with a lack of attention to discursive strategies and the function within the discourse. I was aware of this error occurring during the early stages of the analysis when theming and describing the data which resulted in the loss of the subtleties, the context and the overall meaning.

The second pitfall is "under-analysis through taking sides" (Antaki et al., 2003, p.15). This occurs when the researcher simplifies the data into themes or summarises statements with value judgements to provide arguments which are not substantiated by extracts from the transcript. The third pitfall "under-analysis through over-quotation or isolated quotation" (Antaki et al., 2003, p.18) also loses meaning due to the lack of contextual data and interpretation of the quotations presented. A fourth pitfall "circular identification of discourses and mental constructs" (Antaki et al., 2003, p.20) occurs when researchers fail to evidence claims. For example, using discourse as stemming from, and also influencing the data. As indicated earlier, to overcome these potential pitfalls, I engaged mindfully with the data and applied the GRRAACCEESS model (Burnham et al., 2008) to promote self-reflexivity. I also reviewed my analysis on numerous occasions and supported the analysis with contextual data and extracts from the transcript. A fifth pitfall is that of "under-analysis through false survey" (Antaki et al., 2003, p.26) in which findings suggest an overgeneralisation to the wider population. Findings from the current research have therefore

been placed within the context of the SHIFT trial and it is hoped that further research will be undertaken to extend the applicability of findings to other areas. The final pitfall is "under-analysis through spotting" (p.27, Antaki et al., 2003) which identifies discursive strategies in the data, but fails to synthesise and interpret these findings. Detailed analysis requires identification of specific discursive manoeuvres, their performance and also their function as is the expectation in DP. The current study therefore indicates how the discursive strategies were used and what they were used to achieve.

Uncertainty regarding the most suitable strategy stalled the analysis. At times I was concerned to complete the analysis in the 'correct way' and overlooked the subjective nature of analysis. As indicated by Bartlett (2008) there is not a single 'correct way' to undertake analysis, but rather, there are a number of ways in which 'heuristics' and 'hermeneutics' can be combined so as to lead to a better understanding of the unfolding interactions and meanings between participants. As the research progressed I became more aware of the transitional nature of knowledge and research methodology (Lucas & Tan, 2007). Subsequently, I was able to make progress towards finding a suitable solution to address the research aims.

CHAPTER FOUR: RESULTS

Three therapy sessions were included in the analysis from three different families representing a multiple case study. I will present the individual analysis of each case in turn, beginning with a pen portrait and overview of the family and therapy session in order to contextualise the data. Where relevant to the analysis, I will also note my initial impressions of the family. I will present the analysis in a way which best represents how it occurred during the therapy sessions. Following the individual analyses, I will present a summary and comparative analysis of all three cases which will be discussed in the subsequent chapter.

To address research question one, I will begin by presenting the main storylines and positions adopted by the family prior to RT intervention with particular attention to how they position one another in relation to the most prevailing and meaningful storylines. I will go on to address the second research question by presenting the storylines and positions discussed by the RT. Here, I will also consider the third research question by presenting each of the discursive strategies utilised by the RT. As outlined in the method, DP requires consideration of the performance and also the function of the discourse, I will therefore outline how the discursive strategies were used by the RT and what it seems that these discursive strategies were used to achieve. I will address the fourth research question by noting whether there appears to be a shift or expansion of the family meaning system as a result of input from the RT by comparing the family's pre and post storylines and positions. I will also consider whether the family continue or reflect on any of the alternative storylines and positions offered by the RT. Finally, I will conclude this section with a summary of the main findings before going on to discuss these in the subsequent chapter.

Case One

Pen portrait

For family one, the therapy session selected for inclusion in the current study was the second of six therapy sessions attended by 14 year old Jasmine, her mother Helen, and father Peter. During the session, Jasmine makes reference to her older sister Chrystal who is not present. Chrystal does attend one of the subsequent sessions, however, the later sessions did not meet the inclusion criteria as problems arose such as the RT not taking place, or undertaking a role play, or there was insufficient post RT dialogue available to analyse. As this session met the inclusion criteria, it was selected as it was considered to illustrate the RT practice and influence during the early stages of therapy.

At the time of therapy, Jasmine, Helen, Peter and Chrystal were all living together at home. Jasmine had recently changed secondary schools, apparently due to being 'gifted and talented' in art. This change in school had resulted in separating Jasmine from some of her close friendships. During the session, Jasmine often appeared uncomfortable and nervous as she held her head down when talking, fidgeted and tucked her hands into her sleeves and frequently looked to her parents as though seeking reassurance or approval. Jasmine also spoke in a soft and quiet voice which, on occasion, resulted in difficulties for the therapist and the researcher hearing what she was saying. There was a sense that Jasmine was struggling to vocalise her thoughts and feelings as her responses to the therapist's statements and questions were sometimes limited. At times she made use of one word answers to indicate agreement or disagreement with the therapist's comments with little further elaboration. Over the course of the session however, there were times when Jasmine became more expressive and animated, particularly when describing her emotional experiences which related to her parent's relationship, her mother's anxiety and her own self-harming behaviour.

Peter appeared quiet, reserved and patient during the therapy session. I initially interpreted his manner as his way of potentially providing space for his family members to share their experiences. He also waited for prompting from the therapist before interjecting with his perspective. It is important to note the therapist's comment that this was the first time she had met Peter as he had not attended the initial therapy session with the rest of the family. This may

partly explain why Peter appeared less forthcoming in the conversations observed. An additional or equally valid explanation is that Peter's temperament and position within the family was beginning to be revealed by his measured contributions to the discussions. Peter's description of himself as 'laid back' also goes some way to supporting the hypothesis regarding his contributions being a reflection of his character.

In comparison to Jasmine and Peter, Helen appeared much more talkative and eager to speak during the observed therapy session. She was actively involved in discussions about a range of difficult issues, acknowledging her difficult emotions and concern regarding Jasmine's self-harm. Whilst the family characters and contributions to the conversation differed, both parents appeared supportive, relatively calm and reassuring towards Jasmine as they provided specific praise and encouragement to her at times during the session. This included acknowledgement of the positive action she had taken to manage her self-harm to date. Towards the end of the session, they also acknowledged the potential contribution of their own personal characteristics and difficulties in understanding and managing Jasmine's self-harming behaviour.

The therapist initially established a sense of collaboration and rapport with the family by checking the suitability of the appointment time and checking in with Peter as to whether the time fitted with his work commitments. Following this, the therapist appeared to make a conscious effort to engage Jasmine in general, non-threatening conversations which lead them into a more therapeutic dialogue. The therapist was also seen to establish a non-blaming, collaborative, strength focused dialogue by encouraging the family to take part in agenda setting and referring to therapy as a means for 'tapping into family resources'. The therapist appeared to be working strategically to engage and build relationships with all individual family members. For example, when Jasmine spoke quietly the therapist appeared unable to hear what was being said but attributed this to interference from her earpiece as opposed to Jasmine's speech. The therapist also appeared to facilitate the communication of Jasmine's perspective by elaborating on what she had said. She also made suggestions regarding Jasmine's feelings and the function of certain actions such as the act of lining her crayons up being calming.

The format of the session appeared typical of an early therapy session whereby the therapist explored and reflected upon the family experiences and emotions in relation to noteworthy events whilst also reflecting on knowledge gathered from the previous (first) session. The

emotional tone within the room was at times tense and tearful, however, the family did share humour on occasion and made light of some difficult issues such as discussions around their checking up on Jasmine when alone in her room. The focus of therapeutic discussions centred on events which proceeded past incidents of self-harm. A substantial proportion of the early session involved talk of Jasmine's emotional experiences, an incident of conflict between Helen and Peter, and Helen's anxiety. During my early observations, I had a distinct impression that Jasmine was struggling with her transition to the new school. She talked about her frustrations with the school rules, being separated from her friends in class and wandering around school alone. As the session progressed, she began to discuss concerns about her parent's conflict and feelings of self-blame. When I initially watched this therapy session, I was struck by the obvious parallels between Jasmine's and her mother's anxieties. It seemed that Jasmine and her mother's problems were entwined and that their relationship was potentially enmeshed.

Family one analysis of pre reflecting team dialogue

On analysis of the pre RT therapeutic dialogue, five central storylines were identified; Jasmine's desire for autonomy, Helen's maternal protective instinct, Jasmine's sense of responsibility, Parental conflict and Helen's anxiety. I will outline each of these storylines in turn before going on to consider the RT intervention. To provide a sense of coherence and flow to the dialogue, I will present the storylines in the same order as they emerged during the session. At times the storylines were intertwined throughout the session, particularly the first storylines which related to Jasmine's desire for autonomy and Helen's protective instinct. The first two storylines will therefore be presented together to highlight how they arose and interacted throughout the session.

Storylines 1 and 2: Jasmine's desire for autonomy and Helen's maternal protective instinct

Jasmine's desire for autonomy emerged early on in the session as she began to establish a position of herself as a capable individual who is in need of her own space. The therapist provided the initial focus to the session by prompting the family to discuss their hopes and wishes in coming to therapy. In response, Jasmine suggests that she wants to be left alone and treated more like an adult as she positions herself as somebody who does not have enough privacy or independence, particularly from her parents; *"I want, like, no-one to, like, worry about me, like... coming up in my room"* (Jasmine, 67). Jasmine suggests that being autonomous is an area of tension within her

70

relationships, both at home and with friends; *"I mean mum and dad the most but, like, my mate [name] worries about me a lot as well"* (Jasmine, 75).

A tension seems to emerge between Jasmine's desire for autonomy and Helen's desire to protect. Initially, Helen agrees with Jasmine's account that both parents worry about and check up on her, as Helen positions herself and Peter as overprotective and intrusive; *"She can't go into her room for more than five minutes without one of us checking up that she's OK"* (Helen, 68-69). Helen's desire to protect is interpreted by Jasmine as a lack of trust and confidence in her ability to keep herself safe; *"I told my mum 'Ah... I just burnt my hand' and she was like 'Oh, you didn't do it on purpose did you?... that upset me"* (Jasmine, 93-94). Jasmine's account of events suggests that she feels smothered by her parents' worrying, checking and accusations. In response, Helen indicates that she is vigilant for signs of self-harm and is fearful that this behaviour may escalate; *"But that was my reaction, I was like 'Oh gosh has she... has it gone up a level...?'"* (Helen, 99).

From this protective and vigilant position, Helen describes responding with alarm to Jasmine's self-harming behaviour as she fears for her safety and wellbeing. This involves continually checking on and questioning Jasmine when she is quiet or alone in the house; *"I know that if you go in the shower one of us will, at some point, shout upstairs and ask if you're OK"* (Helen, 145-146). By positioning Jasmine as vulnerable, Helen indicates a need for parental protection and positions herself and Peter as responsible for providing care and protection. In doing this, Helen appears to provide justification for her protective parenting style.

Throughout the discussions, Helen and Peter appear keen to protect and support Jasmine and they both express hope for change, however, they communicate this in different ways. Peter facilitates a storyline of development and change as he draws attention to the present by reminding Helen that Jasmine has not recently self-harmed; *"But… she's not done it"* (Peter, 302). In contrast, Helen refers to a point in the future when she believes things will improve; *"It'll get better"* (Helen, 303). Peter acknowledges Helens perspective of change being a process which takes time, however, he states this in a way which recognises the current progress and efforts Jasmine has made thus far *"...you're not gonna just click your fingers and be right"* (Peter, 304). In concluding the pre RT therapy dialogue, Peter takes a supportive position through an expression of hope as he positions Jasmine as a survivor indicating support for her desired autonomy; *"It's good to think that she's actually finding ways of dealing with it"* (Peter, 298). In response, Helen appears

to talk from a position of fear to suggest that Jasmine is not currently capable of being autonomous, positioning her as emotionally unstable as she suggests that Jasmine is not coping consistently; *"Mmmm. Yeah. Sometimes... Sometimes not"* (Helen, 300). Helen's comments appear to support and maintain the status quo, a lack of confidence in Jasmine's ability to cope implies that she should remain dependent on her parent's care thus preventing her from becoming autonomous or developing her independence.

Pre RT storyline 3: Jasmine's sense of responsibility

Prior to involvement from the RT, the family's construction of their situation is saturated with reference to individual positions of blame and responsibility. Jasmine positions herself as blameworthy implying a sense of responsibility for the family's current predicament as she describes being worthless, always at fault, letting other people down and being undeserving of other people's care and attention; *"I just feel really sad, like, and then I get angry with myself as well. I'm just, like 'why do I even bother?' Like, I don't even deserve these people"* (Jasmine, 383-385). Jasmine relates these feelings more specifically to her parents who, according to Jasmine, have to *'put up with' her.* Consistent with Jasmine's self-blaming position, Helen suggests that Jasmine is responsible for the family's emotional climate, positioning her as a troubled teenager as she describes the pervasive influence of her moods on the family; *"If Jasmine wasn't happy there was like a big cloud that descended over everybody... it brought us all down"* (Helen, 461-462). By highlighting Jasmine's influence on the family, Helen seems to locate the family problem within Jasmine as opposed to considering the wider family dynamics and events.

Facilitated by the therapist, the family begin to explore the events preceding Jasmine's perceived change in mood. In addition to the stressors of school, Jasmine suggests a sense of responsibility for her mother's wellbeing; *"But I think I was just worried because... I was worried about, like, mum, like, getting, like, worried as well. Like, I was worried about you"* (Jasmine, 541-542). From this opening, two further storylines of parental conflict and Helen's anxiety emerged.

Storyline 4: Parental conflict

The therapist initially picks up on Jasmine's position of responsibility and draws attention to an incident of parental conflict which was discussed in the previous session; *"From that holiday then there were some times, you know, ever since, if you two have kind of raised your voice together then you're there... [Pointing at Jasmine]. Little, you know... sort of, radar"* (Therapist, 552-554).

Here the therapist suggests that Jasmine has been hyper-vigilant to parental conflict, fearing parental separation which has resulted in her being protective of their relationship. Helen and Peter go on to challenge the perception of their relationship being conflictual by positioning their current relationship as harmonious and contrasting this with past events. They both state that it is such a long time since they argued that they cannot even remember it. Helen states to Jasmine; *"Can you remember the last time dad and I fell out?"* (Helen, 561). Despite Helen and Peter's refutation, Jasmine continues to position their relationship as conflictual and suggests that it is also fragile and in need of protection; *"I still like… if they did start I'd be, like, right there"* (Jasmine, 584). In response to Jasmine's position of responsibility and hyper-vigilance, Helen assumes a silenced position as she describes holding on to her emotions and not engaging in conflict or even minor disagreements with Peter for fear of Jasmine overhearing and becoming upset by this. Helen and Peter subsequently engage in a joint dialogue in which they normalise disagreements and arguments as a natural and necessary aspect of all relationships.

Extract (619-626):

> Helen*: "Yeah? You know, and I've always tried to reassure that... you know, everyone has moments and sometimes...*
>
> Peter: *Sometimes you need to get it out...*
>
> Helen: *...you need to have a bit of a blowout and then you move on...*
>
> Peter: *Blow a bit of a fuse, just to...*
>
> Helen: *...say what you need to say, and then you make up and everything is fine. But then when … you know that you're (to Jasmine) there we end up having to stop and things just... get... underneath...*

Helen and Peter suggest that their opportunities for healthy conflict and disagreement are restricted due to Jasmine's hyper-vigilance as they fear upsetting her. This highlights Helen and Peter's account that Jasmine has an influence on, and is partly responsible for the family tensions. As the storyline of parental conflict unfolds, the storyline of Helen's anxiety also begins to emerge.

Storylines 5 and 6: Helen's anxiety and Peter's supportive role within the family

Helen acknowledges the severity of her conflict with Peter in the past, positioning the family as having been at a point of crisis; *"That incident two years ago, it was horrific, it was awful, it was awful for all of us…"* (Helen, 639). Helen goes on to minimise both the significance and

responsibility for her behaviour by contrasting this with the family's *usual* behaviour; *"But... That's not how we normally behave. And my response... is not how I normally behave"* (Helen, 639-640). Helen subsequently attempts to contextualise her behaviour which she attributes to problems with her mental health. Helen goes on to outline factors associated with the deterioration of her mental health; *"I was worried about losing jobs, losing the house, losing... everything"* (Helen, 692-693). A shift in Helen's attribution of blame occurs here as she positions herself as responsible for her daughter's self-harm and guilty of not protecting her emotionally; *"She said that she was scared that we'd split up... Erm... Because I responded the way that I did"* (Helen, 646-647). As a result of this shift in Helen's positioning, a related shift occurs with Helen beginning to consider the potential impact of maternal anxiety and parental conflict on Jasmine. In doing so, Helen's positioning of Jasmine as a troubled teenager also shifts to that of a victim by reference to her having witnessed an overwhelming family incident and maternal distress; *"I'm just sorry that you had to witness it Jasmine, because... I never ever thought for one minute that we'd end up here"* (Helen, 640-641).

Helen later returns to position her difficulties as a medical problem which seems to minimise her sense of agency and responsibility to control her past behaviour; *"I knew I was behaving... irrationally […] completely irrational... crazy... and if I could pull myself together I would... but I can't"* (Helen, 688-690). From this helpless position, Helen describes a constant need for reassurance from Peter who is positioned as her primary source of emotional support. Peter demonstrates agreement with Helen as he talks of actions he has taken to support her and in doing so positions himself as a source of emotional and practical support. Peter adopts a similar position in his relationships with both Helen and Jasmine which suggests that he considers himself the main source of emotional stability within the family.

Prior to intervention from the RT, the therapist facilitates an initial shift in the family's discourse from discussing Helen's anxiety to reflecting on Helen's improved mental state and in doing so positions her as calm and well in the present. The therapist encourages Jasmine to reflect on Helen's improved disposition which opens up a discussion about the impact of Helen's mental state more generally. Jasmine is subsequently able to communicate aspects of vulnerability as she acknowledges how she has been affected by Helen's distress; *"I don't like seeing her upset"* (Jasmine, 734) The RT enters the room shortly after this point.

Input from the therapy team with family one

I will begin this section by providing an overview of the RT dynamics within the session before outlining the RT's reference to the main family storylines and positions. Following this, I will go onto provide further examples and details of the discursive strategies utilised by the RT.

The therapist sets the scene and explains the RT process before inviting the RT in to the therapy room. Prior to the RT's involvement, Helen comments that in the previous session, reflections from the team 'made her cry' indicating an emotional response to previous input from the RT. The RT observe the therapy session in an adjacent room behind a one-way mirror. Following the therapist's invitation, the RT enter the therapy room from behind the one-way mirror. The RT provided a brief introduction to the process of RT conversations before going on to reflect upon aspects of the session which had stood out to them. These reflections took place in the presence of the family who observed the RT conversation without comment or direct interaction with the RT.

The RT did not make any personal disclosures and maintained a professional demeanour which enabled them to raise difficult issues considerately. There was limited humour observed in their interactions with one other, or with the family. However, the RT were seen to demonstrate warmth and compassion by validating everyone's positions and remaining respectful to the perspectives of each family member. They also opened up the potential to question and challenge current thinking which enabled change to take place. The RT members often indicated verbal and non-verbal agreement with each other through physical gestures such as a nod of the head, or verbal statements such as 'yes' or 'aha' as the other RT members spoke. One of the RT members acknowledged that different perspectives exist in relation to self-harm however, there did not appear to be any contradictions or sharing of different perspectives between the two RT members. However, within their reflections, the RT acknowledged the importance of Peter attending the session and the invaluable opportunity to share individual opinions and experiences together as a family.

Intervention from the reflecting team

RT's reference to storylines 1 and 2: Jasmine's desire for autonomy and Helen's protective instinct

With reference to the storyline of maternal protection, the RT normalise parental worry in response to self-harm; *"Self-harm brings to... most parents' the need... the kind of wanting to check..."* (RT, 803). However, they invite Jasmine to talk about her perspective of parental worry in relation to self-harm and question whether the worry is necessary; *"Does she think that there isn't really a need to worry about her?"* (RT, 811-812). The RT also attempt to elicit a more positive, solution focused narrative by questioning Jasmine about exceptions to her self-harming behaviour; "*What does she know about herself that, you know, could maybe give other people confidence?*" (RT, 818). This statement facilitates further questioning and challenge to Helen's vigilant and protective position. The RT subsequently shift their gaze from the parent's protective instinct, to Jasmine's desire for autonomy which aids their acknowledgement of the family member's individual perspectives. This is achieved by re-positioning and reframing parental checking as untrusting within the context of recovery; *"Sometimes the natural response is to check and double check and treble check […]. When the young person's beginning to recover… double and treble checking can make them feel worse again, or can make them feel that nobody trusts them or they're not doing so well"* (RT, 851-855). Here the RT cautiously positions the parents checking as over-protective as Helen herself did, and tentatively suggest that this could be counter-intuitive to Jasmine's progress.

Reference to storyline 3 and 4: Jasmine's sense of responsibility and parental conflict

The RT build on the parents' storyline of conflict being a natural part of healthy relationships whilst also indicating the need for Jasmine to hear a more balanced story which acknowledges both the conflicted and cohesive aspects of their relationship; "*As a young person you need to know what are the things that are keeping us together? So we may not be arguing… But, actually, what are the positive signs?*" (RT, 869-871). Here the RT reframe the focus of the pre RT storylines to parental responsibility and parental cohesion and encourage Helen and Peter to provide evidence for the harmonious position of their relationship (see discursive strategy 5).

Reference to storyline 5: Closed down – thinning narrative

The RT make only brief reference to Helen's struggles and do not directly discuss the storyline regarding Helen's anxiety which appears to close down further discussion of this topic.

Reference to storyline 6: Peter's support within the family

The RT do not make direct reference to Peter's supportive position within the family, however, they appear to refer to Peter's positioning and the strategies mentioned by him and apply these to the whole family as a supportive, unified force as opposed to recognising only Peter's input; *"And they've worked it out. They've found ways of... managing some of those stresses and printing things out and planning ahead of time was helpful"* (RT, 767-769). The RT continues to build on and strengthen the position of family unity by referring to prior achievements and success that the family have demonstrated together and applying these attributes to the present; *"Perhaps they're doing the same now with Jasmine... as a family they've got together again and said 'right, we need to do something'* (RT, 787-789). The RT also positions the family as determined and resourceful in the present and frames this positively in terms of their future prospects; *"So coming here's part of that.... that family togetherness that says 'we're going to sort this, we're going to get this... worked out. We're gonna find out how we get through this'"* (RT, 789-791). In response, the other RT member reinforces the families position as a unified force and forecasts positive outcomes as a result of their commitment to one another; *"It's a real... commitment to each other and a real commitment to... their future as a family"* (RT, 795).

Discursive strategies utilised by the reflecting team

To provide an overview of intervention from the RT, I will present examples of each discursive strategy sequentially as they occurred during the reflections.

1. **Empathising and normalising**

The RT initially provides empathy for the family's situation by acknowledging their struggles whilst also placing these within a historical context. In doing so the RT subsequently positions the family as resilient in the face of adversity thus reframing the storyline from parental conflict to that of stability and cohesion. *"One thing we noticed... just to start us off, perhaps, is about... goodness, how much the family have been through, you know, the struggles and some of the difficulties and... and hearing about Mum and some of the anxieties that she's carried for quite a long time, and managed on the whole..."* (RT, 761-763). The RT also normalise the family experience, and position them collectively as a unified force by acknowledging that things have been difficult for '*all*' family members whilst emphasising their ability to cope by reference to various strategies they have

implemented together; *"…We heard about how difficult that was for all of them. But they've got through"* (RT, 766-767).

2. Reframing - strengths and solution focus

The RT provide a strength and solution focus to the therapy session by suggesting that the family have other resources and strengths in addition to those that they have discussed;. *"And there'll be other ways that have helped them sort it out and helped each other and helped themselves as a family to be stronger"* (RT, 769-770). The RT later attempt to reframe the family narrative from problem focused to more strength focused by encouraging them to consider family and individual strengths and progress; *"Sometimes we can lose sight of… the strengths and the positive things that are there as well"* (RT, 825).

3. Use of tense

The RT make use of past and future tense in order to frame problems as historical issues *"One thing we noticed… is… how much the family have been through"* (RT, 761-762). They also continue to build on and strengthen the position of family unity by referring to prior achievements and success that the family have demonstrated together and applying these attributes to the present; *"Perhaps they're doing the same now with Jasmine… as a family they've got together again and said 'right, we need to do something'"* (RT, 787-789).

4. Collaboration and use of pronouns

Making use of plural pronouns such as 'we', the RT create a sense of collaboration and unity to suggest that they are all equal and working together; "*When something difficult happens, as families 'we' tend to focus on the problems*" (RT, 823-824). This collective sense of the family members and the therapy team working together minimises the potential for power imbalance and normalises the family's experience and response to their situation.

5. Expert supervisory position regarding areas of concern

As the session progresses, the RT shift from their prior collaborative position to a more directive, expert position to advise on areas of concern. This directive stance is specifically in relation to the issue of parental conflict which is linked to Jasmine's emotional state; *"As a young person you need to know what are the things that are keeping us together? So we may not be arguing… But, actually, what are the positive signs?"* (RT, 869-871). The RT give advice whilst also positioning the parents as having a responsibility to provide Jasmine with reassurance. The RT's use of questioning also invites the parents to respond whilst giving direction to the therapist to elicit this information "*And maybe that's something that Jasmine would find it helpful to know a bit more about. What it*

is that... keeps them so strong together?" (RT, 878-879). Here the RT position themselves as supervisors to advise the therapist of an area for further exploration.

6. Tentative use of questioning

Phrasing their reflections as tentative questions, the RT initiate a further, more open dialogue about self-harm and parental concern; *"What... are they worried about?" What do they...? How are they thinking about what's happening, you know?"* (RT, 842-845). Such questioning also encourages the family to reflect on their situation, thoughts and worries.

7. Promoting a "multi-versa" position

The RT also acknowledge and encourage different perspectives; *"We meet lots of families where there is self-harm and... parents come with different ideas... and it would be good to hear Jasmine's ideas about that as well"* (RT, 838-839). This opening encourages the acceptance of difference and the promotion of a "multi-versa" position.

Family One: Analysis of post reflecting team dialogue

Storylines 1 and 2: Helen and Jasmine's negotiation of autonomy

In the post RT discussion, Helen follows up on the RT's questions regarding her concerns of Jasmine's self-harming behaviour. A shift from parental protection and vigilance to a more accepting and supportive position emerges as Helen acknowledges that despite her efforts to stop the self-harm, Jasmine continues to do this independently. Helen subsequently recalls how she has managed this by facilitating and encouraging Jasmine to choose safer methods to self-harm; *"A clean razor is less riskier than a... dirty old badge or a... pair of old tweezers"* (Helen, 1244-1245). She goes on to position herself as more accepting of self-harm; *"And we've always let her have... you know, if she's asked for a razor" (1245-1246)* whilst also taking steps to manage the risks; *"I'd rather you came... after you've done it, at least if you come and then tell me we can check it's okay"* (Helen, 1210-1211). Helen's post RT positioning of support and acceptance indicates recognition of Jasmine's developing autonomy, a definite shift from her prior construction of Jasmine being vulnerable and dependent.

Despite the momentary shift in Helen's positioning, there is a continued sense that Helen wishes to monitor Jasmine's self-harm and injuries. This corresponds with Jasmine's positioning of herself as a maturing and autonomous individual who is willing to hear her parent's worries and concerns but who also seeks the approval and support of her parents. The apparent shifts in the negotiation

of autonomy and dependence from pre to post RT are only transient and there is an ongoing tension between the positions occupied by Jasmine and her parents throughout the therapy session. A return to more familiar and conventional relational positions is apparent at the end of the session when Helen re-establishes a position as a protective parent in relation to Jasmine who is re-positioned as a vulnerable dependent child; *"D'you want a tissue... before we leave? I need to be counsellor now* (Helen, 1397-1398). *Right, come on babygirl"* (Helen, 1401). These statements could be considered playful and caring, however, taken collectively, they could illustrate Helen's tendency for overprotection and the potential to infantilise Jasmine, thus debilitate her developing autonomy.

Storyline 3: The family establishing a shared understanding

In contrast to the pre-RT storyline of Jasmine's sense of responsibility, there is a sense that the family members are less blaming of one another. The family begin to share their individual understandings and begin to establish a shared understanding of their problems. Jasmine begins to edge away from her prior self-blaming position and takes a more open and expressive position as she discusses her emotional responses within the context of the family's concern that she is not progressing. "*I feel bad after I've done it because, like... I feel like, it just, like, makes everyone else worse, like... I feel like they think that I'm not getting better"* (Jasmine, 1206-1207). Jasmine's opening up about her emotional experiences appears to be in response to the RT's acknowledgement that she may not feel trusted by her parents and that the checking behaviour has a detrimental effect on her progress. Helen also takes a less blaming position as she demonstrates an understanding and acceptance of the longevity of the recovery process; "*I think that we know that it's going to take a while Jasmine. We've always said it's OK, haven't we?"* (Helen, 1208) Peter also moves away from his prior position as the family's source of stability and support as he takes a not knowing position to acknowledge his lack of understanding regarding Jasmine's experiences**;** *"I find it difficult to... understand, why you do that* […] *I'm... too laid back for my own good"* (Peter, 1021-1042). By openly sharing and expressing a desire for her family to understand her experiences, Jasmine also demonstrates her commitment to a shared resolve of the family problems; "*I want them to know how I feel* […] *Understand my, like, feelings, like... why I do it"* (Jasmine, 1177-1204).

Storyline 4: Family cohesion

Following intervention from the RT, the storyline of parental conflict is reframed to that of family cohesion. There is also a comparative shift in the family member's relative positioning from that of individual blame and responsibility to a more collective sense of shared responsibility. Helen responds directly to the RT's opening for parents to take responsibility, provide reassurance by positioning herself as a responsible parent as she offers reassurance to Jasmine by considering the positive aspects of her relationship with Peter. Helen and Peter position themselves as united in a partnership ad suggest that they are soul mates as they describe themselves as 'best friends' who 'like the same things'.

Extract: (line 896-908)

> Helen: "*And the bit about our relationship... [to Peter] What does keep us together?*
>
> *[pause] We're happy... We're best friends...*
>
> Peter: *Yeah*
>
> Helen: *We do things together*
>
> Peter: *Hmm*
>
> Helen: *You know, we like the same things. We've been through a lot. We've got two*
>
> *gorgeous girls*
>
> Peter: *We just like the same things, doing the same things, going to the same places.*
>
> *Well it's like you say... best friends as well*".

Helen also identifies Peter as her main source of support *"I couldn't do... the job I do and the work... that I do...the full-time working, if it wasn't... for you"* (Helen, 904-908). As the storyline of family cohesion unfolds, Helen and Peter discuss the opportunity for them to rekindle their relationship as their daughters increase their autonomy. Helen and Peter move away from their prior positioning as vigilant, protective and supportive parents to discuss their offspring's increasing age and reduced dependency which has enabled them to spend more time together as a couple; "*I think now they're getting older as well, as a couple we're getting a little bit more time to ourselves"* (Helen, 974-975). Helen and Peter also recognise their own need for autonomy as a couple which could indicate that they are also more accepting of Jasmine's developing autonomy; "*We love having you around, but, actually we need a little bit of time as well"* (Helen, 978-979). Reflecting on their daughters reduced dependency, Helen indicates that there is now more time available to devote to her partnership with Peter which is beneficial for them; "*Whereas now we*

have time to do that, so I feel that our relationship is probably... as good as it's ever been..."
(Helen, 983-984).

Reflections on the analysis of family one

The storylines discussed by family one in the pre RT discussion were negatively skewed. The pre RT storylines appeared to be focused on Jasmine's desire for an increasing level of autonomy from her parents and her friends. Jasmine also expressed a sense of responsibility for the family's predicament, the conflict between her parents and Helen's anxiety. While Helen and Peter's protective parental instincts appear to have been positively intended, this was also framed negatively in the pre RT discussions as their 'checking up' on Jasmine seemed to be detrimental to her progress and problematic to their relationship.

Prior to the RT, the therapist gave space for Helen to discuss her worries and the impact of her historical mental decline on the family, particularly Jasmine. The RT pass comment on Helen's ability to cope despite the anxiety and do not discuss this storyline in any more depth in effect appearing to close-down further conversation about this topic. The RT's move away from discussing Helen's anxiety encourages the family to focus and elaborate on their individual understanding of Jasmine's emotional experiences. Here the therapist and the RT are working together, building upon each other's progress to enable therapeutic discussions to take place which are helpful to the family. Jasmine is initially positioned as a troubled teenager and also a potential victim of her mother's anxiety and parental conflict. The pre-RT dialogue is heavily focused on Jasmine's pre-occupation and attempts to make sense of and negotiate rules and boundaries. Jasmine's dislike of rules and desire for autonomy is consistent with the stage of adolescence when young people develop a sense of their identity as separate, independent and distinct from others.

Overall the family demonstrated receptivity to the RT, with Helen and Peter immediately following up on what the RT had said and repairing the issue of parental conflict. However, Jasmine did not follow up on the RT's attempt to elicit exceptions to her self-harming behaviour during the post RT discussion. This may be reflective of the stage of therapy and the full influence of this RT intervention may not become apparent until later in the therapeutic process. It may be that this suggestion did not have time to be addressed during the session, or that it was addressed outside of the therapy room or in a subsequent session. Alternatively, it may be that Jasmine was not at a

point where she had exceptions to self-harm to draw upon, or that she was not able to formulate or communicate these ideas at the time and early stage of therapy.

A representation of the family meaning system is presented in figure 7. This includes the key positions and constructs negotiated in family one's pre to post RT dialogue. The family meaning system shifted from positions of blame, dependency and conflict to those more representative of understanding, autonomy and cohesion.

BLAME

Conflict

Intrusive

Troubled Teen

Emotionally Unstable

Overprotective

DEPENDENCE — **AUTONOMY**

Baby Girl

Capable Adult

Vulnerable

Cohesion

Acceptance

Key:
Key positions pre RT
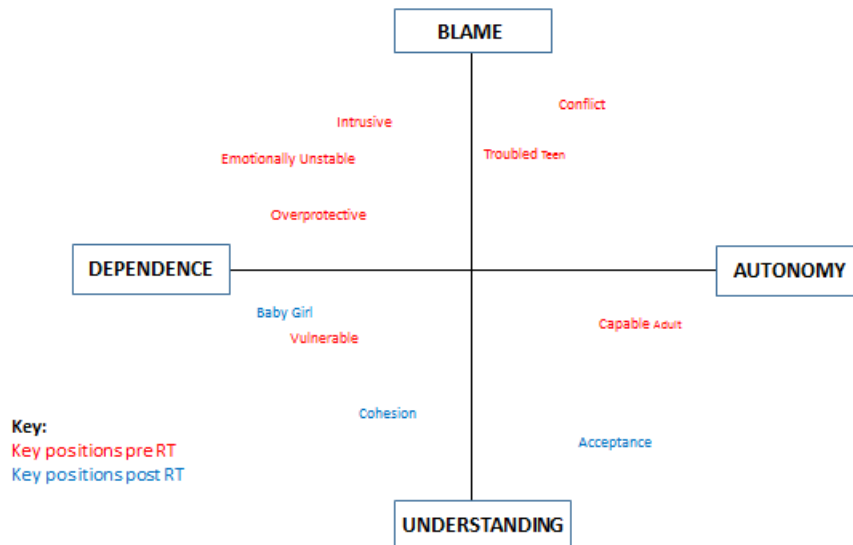Key positions post RT

UNDERSTANDING

Figure 7: Case One - Representation of Family Meaning System

Case Two

Pen portrait

Session five from the six available therapy sessions was chosen for inclusion from family two. This particular family was selected specifically due to it having two therapy sessions which met the inclusion criteria which were at a later stage in the therapeutic process in comparison to that included from family one. This session therefore provided the potential for insight into the workings of the RT at a later stage of therapeutic change. The final therapy session was also available which had all family members in attendance. However, the introduction of the two additional family members to this final session was considered unsuitable for the current research as the family would have been unfamiliar and potentially unprepared for the RT process.

The session selected was attended by 15 year old Carly and her mother Sandra. Carly's father, Brian did not attend this session but attended a subsequent session along with Grandma. Carly was an only child who lived at home with her mother and father. She was being informally educated at home having been excluded from secondary school. According to Carly and Sandra, she had stopped attending school as a result of being bullied. Both Carly and Sandra expressed frustration and anger towards the school situation and they expressed concern regarding the lack of formal education arrangements. I got a sense from the therapeutic conversations that Carly did not have many close trusting friendships but that she had recently become more comfortable and confident within herself potentially as a result of therapy or not attending and being bullied at school.

Throughout the session Carly appeared at ease, confident and outspoken. She openly discussed her thoughts and feelings regarding a range of topical issues. This included expressions of anger in relation to her sense of lacking educational support, her fears regarding potential unemployment and the prospect of claiming benefits whilst making insightful reference to societal issues, social media, British sub-cultures and stereotypes. In a similar manner, Sandra appeared confident and able to express herself openly as she engaged well in conversation. Sandra however appeared a little calmer and less visibly agitated by the situation with education as she stated that she was 'past anger now'.

The session oscillated between humorous exchanges between Sandra and Carly, to discussions of more serious issues. At times, Carly and Sandra chatted freely together in a friendly manner, sharing humour and laughter as they discussed family life, events and family outings in addition to an upcoming family holiday. At other times, there appeared to be an undertone of tension and subtle conflict within their relationship. I was initially struck by the inconsistencies and change in Carly's relationships with her two parents, particularly the relationship between Carly and her mother during the session. It appeared that their relationship was strained and I had a sense that Carly was suppressing, avoiding or struggling to communicate information directly with Sandra. Throughout the therapy session, the relative positioning of family members was also in constant flux. Similar to family one, the storylines were fluid and interwoven throughout the dialogue. This resulted in a complex and ever changing flow of interactions between family members which reflected the complexity and nature of family relationships and life events under discussion.

At the start of the session, Carly apologised for being late and the therapist engaged in a general conversation about recent events which appeared to ease the family into the session. The male RT member also entered the room to greet the family before the therapeutic discussions began. The therapist moved on to introduce more therapeutically orientated discussions by providing an overview of where the family were in terms of their stage of therapy and nearing the end of the therapeutic offer. In this session, the therapist was active in setting the agenda for the family with less negotiation and collaboration taking place than observed with family one. This was accomplished by the therapist emphasising the stage of therapy and the ongoing risk of self-harm as a key issue to be focused upon from the outset. During the session, the therapist appeared to guide the family by asking direct questions regarding issues of risk and family relationships. The therapist was also observed facilitating self-reflexivity as she encouraged Carly to think through past incidents and events and reflect upon her problem-solving processes and achievements to date.

Family two: Analysis of pre reflecting team dialogue
Isolation and exclusion were prominent themes within Carly's pre-RT dialogue as she recounted feeling ignored by her peers at school, ignored by her parents at home, and pushed out and let down by the education system. On analysis of the session, eight storylines were identified in the pre RT discussions which included Carly's developing self-awareness, Carly's exclusion from education, Carly's hopes and aspirations for her future, Carly's feelings of loneliness and isolation,

Carly's conflicted and competing relationships with her parents, Carly's developing relationship with her father Brian, Contradictions within Carly and Sandra's relationship, and Sandra's busywork life. I will present the data in a manner similar to that of family one, outlining each of the storylines in the order they emerged over the session before going on to consider the RT intervention.

Storyline 1: Carly's developing self-awareness

Overall, within storyline 1, Carly positions herself as less irritable and more self-reflective than she was in the past as she describes being somebody who is considerably more able to manage her emotions and behavioural responses. Carly refers to the past as a *"disaster"*, suggesting that her self-harm had taken place at a time of crisis. She indicates that school was key to her self-harming behaviour as she discusses the progress she has made in managing her emotions since leaving school; *"I don't get angry as quickly"* (Carly, 168). Here, Carly indicates that she has an increased level of self-awareness and self-control over her anger and goes on to acknowledge that her anger is now less severe and delayed; *"I still get really angry really easy but... Not as much as it would be"* (Carly, 168-171). Carly describes that she is now able to pause, if only momentarily, before becoming angry; "*Before, you could click your fingers and now it's like three clicks [all laugh]"* (Carly, 173).

Carly describes a change from her prior 'hot-headed' and quick-tempered character to being less irritable and less reactive. She also positions herself in comparison to the past as somebody who is now more able to self-regulate. She goes on to outline her developing capacity to use strategies to help her deal with her emotions; "*It's like now if I feel angry I go for a walk... which is good"* (Carly, 427). Sandra indicates agreement with Carly, supporting the view that Carly is developing an increased level of control over her emotions; "*I think you lose your temper less now than you used to"* (Sandra, 183).

Storyline 2 and 3: Carly's exclusion from education and her hopes and aspirations for the future

Carly positions both school and the education system as being at fault for her current lack of education; *"That school is terrible, they forced me to leave!"* (Carly 661-663). Carly describes feeling forced out of school and being left without help; *"There's just no one to help. The system is so poor"* (Carly, 656). Here Carly positions herself as marginalised and powerless within a defective system. Carly goes on to compare her current difficulties with education

to those of her father's; *"I've seen what it's done to dad […] my dad left school at fourteen"* (669-670). Carly admits to having no knowledge of the reasons for his lack of continued engagement with school and subsequently shifts to position her father as being at fault, suggesting that he was an unruly teenager; *"My mum was telling me 'your dad was so bad at school'"* (Carly, 671).

Carly goes on to highlight the importance of education and qualifications in enabling her to attain her aspirations. *"It sounds awful, but I don't want to end up with no qualifications* (Carly, 680-681). She refers to Jeremy Kyle's television programme which highlights the chaos and dysfunction in some families' lives. By reference to this programme, she positions people on benefits as dysfunctional and expresses an ambition for herself to be different; *"It annoys me because the people that go on Jeremy Kyle that have got no teeth and stuff, and I don't want to end up like one of them just claiming on benefits"* (684-685). In contrast, Carly talks of her desire to have a successful career and not be reliant upon benefits "*I want to have a job"* (686). Carly likens being unemployed and in receipt of benefits to her current situation, sitting at home, alone, presumably with little stimulation or purpose; "*Cause otherwise I'll be like I am now, sat on my own at home all day and... I couldn't do it"* (Carly, 688).

Carly indicates that she has now has a purpose in life which was lacking in school. She positions herself as more mature and self-motivated as she contrasts her previous lack of motivation to attend school with her current level of motivation to proactively engage with opportunities for her career. *"It's like now I've been given a job […]. And I have to get up early as well. [...]. It's like when I went to school it was like I'll just have five more minutes, ten more minutes, or twenty more minutes"* (Carly, 191-211). She talks about her current college course being something that she is motivated to engage with which she contrasts with schooling; "*I think school would be a lot different to college because at school no one really wants to be there, but at college it's optional […] You've got to pay for it so you're not going to pay for something that you don't really want are you?"* (Carly, 215-220). Sandra supports Carly's progress as she comments on her motivation to get out of bed and implies a positioning of herself as a proud parent; *"I think it's ace, I think she's, and, you know she just gets up and goes […] the motivation of her getting out of, you know something that gets her out of bed"* (Sandra, 207-208).

Storyline 4: Carly's feelings of loneliness and isolation

Carly indicates that she is generally lonely as she positions herself as someone who is overlooked and ignored. She initially compares her past experiences in school to her current situation at home to position herself as more lonely in the present; "*I'm a lot more lonely day to day*" (Carly, 232). She goes on to contradict this by stating that she has more company at home; "*I've got more company than I did at school*" (237). Carly then states that she is ignored at home but quickly moves on to say that she feels less ignored at home than she did at school as there are less people ignoring her; "*At home I do get ignored [nervously laughs]. But I don't get ignored that much. I am only getting ignored by two people at home, but when I were at school I were getting ignored by everyone*" (Carly, 237-239).

Carly appears more able to openly discuss her feelings in relation to her peers at school, positioning herself as overlooked, invisible and rejected as a result of being isolated, ignored and pushed around by her peers; "*It's like I was invisible, I used to get pushed and shoved about and... like if I talked to someone they'd just ignore me and... It's like I were alone yet I was in a room full of people*" (Carly, 239-241). There are also subtle contradictions in Carly's account of being ignored by her parents as she goes on position her father's ignoring of her as being due to a lack of engagement which is not intentional whilst also acknowledging that he does not listen to her. Whereas, with reference to school, Carly position ignoring as deliberate; "*Yeah it's like it was more... like deliberate to me, but... at home I know it's not deliberate because my dad's just selective hearing to me*" (lines 244-245). Carly's changeable and inconsistent account of her experience of being ignored at home suggests that she is struggling to articulate or make sense of her experience and may be confused about her relationship to her father.

As the session progressed, Carly associates her experience of being ignored at school with feelings of anger, frustration and despair; *"What wound me up when I was at school is when people were ignoring me and that's one thing that sets me off"* (Carly line 633-634). Carly also builds on this to generalise this response to other people; "*I can't stand ignorant people […] That ticks me off really bad, that's one of the worst things*" (Carly, 634-636). This statement suggests that Carly may be sensitive and reactive to being ignored by other people whom she perceives as being rude to her. Although this is only indirectly inferred, Carly's statements suggest that she may also be

experiencing a sense of rejection, anger and despair when she feels that she is being ignored by her parents at home.

Storyline 5: Carly's conflicted and competing relationships with her parents

Carly appears to create a dynamic of conflict and competition between her parents in relation to herself. Carly counter positions her mother, Sandra, and father, Brian, in terms of their availability, attentiveness, and ability to protect her. Carly initially defends her father; "*It's not that he doesn't care*" but suggests that he does not know about her risk of self-harm. Carly suggests that this is due to him being inattentive; "*He just doesn't pay attention to it*", and preoccupied; "*It doesn't look like it crosses his mind*" (Carly, 106).

The therapist facilitates a dialogue which provides a counter argument to Carly's positioning of her father to suggest that he is concerned and attentive: *"He does take some notice doesn't he"*. To emphasise this point, the therapist recalls Carly's statement from a previous session; *"You said last time [...] the tablets had been moved [...] he'd actually moved them"* (Therapist, 109-110). Sandra follows the therapist's lead and continues to challenge Carly's positioning of Brian; "*He just doesn't let you know that he's paying attention to it*" (Sandra, 105). Carly doubts this account of Brian's attentive actions, instead positioning her mother as the one who is both concerned and protective of her and her father; "*[To mum] I think you actually told him to move them [...] It's kind of a coincidence how she had said it and then they disappeared the next day*" (Carly, 116).

Carly goes on to discuss her relationship with her father in a negative way as she likens it to that of the Simpsons characters 'Homer and Lisa' who have different personalities and a conflicted relationship; "*They don't really click... just clash*". Carly continues to position her father as inattentive; "*I don't really think he thinks about what goes through my mind and what's going on in my mind*" (Carly, 123) and that his perception of her is negative; "*He probably just thinks I'm just a stroppy teenager*" (Carly, 124). In response, Sandra goes on to defend Carly suggesting agreement; "*Next time he starts you know sort of moaning about whatever you're doing... I'll say 'well at least she isn't doing what you were doing'.* Sandra then positions Brian as a rebellious teenager as she recollects misbehaviour in his adolescence; *"He was being a bad boy when he was your age"* (Sandra, 129-130). Sandra's defence suggests alignment with Carly. The positioning of Brian implies the sense of understanding and tolerance of disobedience in adolescence.

Storyline 6: Carly's developing relationship with her father Brian

As the session progresses, there is a shift in Carly's positioning of the father as she acknowledges recent developments in their relationship. Carly positions him as more available and attentive; *"I'm closer to my dad because like he'll come home and he'll talk to me"* (Carly, 264) suggests that she values her father's time and attention and the increased closeness of their relationship, even though he often talks about topics which are of no interest to her. *"Now we talk about bread which is like another step, (laughs). I don't even like bread but..."* (Carly, 275-276). Emphasising this change, Carly again positions her parents in contrast to one another as she states that Sandra is busy and unavailable *"but not really with my mum sorry [...] because you're working, I can't really talk to you whilst you're working"* (Carly, 264-266). Carly continues to talk of her growing relationship with her father as she discusses their shared interests, humour and potential to 'have a laugh' together; *"When we're on holiday I have a laugh with him [...]. It's good though because like me and my dad both like curry"* (Carly, 385). In contrast, Carly compares this to her relationship with Sandra who she mimics; *"But you're always like 'uurrgh, I don't like it'"*. At one point Carly directly positions her parents in opposition with one another stating directly to Sandra; *"I want to go to the gala with dad instead of you, no offence on you"* (Carly, 392-393). Despite positioning her relationship with Brian more positively than that with Sandra, as the session progresses Carly returns to acknowledge tension and ambivalence in her relationship with Brian. Carly re-positions Brian as an aggressor as she discusses her negative emotional response to his actions; *"If my dad shouts at me, that get's me angry, as well as upset [...]. I've never known a dad to shout at their daughter like that"* (Carly, 510-512).

Storyline 7: Contradictions within Carly and Sandra's relationship

The therapist recalls one of Carly's early hopes was for a closer relationship with her parents; *"One of your things at the start of therapy was wanting to be closer to your mum and dad"* (Therapist, 383-384). Similarly, Sandra indirectly indicates that she would like a closer relationship with Carly; *"You still don't talk to me about stuff that's bothering you"* (Sandra, 550). However, there appears to be a contradiction between Carly and Sandra's words and actions. Sandra expresses a desire to help her daughter whilst positioning Carly as resistant to receiving her support; *"I don't think you believe I can help [...] I'd like that to be different because then I can help you"* (Sandra, 556). Sandra positions herself as rejected by Carly in her attempts to be supportive. Prior to input from the RT, Sandra positions her relationship with Carly as close and caring at times as she describes being emotionally supportive and responsive to Carly's emotional distress in times of need, and the

humour they have shared at these times. "*We called back in and granny asked if you were ok, and by that point [...] you'd sort of been joking with me and stuff*" (Sandra, 503-505).

Carly initially attributes her lack of communication with Sandra to an aspect of her personality by positioning herself as un-communicative; "*I'm just not a talkative person*" (Carly, 551). However, Carly goes on to contradict this by positioning herself as communicative with her peers; "*I prefer to speak to someone my age, like Sarah [...] I prefer to talk to her [...] she's my age, so she understands*" (Carly, 557-560). Furthermore, Carly actively demonstrates her capacity to be articulate and engage in conversation as she talks at length about issues which she appears passionate about and interrupts the therapist on a number of occasions. On one occasion, the therapist struggles to interject and asks Carly for permission to re-engage with the conversation; "*Can I just share [...]. Can I just share something?*" (Therapist, 528-583).

Storyline 8: Sandra's busy work life

Despite Sandra's indication that she wants to be available and supportive, Carly suggests that Sandra's capacity to respond to her needs is compromised by her busy work-life; "*It winds me up sometimes when I'm trying to talk to you whilst you're working*" (592-593). Carly positions Sandra as pre-occupied, distant and unavailable by suggesting that her work and the time she spends on her laptop are preventing them from having meaningful conversations; "*I know your full concentration is not on me [...] I don't like speaking to you when you're behind your laptop*" (Carly, 571). Carly emphasises the laptop being a barrier to their communication; "'*Cause I feel like, physically as well, I can see her, but [...] it's a distraction*" (Carly, 594-595).

Carly's self-positioning in her relationship with Sandra appears to parallel Sandra's self-positioning in her relationship with Carly as they both indicate a sense of rejection. Carly links this rejection to feelings of anger and frustration; "*that's another thing, if you don't understand me then it winds me up*" (Carly, 599). In response, Sandra draws upon and identifies with her work-role as a personal assistant to position herself as somebody who is able to multi-task to suggest that she is able to attend to Carly even though she is working on other tasks; "*My full concentration probably isn't [on you], but I can multi-task really quite well because I am a PA and that is what I do*" (Sandra, 594-595). By choosing to refer to her working role in this way, at this time, Sandra appears somewhat defensive in response to Carly's statements and dismissive of her expressed emotional needs. Sandra also appears to be communicating that she is 'too busy' to attend to her

daughters needs thus inferring a position of Carly being less important than her work. Sandra seems to deflect Carly's claims by changing the focus of the discussion to Carly's temperament. This shift in conversational focus begins to develop a position of Carly as short-tempered and unreasonable; *"You do get yeah, quite snappy on that because she will say something, and I don't understand what she's said"* (Sandra, 600-601). Sandra's positioning of Carly shifts across the pre-RT discussion from considering her as developing an increased level of control over her emotions to later re-positioning her as short tempered and unreasonable.

Input from the therapy team with family two

The therapist invited the RT into the therapy room whilst conversations with the family were still underway. The family and therapist continued to engage in a discussion as the RT entered the room from behind the one-way mirror. The therapist also made reference to 'time marching on' which gave the impression that they were short of time. The therapist briefly introduced the RT and offered paper and pens to the family to take notes. The RT then went on to begin their reflections in the presence of the family members who observed the RT discussions. Both RT members demonstrated agreement with one another by use of verbal and non-verbal gestures throughout their reflections. The male RT member briefly introduced the RT by stating that they had had some thoughts; his reference to the plural 'we' suggested a common stance from the two RT members. Similarly, the female RT member referred to the plural 'us' at the opening of her contributions which gave a sense of the RT continuing from this common, shared position. Both RT members continued to refer to the plural 'we' throughout their reflections and only on occasion made reference to the singular 'I' such as the statement; "I wonder will that really change" (738-739). The RT maintained a professional demeanour and shared subtle humor in their reflections with the family which appeared to facilitate and strengthen the therapeutic alliance. This appeared to enable a more challenging approach with the RT questioning family interactional patterns and emphasising the benefits of further change. For instance, the RT acknowledged ongoing risks and made advisory statements regarding the parent-child relationships not being as secure and protective as they felt they could be.

Intervention from the reflecting team

Similar to family one, I will present the RT's reference to the family storylines before providing details of the main discursive strategies. The RT interlinks aspects of storylines which relate to

Carly's developing self-awareness, Carly's hopes and aspirations for her future, Carly's feelings of loneliness. These storylines will therefore be presented together.

Reference to storyline 2: Carly's exclusion from education

The RT appear to build upon storyline three, 'Carly's hopes and aspirations for her future' and they do not make any reference to 'education' in effect closing down any further discussion of this storyline. No further details of Carly's exclusion from education are therefore presented here.

Reference to storylines 1, 3 and 4:
Carly's developing self-awareness, Carly's hopes and aspirations for her future, Carly's feelings of loneliness

The RT appear to build upon Carly's developing self-awareness and highlight a sense of personal agency which began to emerge in the pre RT discussions as they do not refer to her prior sense of powerlessness but instead focus their attention on her potential, opportunities and choices for a more prosperous future. By making only brief reference to the storylines of loneliness, aspirations and self-awareness whilst also highlighting the positive progress that Carly has made, the RT reframe these storylines to reflect positive change which reflects maturation, independence and an ability to manage herself. The RT's reference to these storylines creates a sense of development and change over time in recognition of Carly's progress. The RT suggest that Carly is changing on the 'inside' implying a sense of personal development associated with her being more mature, independent, accepting and able to manage her emotions. *"There's something about Carly changing (…) there is something inside her that I have heard that she is becoming different around aloneness, and some of that's about her maturing and growing up and managing herself differently, some of that's about perhaps being happier and to be independent and on her own and sometimes it's still aloneness"* (Therapist, 792-800). The RT recognise Carly's ongoing sense of loneliness, which, if considered within the context of her past self-harming behaviour, highlights a small but ongoing risk of self-harm, despite the positive progress she has made.

Further building on the storyline of Carly's developing self-awareness, the RT positively reframe the storyline of Carly's feelings of loneliness by suggesting that she is developing a greater sense and acceptance of herself as an independent individual. This is apparent as the RT highlight the ways she has begun to manage her emotions independently; *"There is something different in her, I think she can take herself off and go for a walk rather than get angry and shout too much"* (801-

801). Appearing to reinforce this point further, the RT acknowledge that Carly has begun to enjoy time alone; *"she can go to her room and perhaps not be at risk but just happy to be on her own sometimes"* (802-803). Here the RT positions Carly as a young adult who is changing and maturing into a better-managed, independent individual who may be at a reduced risk of self-harm. They also open up the possibility of exploring this change and development further with Carly to reinforce and further facilitate these changes; *"And I'm wondering if there is something changing inside of her, and what it is that's changing, so that we notice that with her"* (803-804). The RT then suggest the need to support Carly's developing independence whilst also acknowledging the importance of her parents continued involvement; *"encourage that side of her independence in being happier to be herself but not losing site of how important it is for mum and dad to be there"* (804-805).

Reference to storylines 5, 6 and 8:

Carly's conflicted and competing relationships with her parents, Carly's developing relationship with Brian and Sandra's busy work life

The RT begin their reflections by identifying key topics that stood out to them from the pre RT dialogue; *"One of the things that stood out to us was the idea about conversation and the idea about being listened to and heard"* (707-708). This statement positively reframes the storyline of 'Carly's feelings of loneliness' to a storyline which captures the importance of communication, conversation and being listened to and heard. In reframing the storyline, the RT acknowledges whilst also brining challenge to her position as invisible, rejected and her sense of being isolated and ignored. The RT also tentatively suggests communication as an area for potential change. The RT incorporates the storyline of 'Carly's developing relationship with her father' Brian here which highlights the importance of communication as a key aspect of this change. *"Carly's need for a chance to talk, and that sounds fantastic that with dad it's developing* […] *and they're going to talk lots about* […] *all the things I like talking about"* (709-711). By comparing and contrasting the relationships Carly has with her two parents, as Carly did, the RT are able to emphasise the barriers to Sandra and Carly's relationship as potential areas for change.

The RT go on to discuss Sandra's busy work life; *"Then we heard about Sandra and Carly and the fact that this laptop! And the work! It seems to be in the middle all of the time and is in the way"* (RT, 712-714). By clearly emphasising the words 'laptop' and 'work' with a slower pace, higher pitch and slightly more pressured tone, the RT emphasise that these factors are both clear barriers

to their relationship. The RT also highlights an unhealthy work ethos created by Sandra's boss and the likelihood that this brings a pressure and expectation for her to overwork. "*And it might be quite... a challenge for Sandra too, […] when you work with someone who is clearly overworking a lot of the time, 'cause we have heard about how her boss has been off for six weeks rest, and if you're working for that type of boss then the chances are you're expected to be like them*" (758-761). By acknowledging that 'overworking' has been detrimental to her boss's health, the RT are make a direct suggestion to Sandra that she establish a boundary by asserting her needs and setting a limit with her boss as to the amount of work that she takes on; *"And actually as a worker, you have to sometimes put your hands up and say I can't do it anymore"* (RT, 762-763).

The RT seem to shift between taking a position which is non-threatening and collaborative to a more expert advisory position as they continue to acknowledge the difficulty of the tasks faced by Sandra whilst also making suggestions and offering to help consider ways in which she can establish the boundary at work. These suggestions are framed to be of benefit to Sandra in terms of her relationship with Carly and also in achieving a healthier balance in her life. *"How strong do you have to be to be able to do that? […] Maybe we can help her think that through. If she wanted to spend more time with Carly then how possible is it for her in those circumstances? What would she say to the boss? What would she say about work, how would she change the priorities a bit, or change the balance of life a bit?"* (766-769). The RT's suggestions are concluded, supported and softened by empathic acknowledgement of how difficult these negotiations can be; "*Sometimes it can be really difficult*" (769).

As therapy nears the end, the RT make reference to the stage of therapy and the possibility of further important changes; "*It's good that we've got another possibility of a few more times because some really important stuff happens at the last bit of the work*" (785-786). However, the RT continue to discuss their reflections with concern towards the likelihood of change as they point out that Sandra's work and communication with Carly is a recurring issue; "*I'm aware you know that this has come up before […] because this is us coming towards the end of therapy, I wonder, will that really change?*" (737-739). The RT re-emphasise the importance of this issue and stress the need for Sandra to take responsibility and make this change; "*That's maybe down to Sandra to let us know or help us understand if we should still be quite worried about that, erm, or whether it is genuinely something that's going to shift between her and Carly*" (739-741).

Reflecting team's reference to storyline 7: Contradictions within Carly and Sandra's relationship

The RT make only brief reference to pre RT topics and it seems that they intentionally shift the focus of the discussion to the relationship between Carly and Sandra; *"I wonder whether it's easier in these sessions for Carly and Sandra to talk about some things that are outside of their relationship"* (730-731). The RT acknowledge that talking about their relationship may be difficult; *"I wonder if what's happened between them is actually... really quite hard..."; whilst the RT* also stress the importance of relationships; *"But we're bothered about it because it's a very central protective factor"* (733-735). Subsequently the RT focuses the majority of their reflections on the relationship between Carly and her parents, particularly her mother.

Picking up on Sandra and Carly's expressed desire for an improvement in their relationship, the RT draw attention to their different communication styles; *"And when therapist was saying she's noticed that Carly is someone who does talking with eye contact, I wondered about Sandra, what it would be like for her, is she someone who communicates in a slightly different way"* (752-754). The RT also speculate as to whether Sandra could be more engaged in her communication with Carly; *"Is she comfortable with that kind of putting aside those things"* (754-755) and the importance of making time for Carly; *"When does mum put the laptop down […] and come say 'Carly we're off to do something' or 'let's talk"* (719-720). This statement seeks to find exceptions to Carly's discourse of 'feeling ignored'. The other RT member re-emphasises the importance of communication with parents as a common protective factor against self-harming behaviour; *"For us that's not a casual wondering, because relationships with parents […] really builds the protective side"* (723-728).

The RT draw attention to the contradiction in Carly's response to Sandra; *"Carly says 'I don't talk to you because erm, I'd rather talk to other people'...and then she says 'I don't like talking'"* (742-743). The RT subsequently reframe the storyline of contradictions within Carly and Sandra's relationship by positioning them as having a 'lovely relationship' whilst acknowledging that it could be more 'open'; *"And there's obviously a lovely relationship there but it feels like it's not open, enough at the minute"* (747-748). The RT then go on to state their concerns regarding Carly not being safe and protected in the relationship to highlight why there is a need for change; *"For Carly to be as safe as we would like her to feel safe... or not as protected or as close to mum as maybe she needs to be"* (748-751). Before moving on to reflect on another issue, the RT emphasise Carly's relationships with her parents as a key target for change and future progress; *"We didn't want to*

take away from the importance of the relationship with mum and dad, because […] that's probably perhaps the most important thing at this point" (793-795).

Discursive strategies utilised by the reflecting team

1. **Acknowledging change and promoting personal agency**

   The RT suggests that Carly is changing on the 'inside' *"There is something different in her"* (797) which implies a sense of personal development associated with her being more mature, independent, able to manage and accept her emotions. The RT also reframe the storyline 'Carly's feelings of loneliness' by suggesting that Carly is developing a greater sense and acceptance of herself as an independent individual "*being happier and to be independent and on her own*" (799).

2. **Taking an expert position regarding areas of continuing concern**

   Expanding on the initial agenda set by the therapist, the RT prioritised the focus of the remaining therapy sessions by identifying key areas for change and expressing concern regarding areas of ongoing risk. This was particularly evident when the RT emphasise Carly's relationships with her parents as a key target for change and future progress. The RT express concern regarding risk and the relationship between Sandra and Carly in which change does not appear to be have been made to highlight this as an area of need; "*That's maybe down to Sandra to let us know or help us understand if we should still be quite worried about that, erm, or whether it is genuinely something that's going to shift between her and Carly*" (RT, 739-741). The RT's suggestions are only tentative; however, they take a more expert position in response to an area of perceived need for change: *"Maybe we can help her think that through. If she wanted to spend more time with Carly then how possible is it for her in those circumstances? What would she say to the boss? What would she say about work, how would she change the priorities a bit, or change the balance of life a bit?"* (766-769). Th questioning response from the RT appears to facilitate reflection with regards to the ways in which change can be achieved.

3. **Taking a non-threatening, collaborative position and use of pronouns**

   The RT take a non-threatening position by empathising, normalising, validating, acknowledging and understanding the family members' perspectives and dilemmas. For example, the RT demonstrates empathy and understanding in relation to Sandra's hectic

work schedule; "*And it must be really hard working from home*" (714-715). This strategy appears to facilitate the therapeutic alliance. The RT's suggestions are also softened as they provide empathy, validation and acknowledgement of how difficult Sandra's negotiations with her employer may be; "*Sometimes it can be really difficult*" (RT, 769). The RT also work collaboratively with the family to identify areas for potential change: "*Maybe we can help her think that through*" (766). By use of the plural 'we', the RT position all members of the therapy team and family together collectively in unity. They also appear to create a sense of safety by positioning the relationship between the RT and the family positively which suggests a level of trust and collaboration; "*They've had a good relationship with us as a team haven't they?*" (773-774).

4. **Encouraging alternative explanations and exceptions**

   The RT ask questions to encourage exceptions to the status quo, for example, challenging Carly's perception of 'feeling ignored' the RT ask: "When does mum put the laptop *down and come say 'Carly we're off to do something' or 'let's talk'*" (719-720). The RT also encourages further discussion regarding Sandra's work demands and her consideration or attempts to negotiate her work load with her boss; "*And how easy is it for Sandra to do that to her boss, erm... or not*?" (764-765).

5. **Modelling effective interpersonal skills and open communication**

   This overlaps with taking a non-threatening collaborative positions and the use of generic therapeutic skills. The RT model effective interpersonal skills such as attentive listening and demonstrating authenticity by use of open reflections which acknowledge tensions, difficulties and dilemmas. For example, following discussions of Carly and Sandra's relationship, the RT acknowledge that they are raising tricky issues and openly consider how Carly and Sandra may be experiencing hearing these reflections; "*I wonder what it's like for Carly and Sandra for... me to say that I'm a bit worried and say this kind of thing […]. I don't know how much they like straight talk*" (RT, 770-773). Following this, the RT offers Carly and Sandra an opportunity to respond to their reflections; "*We can hear back*" (773). Whilst not typically of RT practice, Carly responds directly to the RT to indicate that she would like them to be honest and direct; "*As straight as possible*" (Carly, 775). The RT agreed that it is important for them to be open, honest and direct "*Yeah I think it is really important isn't it that we are that straight*" (RT, 780).

Family Two: Analysis of post reflecting team dialogue

During the post RT discussions, the therapist engages in a long monologue which summarises and emphasises the messages relayed by the RT including relationships with parents as a central protective factor: "*A massive protective factor we see is when young people can talk or be closer to their parents in ways that maybe they haven't done before*" (Therapist, 920-921).

Storyline 1: Carly's progress

There does not appear to be a distinct reference to Carly's developing self-awareness in the post RT discussion. The therapist makes only brief reference to Carly's progress at the end of the session as by discussing the strategies Carly has implemented; "*So going for a walk when you're feeling angry, karting has improved it etc.*" (Therapist, 918). This summary appears to capture the progress that Carly has made independently. The therapist subsequently focuses on Carly and Sandra's relationship as an area for further improvement.

Storyline 2: Carly's exclusion from education

The RT's lack of attention or reference to Carly's exclusion from school appears to have thinned this storyline as Carly refers only briefly from a marginalised and excluded position as she returns to the topic of education; "*the other day I went up to school […] and they were like no, no you can't be in here, you can't be in school*" (Carly, 1016-1018). However, the Therapist follows this up and offers a letter of concern to take to the Education Department; "*One thing I did do, but I don't think you'll need it now is, I did write a letter about education*" (Therapist, 1079-1080). The therapist's action emphasises the importance of this issue to validate Carly's experience and address the families concern.

Storyline 3: Spending time together as a family

Following the RT, there is a further shift in the mother-daughter dynamic as Sandra positions herself as a caring and concerned parent as she recounts a time when she expressed concern and protection which was not understood or accepted by Carly; "*She's wandering around the street*" (Sandra, 951). "*You didn't understand why I was, why it bothered me*" (Sandra, 956). In response, Carly states that she was not "*wandering around, I went straight there and straight back*" (Carly, 952). Sandra's positioning of herself as caring and concerned is in contrast to Carly's prior positioning of her mother as unavailable and their relationship as distant. Following this the therapist draws attention to the opportunity

and importance of Carly and Sandra spending time together and improving their communication to enable mutual understanding; "*So there's something about listening and understanding from each other's point of view isn't there, and seeing that grow more and that communication more*" (Therapist, 957-958).

By use of the plural 'we', Carly shifts from referring to her relationships with her parents as individual, separate and distinct to discuss the family as a whole in the post RT discussions. She also considers activities that the family enjoy collectively as opposed to her prior discussions about things that only she and her father shared an interest in; "*We all like motorsport it was something that we all enjoyed, it's not like when we were talking about going out before... we went out somewhere and only one person liked it*" (Carly, 966-968). Building on the RT's recommendations, in the post RT discussions, Carly directly states that she enjoys spending time with the family, even though she found the outing itself un-entertaining; "*And why I'm so excited is because we never really spend any time together and go out [...] I like going out... it's like when we went to Blackpool, it were quite nice and even though it was really boring*" (Carly, 957-960). Sandra reflects back that the family did previously make a plan to spend more time together but had not followed this through.

Storyline 4: Considering barriers to communication

Reviewing the session, the therapist encourages Sandra to reflect on what she has learnt with specific reference to her relationship with work; "*What have you taken from today? Or what have you taken from thinking about your relationship with, in the business?*" (Therapist, 1047-1049). The therapist's statement and choice of words appears to build on the RT's drawing together of the concepts 'work' and 'relationships'. Sandra positions herself as being open to change as she builds on the RT's suggestion of 'putting the laptop down'; "*Sometimes I can you know shut my laptop and go and sit in the living room, but sometimes she's there and sometimes she's not [...] So I don't know, I don't think, I can't plan because everything is too random but, I don't know, I can be more aware*" (Sandra, 1055-1056). To encourage further dialogue about the issue, the therapist questions Sandra; "*More aware?*" (Therapist, 1075). Sandra responds by considering how she and Carly can remove the barriers to their communication indicating that she is motivated to change by giving more priority to their relationship; "*Of me sitting there behind my laptop [...]. Yeah if I shut my laptop then you have to put your phone down*" (Sandra, 1028-1067). However, as the session ends, Sandra refers back to her positioning as a competent multi-tasker, suggesting that

she was able to follow the conversation whilst inputting the details of their next appointment into her electronic diary. "*See I was doing that then but I was taking in everything that was being said*" (Sandra, 1134). This statement implies that there may be some ambivalence or resistance to change as Sandra disregards the importance of eye-contact during conversation. In doing so, Sandra indirectly minimises the potential for laptops and work to be barriers to communication and detrimental to her relationship with Carly. This could be seen as dismissing Carly's feelings of being ignored thus reinforcing her prior position as being overlooked.

Storyline 5: Carly not feeling connected enough

Carly's pre RT storyline regarding feelings of loneliness and isolation appears to be positively reframed to reflect Carly's feelings that she is not connected enough to her parents. Carly states clearly that she likes her parents to show an interest in the things that she does. Positioning Brian as attentive and interested; "*One thing I like is when you and dad take an interest in my bikes. It's like I was really pleased when dad actually wanted to watch my videos*" (Carly, 1033-1034). Carly contrast her father's interests with her Grandma's lack of interest and attention; "*Grandma, she were watching (demonstrates grandma not looking at phone) and it I was like noooo!*" (Carly, 1041-1042). Here Carly appears to have shifted from her prior position of being ignored to being deprived as she discusses her desire for attention from her family. However, despite the shift in Carly's positioning, as the session ends, Carly suggests that the appointment time offered by the therapist is not suitable; "*I won't have woke up... I had three and a half hours sleep...*" (Carly, 1112) and she is ignored by both Sandra and the therapist. This potentially reinforces Carly's pre RT position of being overlooked and ignored which could negate some of the progress hitherto achieved in the session.

Storyline 6: Negotiating Sandra's work-life balance

Carly picks up on the RT's discussion of a lack of boundaries between Sandra's work and home life to position her as hardworking; "*You do do a lot of work, it's like you sit at your desk and you don't sit there from nine to five you'll sit there from like half-seven till like half-nine at night […] you should get a pay rise*" (Carly, 854-862). In response, Sandra positions herself as somebody who has a strong work ethic and is a committed and dedicated worker; "*It's in my nature, the way I am that I commit myself to my job*" (Sandra, 863). Sandra goes on to consider the conflict between managing the demands of work and family life "*Yeah but I don't want it to be detrimental of Carly*" (Sandra, 890). Appearing to respond to the RT's reference to work-life balance, Sandra indicates

the need for greater balance between meeting the needs of her employer and her daughter; *"I've got to find a balance"* (Sandra, 890). There appears to be a transitional recognition of the tension between Sandra's positions as a dedicated worker and a concerned parent. However, Sandra goes on to suggest that she is willing and able to drop her work commitments and can be responsive and prioritise Carly's needs if required; *"I don't mind giving that commitment because I know, I could say to my boss, I need tomorrow to spend the day with Carly and she would not bat an eyelid"* (Sandra, 867-869). In response, Carly demonstrates mutual support for Sandra, positioning them both as co-workers who have mutually benefitted from their shared employment opportunities.

Extract (lines 884-888):

> Carly: *"I am glad, I am glad that 'our' boss. [Mum & Carly laugh]*
>
> Therapist: *So that's your joke that he's your boss as well.*
>
> Sandra: *She always says it's our boss".*

There appears to be a tension between Sandra's positions as a mother and an employee. Sandra subsequently suggests that she does not want to change her working arrangements and links her work to family life by positioning the job as being in the best interests of the whole family; *"I do still want to still do that because this job is very, very important to all of us"* (Sandra, 890-891). Although Carly doesn't directly discuss her ambitions as she did in the pre RT discussions, Carly supports Sandra's account by positioning the work as beneficial for her needs; *"It's helped me a lot as well, it's not just [...] financially but it's helped me psychologically because when she gave me that job of writing it helped me, actually educationally because I'm learning a lot"* (Carly, 892-894).

Reflections on the analysis of family two

In the pre RT discussion, Carly positions herself as less irritable and more self-reflective as she describes being somebody who is considerably more able to manage her emotions and behavioural responses in comparison to the past. Carly initially positions herself as powerless and marginalised as a consequence of a faulty education system. This position appears to be transformed across the pre RT discussions as a further storyline emerges in which Carly positions herself as mature and self-motivated. The progression of the discussion from Carly's exclusion from education to her hopes and aspirations for her future

suggests the emergence of a more positive narrative and identity with a sense of personal agency. Carly shifts from a position of powerlessness to potential with opportunities and choices for a more prosperous future. In addition to the recovery orientated discourse, family two's narrative also contained some problem focused narrative which reflected areas for further change and development, in particular, Carly's continued feelings of loneliness and isolation and the barriers to her relationship with Sandra.

The RT was responsive and active in highlighting ongoing areas of concern and risk. Throughout the therapy session, relationships with parents are discussed as a key priority for change in the family as communication with parents is seen to be a central protective factor against the risk of self-harm. Prior to input from the RT, Carly often talks with reference to tension and conflict in her relationships with her parents. However, the RT draws and builds upon the positive aspects of Carly's relationships with her parents whilst also acknowledging the need for change. The therapist builds on Carly and Sandra's expressed desire to spend more time together and frames this in terms of developing their relationship which is followed up by the RT. Over the duration of therapy, Carly's desire for an improved relationship with her mother appears to have been explored by intervention from both the therapist and the RT which enabled a shift in their dialogue. This shift in dialogue suggests that Carly and Sandra have identified obstacles and differences in their relationship and are now considering shared interests and activities that they can do together. The RT input encourages Sandra to consider being more aware of her interactions with Carly and the things that can come between them and their developing relationship. This may result in her being heard and more effectively supported and protected as a result.

From the pre RT to post RT discussions, Carly appeared to shift from her prior position of being ignored to being unconnected as she discusses her desire for attention from her family. This shift in the conversation enables consideration of how family members respond to Carly and there is potential here for Sandra to adapt to Carly's expressed need. However, as the session ends, Carly suggests that the offered appointment is not a suitable time for her and her comments and concerns are not responded to or acknowledged. It is possible that the pressures of time and modern living have impacted on the therapists interactions. This act may appear subtle, nevertheless, as Sandra's preferences appear to be prioritised, this may communicate to Carly that her opinions and preferences are not as important as

those of the adults in the room. This observation appears particularly important here as Sandra's work commitments and the potential for this to compromise her ability to be responsive to Carly's needs was the key focus of this session.

A representation of the family meaning system is presented in figure 8. This includes the key positions and constructs negotiated in family two's pre to post RT dialogue. The family meaning system shifted from positions representative of insignificance and disconnection to being valued and connected.
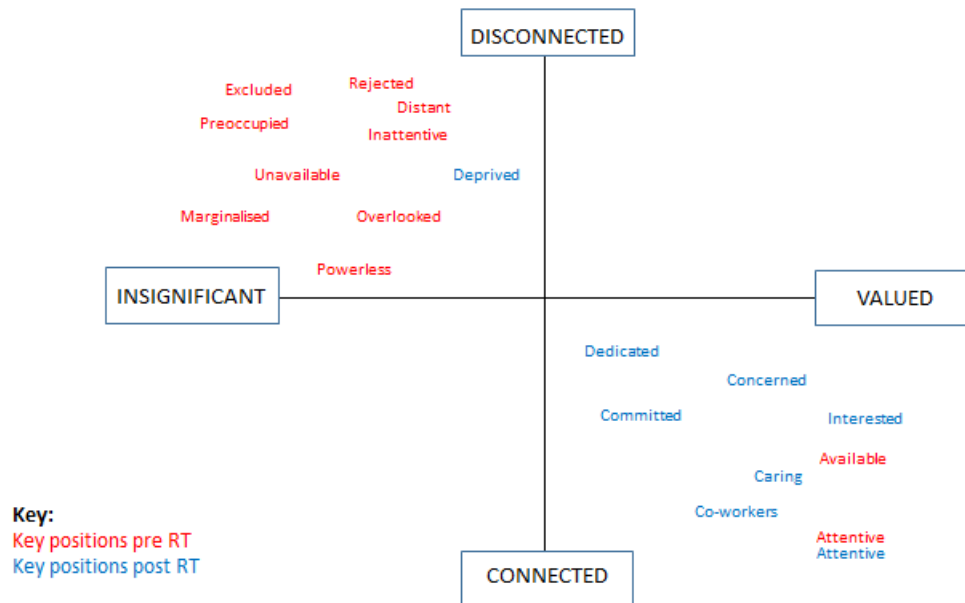

Figure 8: Case Two - Representation of family meaning system

Case Three

Pen portrait

The therapy session selected for inclusion in the current study from family three was the third of seven sessions. As this session was at the middle-phase of therapy, the format of the session was focused on reviewing progress in therapy to date, and enabling the negotiation of future therapeutic aims. Throughout the session the therapist and family made reference to a therapeutic letter which had been sent to the family following the prior session. As a result of including and reflecting on the therapeutic letter in the session, there was an observable difference in the content and flow of the therapeutic conversations prior to the RT in comparison to case one and two.

The selected session was attended by 15 year old Kia the index patient, her twin sister Vanya, her elder sister Elana, their mother Rena and father Alam. The second eldest sibling Nisha did not attend the current session due to her imminent A Level examinations. Session three was the only session from family three which adequately met the inclusion criteria. This was due to either there being no RT involvement, insufficient reflection time post the RT or family members leaving the room to observe the session from behind the one-way mirror. Kia was living at home with her two parents and her three siblings. At the time, she was also revising for her GCSEs, as was her twin sister Vanya. The GCSEs were due to begin the day after the therapy session being observed. During the session, the family indicated that it was a stressful time for everyone as three of its members were preparing for examinations. There also appeared to be distinct differences in the way in which family members referred to each of the twins. Favouritism within the wider family was discussed directly. However, there appeared to be an unacknowledged comparison of the twins and sense of favouritism within the immediate family which was subtle but ongoing during the pre RT discussions.

During the session Kia appeared engaged, open and reflective as she listened to comments made by the therapist and family members and provided thoughtful and detailed responses. Kia reflected on the emotional aspects of her friendships, her position in the twin dynamic, and recent life events. This included Kia feeling that she did not know who her real friends were and seeming to believe that Vanya was the more confident and popular twin. Kia also expressed a sense of sadness and loss as she reflected that it had been her last official day at school in the week prior to

105

the session. The majority of the initial therapy discussions revolved around the reason for the family being referred to therapy and Kia's progress to date. Kia therefore contributed to these discussions more than her siblings. The family reflected that they had recently heard a lot more from Kia in comparison to the past when she was described as typically shy and reserved. The description of Kia being shy was consistent with observations of her physical demeanour within the room. She appeared self-conscious at times as she folded her arms in front of her chest or held her hand up to her face as though providing a barrier or sense of self comfort.

Rena reflected that she was pleased and proud that Kia was able to talk openly with the family. Similar to Kia, Rena contributed significantly to the therapeutic discussions and was most often the first family member to respond to the therapist's questions or comments. Rena seemed to take a leading role on behalf of her children and family during the session. This was emphasised by Alam's suggestion that Rena took a leading position in relation to parenting tasks within the family. Rena indicated that the previous therapy session had been emotionally difficult for her and she had felt tearful after the session. She also stated that it had taken her some time to process what Kia had discussed in the previous session, but appeared keen to reflect upon and further discuss these issues as a family.

Family three appeared to be well established within British society. However, in comparison to the other families, there were more traditional gendered family positions within family three which may have been influenced by Indian cultural norms. During the therapy session Alam appeared to take more of an observing and listening role as though protecting his personal privacy or the parental sub-system. Alam stated that 'there are certain things they don't need to know' in reference to his children. He also suggested that Rena had a leading role in parenting and disciplining the children as he stated 'as a mother' it was her 'duty' to be more active in parenting. Nevertheless, Alam also made some noteworthy contributions to the therapeutic discussions as he shared personal and sensitive information about his health status and ongoing struggle with alcohol use. Alam's contributions were helpful in shifting the focus of therapy from Kia's self-harming behaviour to consider wider family problems, events and dynamics.

Vanya contributed to discussions about the family dynamics and her position in the twin relationship. She maintained a confident presence within the room in terms of her contribution to therapeutic discussions, her position in relation to Kia, and her demeanour which was relaxed and

open. Vanya suggested that she experienced an additional pressure to support and include Kia in establishing herself and maintaining relationships with peers in school and also in anticipation of their future transitions to college. In response, Kia suggests that at times she has found Vanya embarrassing and positions her as overly confident. There appears to be an underlying tension and conflict within Kia and Vanya's relationship and their positions within peer and family relationships.

This therapy session was the first to be attended by Elana. She initially appeared to wait until other family members had spoken before becoming involved in the discussions. At separate times throughout the session, Elana adopted a philosophical position as she reflected on the emotional responses, behaviours and interactions between family members. As the session progressed she made some reference to historical personal problems experienced in her teenage years. Elana was open in discussing past feelings she experienced in response to perceived favouritism and differential treatment between her siblings which enabled the family discussions to become more inclusive and focused upon their interactional dynamics.

At the beginning of the session, the male RT member entered the therapy room to introduce himself to the family. He acknowledged that it was the first time he had met Elana with this being her first time attending family therapy. Key events and topics discussed by family three included the therapeutic letter, the twins' upcoming GCSEs, Nisha's A Levels, recent family weddings and an upcoming family gathering.

Family three: Analysis of pre reflecting team dialogue
Six storylines were identified in the pre RT discussion which included Kia "going with the flow", Vanya and Kia's differences and Kia's ongoing sense of rejection, favouritism within the extended family, Kia and Alam's hidden emotions, Alam's erratic alcohol use and the family's loss of emotional support. A further storyline highlighting the family's resourcefulness also began to emerge with input from the therapist. As with cases one and two, I will address each storyline in turn before outlining the RT intervention and post RT storylines.

Storyline 1: Kia "going with the flow"
Initially, reflecting on the therapeutic letter, Kia states that she found it helpful to read about her life in some "*sort of order*". She also positions herself as being uncertain of her identity; "*well I*

don't even know who I am" (Kia). Over the course of the pre RT discussion, Kia is positioned by herself and her family members as somebody who is recovering and coping much better as they infer that she is less stressed, more sociable, capable and emotionally-regulated; *"She's definitely come on a lot [...]. She definitely shares a lot more. And I don't know, she just seems a little bit more relaxed that she was, she's not as tense as she was before* (Elana, 58-64). Kia agrees with Elana's statements and positions herself as more open and relaxed; *"I do like open up about a lot more now"* (Kia, 492). Alam and Kia emphasise the significance of Kia's ability to cope, positioning her as taking control and coping by pointing out that she is more relaxed in spite of her upcoming exams; *"I felt more relaxed for quite a bit now and even though my GCSEs have been coming, I've just been like well just go with it, go with the flow and it doesn't really matter..."* (Kia, 435-436).

Storyline 2: Vanya and Kia's differences and Kia's ongoing sense of rejection

Linked to storyline one, Kia is positioned as the more timid 'quiet and shy' sibling in comparison to her twin sister who is positioned as the more popular 'chatty and confident' of the two. Kia positions herself as rejected by referring to a mutual friend who only acknowledged her friendship with Vanya and disregarded her friendship with Kia; *"she gave her close friends presents and I'd thought she was considered as one of my best friends [...] and it was just Vanya that got stuff"* (Kia, 253-255). Mum, Rena and Kia continue to highlight Kia's rejection as they reflect on past sleepovers when the twins were young, and how Kia's friends "*would end up being Vanya's friends"* (Kia, 260). Rena goes on to suggest that Kia is no longer left out; "*I think that doesn't happen, because you all slept together in one room"* (Rena, 262). However, Kia suggests that she continues to be left out and rejected; *"No now it still happens"* (Kia, 263). Rena appears to downplay Kia's ongoing sense of rejection as she reflects on her perception of change in the twins' relationships with friends whilst also commenting on Vanya's more outgoing character; *"So it's sort of ironed itself out a little bit now, but you are more chatty (to Vanya)"* (Rena, 269). These comments seem to reinforce Kia's sense of rejection as she is further overlooked and compared to Vanya within the dynamics of the immediate family.

Storyline 3: Conflict and favouritism within the extended family

The topic of favouritism is discussed, however, this is within the context of the extended family and there is no direct acknowledgement of favouritism occurring within the immediate family. Rena positions the extended family as unjust as she refers to a long-standing problem of favouritism within the extended family; *"When you were both born, they used to call me and they*

would take Kia [...] I hated it because they would never take Vanya, and I'd say no if you want to come and babysit my children then you take both of them, and not one over the other" (Rena, 291-293). Kia also comments on the favouritism within the extended family and how this was previously related to Vanya being positioned as a nuisance, being too noisy and loud; "*Vanya kept getting told to shut up because she was very loud and so they always favouratised me"* (Kia, 229-230). Kia goes on to discuss feeling compared negatively to Vanya for being quieter; *"A lot of people at the wedding really liked Vanya and told mum and dad...that she was fun to be around [...]. And so, when it came to me, it was like - you're so quiet"* (Kia, 304 -306). On this occasion Rena positions the extended family as insensitive and immature in their favouritism and comparison of the twins; "*These people are in their twenties and thirties that are doing this and it's really sad [...]. I just think, you've got your own families, you've got your own lives, surely you should be beyond this type of rubbish"* (Rena, 308-310). Alam acknowledges favouritism within his family as being common place; *"they always have their flavour of the week... There's always somebody who is better that the other"* (327-328).

Rena and Alam go on to minimise the impact of the extended family's perceptions by positioning them as distant and unimportant; "*We don't see a lot of them"* (330). They go on to discuss an upcoming family gathering which they feel duty bound to attend. In doing so they position Alam's side of the family as less favourable and more demanding in comparison to Rena's family; *"My family totally understands it, they were like, they can come to the next family wedding it's not a big deal, But then with Alam's family that doesn't cut it, it doesn't matter if you've got exams"* (Rena, 333-336). Kia goes on to compare the paternal and maternal sides of the family. As she discusses issues of conflict and rivalry within the extended family, she positions her cousin unfavourably; *"If my cousins there, it's a bit awkward because none of us particularly like her"* (Kia, 339-340). Kia also refers to a sense of inclusion and acceptance from her maternal family; *"It's a lot more relaxed because they don't single us out as much"* (Kia, 365-366).

Storyline 4: Kia and Alam's hidden emotions

Generally, the family position themselves as more open, recognising that they are all sharing more with one another, keeping less 'inside' and subsequently being more understanding of one another and their individual ways of expressing their emotions. Reflecting on the therapeutic letter, Rena indicates that the family are generally more open but that Kia and Alam are more likely to keep their emotions hidden. Here Rena describes Kia and Alam as having similar

personalities and positions them both as emotionally guarded; *"even though we are talking a lot more...some of us, probably you two the most [gesturing to Kia and Alam] are... still keeping a lot of stuff still inside"* (Rena, 104-106). Elana suggests that Alam and Kia have similar personalities as they are positioned as being more reactive in comparison to other family members and more likely to become angry than they are to expose their vulnerability; *"When Nanni died and Kia didn't want to talk to anyone about it... and Kia didn't cry"* (Elana, 120-121). Elana compares this to Alam; *"And even dad like doesn't cry about anything he just gets angry and they both are really similar. Like you'll tell them something, ...and you'll get emotional and they just get angry"* (Elana, 124-126).

A shift in Alam's positioning is suggested over the course of the pre RT discussions as Alam demonstrates a more open position and goes on to discuss his emotional experiences. Alam positions himself as initially shocked and angry during therapy as he describes being 'thrown in at the deep end' as he found the discussions 'a shock to the system'. Alam also acknowledges that with this new awareness of what brought the family to therapy, he is now able to be more understanding; *"Now as I know why we are here, I can understand it better"* (Alam, 155-156).

Alam positions himself as more reflective and able to listen with empathy as opposed to being reactive and assuming a point of view as he states that he does not interrupt other family members when they are talking; *"now we know why we're here, we don't, if someone's having an argument or debate, nobody else jumps into it because that was a bad habit of mine, always saying and coming in straight away"* (Alam, 158-159). The storyline of Kia and Alam's hidden emotions appears to have developed as the session progresses to reflect more openness in the whole family. Following Alam's open expression of his emotions, he goes on to collectively position the whole family as more open and harmonious by use of the term 'we'; *"We are more open. But, we're not arguing as much, like we used to"* (Alam, 114). He also praises his daughter's for their openness; *"it's good that they're open"* (Alam, 522).

Storylines 5, 6 and 7: Alam's erratic alcohol use, the family's loss of emotional support and the family's resourcefulness
Prompted by the therapist, the family reflect on Alam's change of personality following alcohol misuse. Elana indicates that Alam does show his emotions at these times; *"sometimes he'll feel really sorry for himself so he gets really emotional when he's drunk"* (Elana, 556-557). Alam

positions himself in the process of recovery as he indicates that he is better but not always fully in control of his alcohol consumption; *"I've still got to keep an eye on my drinking [...]. It fluctuates"* (Alam, 531-534). Alam discusses work stressors and social pressures as factors which contribute to his use of alcohol; *"it's to do with the business and then it's an excuse to meet friends... then they start drinking and then you get to two, to three, to four, to five and then it's too many"* (Alam, 541-543). Alam also reflects on times when his drinking has been more restrained; *"But like at the wedding, I didn't drink hardly anything on the Friday"* (Alam, 543). However, Alam subsequently positions himself as powerless when in the presence of others who may be encouraging him to drink more; "*they forced some drinks down me*" (Alam, 546).

In contrast to Alam's position of helplessness, he subsequently positions himself as stubborn and able to control his alcohol intake; "*I was quite stubborn actually; when I make my mind up I just stopped things and just do it" (Alam, 594-595).* Rena positions herself as less tense when Alam is not drinking alcohol; *"I enjoyed the wedding and normally I sit there and I can feel my jaws clenched constantly"* (Rena, 596-597). She reflects on family shame and social acceptability regarding what she considers to be acceptable alcohol consumption; "*I don't want to be embarrassed [...] and yeah you got a bit tipsy... but then everybody was a bit tipsy"* (Rena,600-602).

A storyline of the family's loss of emotional support arises here as Elana suggests that Alam's prior excessive alcohol use was the result of multiple losses; *"His dad died and he lost a load of people, he lost a business, his best friend died and his mum died, he doesn't see his sister and his brothers don't speak to him"* (Elana, 609-611). The family position themselves at an emotional loss as they refer to their grandmother who recently passed away. Elana reflects on how this loss has impacted on the family by positioning their Grandma as having been attentive and reassuring; "*I do really miss her and stuff and I can understand why Kia felt that she was the only person listening because a lot of the time she was the only person paying attention"* (Elana, 374-376). Elana also reflects on how difficult it is to receive individual attention in the busy family; *"We're all so busy and because there's so many of us, it's difficult to get attention on your own"* (Elana, 376-377). Rena also acknowledges the significance of the family bereavement as she reflects on the loss of emotional support; "*It was a very important space and I don't think we really realised, erm, what we lost really, until now"* (Rena, 393-394). Rena also acknowledges the loss of her wider family support as she implies issues of religion, culture and ethnicity have divided her family; "*There's some stuff*

that's happened in my family. I have a sister who... is married to a white guy which is fine by me [...]. But it took away, I didn't realise it until we came here, that even the support of my sister had been taken away at a crucial time because of that" (Rena, 568 -572).

In contrast to the family storyline of a loss of emotional support, Kia positions her family as available and supportive in response to her various needs as she reflects on what she would go to each family member for; *"There's some things I'd go to dad for, there's some things I'd go to mum for and there's some things I'd go to Elana or Nisha about but I'd go to Vanya mainly because she's my twin and she probably won't say anything"* (Kia, 477-479). Building on Kia's statement, the therapist appears to facilitate the emergence of a new storyline by introducing the concept of 'resourcefulness' which positively reframes the storyline regarding the family's loss of emotional support to that of family resourcefulness; *"That's the beauty of having such a big family that you've got so many choices haven't you, you've got so many layers and there's something incredibly resourceful about it"* (Therapist, 480-481).

Input from the therapy team with family three

Prior to the RT entering the room, the therapist reviewed family progress and requested that the family 'pause' their discussions so that the RT could join the session. The therapist also directed the family to listen to what the RT said and suggested that the family members picked up on one thing that stood out for them from the reflections. As the RT entered the room from behind the one-way mirror, they directed the family to turn their chairs around to face them. Before the RT began, they introduced and described the process of the RT as a discussion between the two RT members and advised the family not to be 'offended' by this before they began their reflections. The RT's introduction was distinctly more directive and authoritative in comparison to their introduction with family's one and two. This may have been due to there being more family members in family three or a change in style in response to some aspect of the family dynamics or culture.

The RT reflected on the many topics discussed by the family and explicitly stated that they had selected certain topics to focus their reflections upon. There was no obvious use of humour observed from the RT as they talked in a matter of fact way which gave the impression of knowledge, competence and confidence whilst also making suggestion and speculation as to what things may be of most help for the family. The reflections were generally positive as the RT praised

the family members' progress and commented on how the family group had acknowledged their own progress together as a family. Both RT members indicated agreement with one another's perspectives as they often stated 'yes' throughout the other member's statements.

The RT suggested the possibility of reorganising the following therapy session by having the child sub-system talking together in the room with the parent subsystem observing behind the one-way mirror. The RT appeared to re-balance their expert, advisory position by indicating that their suggestions were ideas that the family could accept or decline. This opened up the potential for multiple perspectives to be considered. As the reflections neared the end, Kia and Elana looked to each other and began to laugh as though they were nervous or relieved in what appeared to be a response to the RT discussion or the session drawing to a close.

Reflecting team intervention

As with the previous two families, to begin I will present the RT's reference to family three's storylines before outlining the discursive strategies utilised by the RT.

Reference to storyline 1: Kia "going with the flow"

The RT pick up the positive progress made by Kia by reflecting on the changes observed by the family. These comments reinforce earlier statements that Kia is developing a stronger sense of herself as calm and competent. The RT acknowledging that Kia is much happier, more relaxed and chilled in the present in comparison to how she was in the past; "*There has been a really big change from Kia... in how she is... in herself. She is saying she feels a lot more relaxed and we're seeing that she is looking happier*" (RT, 699).

Reference to storylines 2 and 3: Vanya and Kia's differences and Kia's sense of rejection - favouritism within the extended family

The RT do not make any direct reference to Vanya and Kia's differences and Kia's sense of rejection or favouritism within the extended family seeming to close down the discussion of comparison and competition between family members.

Reference to Storyline 4: Kia and Alam's hidden emotions

The RT do not directly discuss Kia and Alam's hidden emotions or the family openness, awareness, and understanding. However, in the following extract, these storylines seem to be referred to

113

indirectly as the RT encourage further discussion regarding the family's struggles and the ongoing management of self-harm risk. This intervention from the RT suggests that they are attempting to uncover these hidden emotions. The RT also encourage further openness and understanding between family members by suggesting the possibility of the siblings talking together with the parents as observers*; "We had had an idea about... whether the girls would like a chance to talk together, maybe with parents listening"* (RT, 751-752). This is positively framed to identify and reinforce existing coping strategies and appears to work up the therapist initiated storyline of family resourcefulness by positioning the family as improved: "*That might be about telling each other about some of the struggles that they've had but also telling each other […] how they've helped each other [...] how they would like to carry on helping each other to move further away from those struggles and difficulties"* (RT 755-758).

Reference to Storyline 5: Alam's erratic alcohol use

The RT follows up on the therapist initiated discussion regarding the impact of alcohol on the rest of the family. However, the RT positively reframes Alam's alcohol use to reflect the progress that he has made and the positive impact his progress has had on Rena; "*she appreciates his decisions to drink less, or not to drink at all or have a few drinks but not too many*" (RT, 722-723). The RT's reference to this storyline is discussed further in discursive strategy 3 below.

Reference to Storyline 6: The family's loss of emotional support

The RT do not directly mention the family bereavement and loss of emotional support which leads to a discontinuation of this storyline. Instead the RT appear to focus their attention on the family's resilience and support of one another. The family's loss of emotional support is not discussed in the post RT discussions as it appears to have been reframed as the family being emotionally supportive and helpful towards one another (see discursive strategy 1 below).

Discursive strategies utilised by the reflecting team
1. Emphasising and reinforcing family strengths, progress and resilience

The RT recognise the many changes that have occurred within the family by acknowledging each individual achievement; "*We don't know where to start do we? Because there is something over here that's been really good [gestures at Dad] There's been something really good over here [gestures at Kia] there's a change that's gone on here and it's something else and something else*" (RT, 692-694). Likening the family interactions to a 'celebration', the RT collectively highlight the

positive changes to further strengthen the family relationships. The RT share specific observations to emphasise a positive change in Kia's emotional wellbeing: "*She is saying she feels a lot more relaxed and we're seeing that she is looking happier*" (RT, 700). The RT associate the change in Kia's sociability in the family within the wider context and the family dynamics, noting that as the family step back and give Kia some autonomy she is going to them for support "*instead of everybody going and saying 'what's going on? How are you? What's happening?'…They're backing off so Kia is then going to them and chatting*" (RT, 701-702). The RT also acknowledge that the family recognise their own progress by giving positive feedback to one another. This is particularly evident in relation to Kia's progress; "*The different ways the family are noticing those changes, and each of them at different times said how they were proud of her and how pleased they are and they could see how things had improved for Kia and they could see that she was happier …There's lots of evidence there of those changes*" (RT, 709-712). By further reinforcing the family's helpful strategies, the RT appear to suggest that the family have resources to continue making positive progress; "*this family seems to know ... if someone is doing some good changes and you notice them and comment on them then that's usually helpful*" (RT, 714-716).

2. **Collaboration: sharing ownership and minimising the power differential - use of pronouns**

The RT return to discuss the reason for the referral to family therapy and shift the focus of the discussions by positioning problems as a whole family problem as opposed to an individual problem located within Kia. "*So the reason was Kia, and the concerns about Kia, but then you found ... you realised it was problems with all of them*" (RT, 733-734). The RT go on to outline the family members individual problems before reframing these as 'whole family struggles'; "*Alam and Elana were all also struggling in different ways with the stresses of the last few years and having to manage those stresses. Through self-harming, or through eating struggles or the drinking for dad and the low mood and feeling a bit depressed for mum. So we realise as a whole family there have been these struggles*" (RT, 734-739). With reference to the 'whole family' and 'all' its members, the RT position the family collectively uniting them to overcome their problems together as a family. This is consistent with the traditional intentions of family therapy, moving away from seeing problems as individual psychopathology to consider more systemic issues such as family interactions and relationships.

The RT subsequently question the family about how changes have been made; this seems to be an attempt to shift the focus of discussions from Kia to open up further dialogue regarding other family members' struggles and progress; "*we do want to find out more about how they've changed*" (RT, 738-739). The RT also minimise the power differential by positioning the family as the experts regarding their problems and the organisation of therapy. Taking a non-threatening, collaborative position appears to facilitate shared ownership as the RT encourage the family to be involved in negotiating the focus and direction of remaining therapy sessions; "*usually we are guided by the family aren't we in terms of what, what feels to them as a useful direction*" (RT, 744-745). By referring to the 'family', the RT suggest that the course of therapy is a decision to be made in collaboration with all family members.

3. **Focusing on inter-relational, circular processes and family resourcefulness**

The RT build on the therapist's identified storyline of family resourcefulness by recognising and valuing the richness and diversity within the family; *"I love the way she (Kia) knows what she goes to people for [...] that richness that she's got in the family"* (RT, 703-706). The RT also acknowledge that Alam is making progress by drinking less alcohol and that the family have been supportive of him in relation to this; "*some of those decisions that dad's making about drinking and again really positive feedback from all of them..."* (RT, 721-722). The RT also emphasise the circular nature of relationships and the impact one person's behaviour has on another by reference to Rena's reflections; "*Mum... saying how much she appreciates his decisions to drink less... and how that makes her feel more relaxed and how that changes the way she can enjoy some of the family events*" (RT 721-724). This statement appears to praise and reinforce the family's use of helpful and solution focused narratives which are preferable to problem focused narratives.

4. **Identifying, prioritising and negotiating the focus of therapy**

The RT take an active role in planning the organisation and focus of the session. This includes the RT taking an advisory position to propose that the parents join the RT and act as observers to the young people's conversations. The RT also highlight the importance of monitoring the risk of self-harm thus acting as a supervisory resource to the therapist. This is undertaken by cautiously emphasising the importance of ongoing discussions regarding risk; *"We weren't sure where we were up to with self-harm, for Kia but also I suppose for the others [...] we should maybe check"* (RT, 759-761). Coupled with the following statement, the RT appear to prompt the therapist and the parents to check in regarding ongoing thoughts, feelings and acts associated with self-harm in

order to manage the risk; "*If it's not happening physically... just to check the thinking because sometimes thoughts are the next stage ... sometimes they can disappear and then those thoughts can come back again*" (RT, 788-790).

The RT also suggest the possibility of talking about areas of continuing difficulty and struggles. "*It's ok by us to hear about things that are still a bit of a struggle, as well as hearing about things that they've really began to sort out themselves*" (RT, 795-797). By acknowledging that there may be continued struggles, the RT give permission and encouragement for the family to talk about problems and concerns as opposed to being only focused on progress and positive changes. This intervention appears responsive and appropriate to the family's needs at the mid-stage of therapy.

Family Three: Analysis of post reflecting team dialogue
Storylines 1 and 2: Kia's developing identity and Rena's desire to repair family relationships
In contrast to Kia's positioning as the less chatty one of the twins in the pre RT discussions, Rena reflects on her pleasure at hearing more from Kia, positioning her as more interactive; "*It's been so nice hearing Kia talk so much [...]. Just to hear what is going on inside your mind is so lovely to hear*" (Rena, 622-624). This statement appears to build on the positive reinforcement and comments regarding Kia's more relaxed and happy appearance to acknowledge and position her as a more involved, valued and contributing member of the family.

The pre RT storylines appear to have shifted from Kia "going with the flow" and 'Vanya and Kia's differences and Kia's sense of rejection' to recognising Kia's developing identity and acceptance within the family. A new storyline also emerges of Rena's desire to repair family relationships. This storyline appears to build on the RT's introduced storyline of the family being emotionally supportive and helpful towards one another. Rena reflects on the time needed to process the emotionally charged information discussed during therapy sessions and her desire to resolve the family problems; "*It takes a while to process it in your own mind and work out how you are going to approach that situation now and how you're going to try and repair that situation*" (Rena, 784-785).

Storylines 3 and 4: Elana's past anger and resentment and Rena's more relaxed approach to parenting

Storylines in the post RT discussion appear to shift from inequality and favouritism within the extended family to more open discussion of inequality within the immediate family. Elana opens up to express anger and resentment regarding what she regards as differential treatment of her siblings. She discusses Rena's different rules for her in comparison to her younger siblings whom she positions as 'abnormal'; *"I just remember being really angry at these three [gestures to sisters] and just really, really resenting the whole thing and thinking am I the only one that's normal?"* (Rena, 799-801). Rena reflects on a prior discussion with Elana regarding the expectations that she placed on Elana; *"You said to me 'well I still had to do my chores, I still had to do this and I still had to do that'"* (806-807, Rena).

Rena positions herself as a lenient and changed parent in comparison to the past, where she used to position herself as a rigid new parent. Rena further acknowledges her different parenting style in the past as she explains to Elana; *"You are our first child so I was rigid with you"* (Rena, 810-811). Elana continues to express her frustrations regarding the differential family treatment; *"When I was ill, mum just kind of carried on like everything was normal"* (Elana, 825). Elana appears to make sense of this by comparing her and Kia's different characters, positioning Kia as over-sensitive; *"When Kia had her problem, you couldn't say two words to her about it"* (Elana, 846-847). Elana goes on to credit herself for her ability to cope independently without impacting on family life; *"I was annoyed because I was like why does everything have to change? I'm one of those people where if I have a problem then I just deal with it"* (Elana, 847-849). Within this dialogue, Elana positions herself as more resilient and independent than her siblings. As opposed to being competitive and disparaging of her siblings, Elana appears to take a more philosophical stance when discussing these family dynamics.

Storyline 5: Developing a shared family understanding

Rena positions herself as open and accepting as she follows up on the RT's suggestion of being an observer of her daughters' discussions. Rena indicates that she would like the opportunity to hear more about her daughters' struggles and how they have coped in order to increase her understanding; *"I think it's a really good idea [...]. I would like to understand everything"* (Rena, 777-779). Rena also positions herself as uninformed as she reflects on how little she has heard or understood about her daughters problems until now; *"I haven't really heard the others speak*

about the self-harming, I know you had bulimia [to Elana] but you didn't really talk about that" (Rena, 785 -787).

Rena goes on to position the family members as more understanding of one another, particularly in relation to Kia's need to be left alone; *"I think we all understand it a little bit more (Rena nods to Vanya while speaking to Kia) like you were saying when you need your space we'll try and back off"* (Rena, 901-902). Kia also positions the family as more understanding of one another with reference to Alam's feelings, particularly his alcohol use as she provides as alternate explanation for his apparent intoxication: *" I think we all understand each other a bit more through these sessions because what I found out was that when dad was drunk, or even when he wasn't drunk he would say that I don't want you to say that I am drunk because that makes me feel bad ...he might not even be drunk, it's his diabetes that makes him ill and even if he hasn't eaten anything he'll seem like his drunk"* (877-881).

Reflections on the analysis of family three

Early in the therapy session Kia indicates that she is uncertain of herself and her identity, however, the storyline of Kia "going with the flow" suggests that she is beginning to cope independently by taking control of her emotions. As the session progresses, Rena appears to build on the RT's comments regarding positive feedback as she highlights the progress made by Kia within the session. The family also note that without their continued interference, Kia is maturing and becoming more independent. Such narratives within the family may have implications for Kia's developing identity as she shifts from being perceived as quiet, shy, timid and unconfident to a more confident, talkative, interactive, and valued member of the immediate family.

The focus of family three's discussions shifts across the session from discussion about Kia's difficulties and wider contextual issues prior to the RT to the consideration of the immediate family difficulties and relationships within the post RT discussions. Family discussions evolved from the initial focus on Kia's self-harming behaviour and favouritism within the wider family to consider the problems and difficulties experienced by individual members of the family. The family also indicate some recognition of the systemic nature of family interactions and shared experiences. In contrast to the pre RT discussions which were saturated with discussions about individual differences, comparison and competition, the post RT discussions indicate that the family have progressed as a result of having a better understanding and appreciation of one

another's individual differences, perspectives and coping styles. Rena also expresses a desire to repair family problems and relationships. She acknowledged a shift in her parenting style and behaviour which prompts further discussion and consideration of past emotional difficulties and strengths.

Within family three, the RT referred to the family discussion as a 'celebration' which recognises the family's progress within the therapeutic process. The RT highlights the progress made by all family members in relation to their individual problems as opposed to being focused only on Kia. This input from the RT shifts the focus of the family's discussions as they each consider their individual contributions to the family dynamics. Appearing to provide a more inclusive focus, the family's individual problems and difficulties are also reframed as collective family struggles which gives the impression of the family working together to overcome their problems together collaboratively.

The RT appears to close down any further discussion of the unhelpful comparison between Kia and Vanya as they do not make any direct reference to Vanya and Kia's differences, Kia's sense of rejection or favouritism within the extended family. They also appear to avoid directly discussing the family bereavement and loss of emotional support and reframe this by focusing their attention on the richness and diversity of the family and their capacity to support one another. Furthermore, the RT draws attention to statements such as their noticing, commenting upon, and reinforcement of their own progress which serves to illustrate the family acting as their own therapists. Recognition of the family's positive reinforcements of one another appears particularly evident in relation to Alam's less frequent use of alcohol which was re-framed as having a positive impact on the whole family in addition to Rena's emotional wellbeing and her enjoyment and engagement with family events.

The RT suggest the possibility of parents acting as observers to therapy discussions. This may enable the daughters to discuss their problems more openly and enforce an alteration to the current communication and relational dynamics. Such reorganisation to the subsequent therapy session could have a major influence on the progress of therapy with the potential to lead to more openness, understanding and repositioning within the family. Similar to that observed with family two, with family three the RT draws attention to the need for ongoing monitoring of risk in the therapy session. This appears to be in response to risk issues not being considered in the pre RT

discussion. In this instance, the RT act as a source of supervision, safeguarding against risks within the process of therapy.

Following the RT the family appear to accept the suggestion of talking about continuing areas of difficulty and struggles as they express a preparedness to engage in further discussions about their individual problems, needs and ways in which they can support one another. Rena follows up on the RT's suggestion regarding the parents observing the daughters discussion from behind the one way mirror. She also states that she would like the opportunity to hear more about her daughters' struggles and how they have coped in order to increase her understanding of their problems and how they have managed these together. A new storyline also emerges of Rena's desire to repair family relationships which intertwines with the storyline of developing a shared family understanding. Positioning herself as uninformed, Rena indicates that she knows very little about her daughters past difficulties. Rena's comments suggest that she may feel a sense of not being as involved in the lives of her daughters as she would like to have been. Rena's comments suggest that she has shifted her perspective and role as a parent to reconsider her involvement and communication with her daughters, particularly regarding areas of difficulty and helping their management of these.

Within the post RT discussions, Elana reflects on past positioning of herself as 'normal' in comparison to her family members who she positioned as 'abnormal'. Elana's post RT discussion of the family dynamics indicates a re-positioning from her historical judgemental positioning of all her family members as 'abnormal' to a more positive philosophical perspective. Elana reflects on feelings of anger and resentment which occurred in the past which suggests that she has since re-evaluated and subsequently moved on from this position to consider the individual family members differing needs and coping styles. Elana appears to take a more philosophical stance when discussing the family dynamics as opposed to being competitive and disparaging of her siblings. However, Elana continues to suggest a superior position for herself as more independent in comparison to her siblings, particularly Kia. From Elana's perspective, coping independently without impacting on family life appears to be regarded as more preferable than seeking support, adaptations and individual treatment for problems or areas of need.

Due to the greater number of family members present in the room, there appeared to be more factors and relationships to consider. Reflections on the letter may also have impacted on the

therapeutic process by positively skewing the pre RT discussions as indicated by the nature of the family's discussions. However, discussion of the topics summarised in the therapeutic letter appeared to provide some level of containment and structure to the session as the therapist referred back to the content of the letter at various points during the pre RT discussions.

A representation of the family meaning system follows in figure 9. This includes the key positions and constructs negotiated in family three's pre to post RT dialogue. In comparison to pre RT dialogues, there was less reference to positions of loss and rejection in the post RT dialogues and more reference to positions of resilience and acceptance.
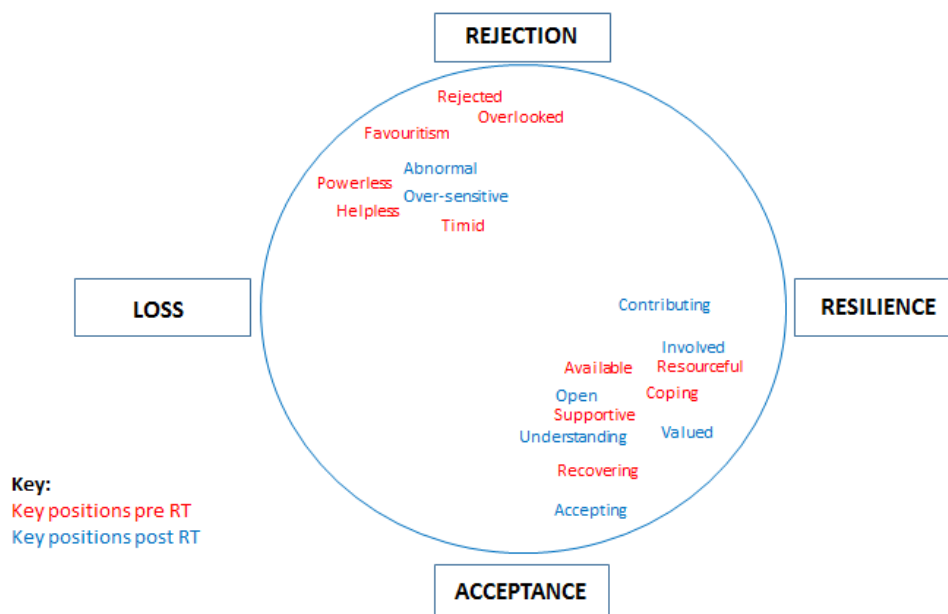

Figure 9: Case 3 - Representation of Family Meaning System

Across Case Comparative Analysis

The following consistencies were noted in the RT's practice across cases;

Collaborative co-positioning and use of pronouns

The RT refrained from extensive use of singular pronouns such as 'I' and 'me' across all three cases and were seen to make frequent use of collective pronouns such as 'we 'and 'us' in reference to both themselves and the family. In addition, the RT collectively positioned themselves with the family. An example of this occurred with family one, as the RT referred to the inclusive pronoun 'we' which appeared to create a sense of unity between the RT and the family; *"When something difficult happens, as families 'we' tend focus on the problems"* (lines 823-824). This use of collaborative positioning introduced the idea that the family and therapy team were all working together as a group in order to overcome the current problems and difficulties

Across cases, the RT also co-positioned the whole family together in unity whilst also making reference to prior achievements which created a sense of the family having strengths and resources. This positioned them as capable of overcoming current challenges. For example, within family one the RT stated; *"as a family they've got together again and said, 'right, we need to do something'"* (788-789). The RT may have adopted this strategy in response to the issues of conflict, competition and favouritism noted across cases.

Directive stance and the reflecting team's expert position

In addition to adopting a collaborative position, the RT shifted to a more directive, strategic approach, at times positioning themselves as experts. This expert position related to central issues within the family which were directly or indirectly related to risk. This was most apparent in family two which was at a later stage of therapy. The RT directly expressed concern regarding the ongoing relational issues between Carly and Sandra and the associated risk of self-harm. In comparison to their other reflections, the RT took a more direct approach on this issue to highlight the need for change and drew on their expert knowledge of risk factors associated with self-harm. Subsequently, the RT go on to make suggestions and recommendations to Sandra regarding her potential options; *"Maybe we can help to think that through. If she wanted to spend more time with Carly […] what would she say to the boss?"* (766-768). However, these suggestions are phrased as tentative questions which do not overstate the RT's expert position. Instead, the RT's

use of questions appears intended to assist Sandra to reflect on the issue in order to consider potential solutions.

Shifting the focus from problem saturated to more recovery orientated narratives

There was an observable shift from problem saturated to more recovery-oriented narratives across families from pre to post RT. This shift appeared to be associated with discursive strategies from the RT which included positively reframing storylines by encouraging the consideration of strengths and resiliencies. The RT also encouraged the elicitation and expansion of alternative stories by encouraging exceptions to the dominant problem-focused narratives. For example, with family three, the RT drew attention away from Alam's alcohol misuse and instead focused on the positive support which had been provided by the family. In doing so, the RT positioned the family as supportive and resourceful by acknowledging their strengths. The RT reframed the scenario and offered praise, reinforcement thus encouraging the family to continue utilising these strategies. The RT encouraged the family to elicit more helpful and solution-focused narratives. The use and impact of discursive strategies also appeared to be mediated by the use of interpersonal and generic therapeutic skills.

The RT influenced the development of therapy discussions by focusing their reflections on certain storylines, making only brief or indirect reference to other storylines, or bringing them to a closure. For example, by paying less attention to the storylines which related to blame and individual responsibility such as Helen's anxiety, the RT brought these storylines to a close. Intervention from the RT shifts the focus of family discussions and encourages a more shared understanding in which the family take on a greater level of shared responsibility and appear to be more accepting of one another.

The following exceptions were noted in the RT's practice across cases;

Stage of therapy

During the earlier stages of therapy, the RT appeared to be more active in promoting collaboration to strengthen and support the development of the therapeutic alliance. The RT's attempts to elicit alternative narratives were also less influential than in later sessions. For example, Jasmine did not respond to questions regarding exceptions to self-harm. The impact of these questions may not become apparent until later in the therapeutic process.

During the mid-stages of therapy, the RT influenced the process of therapy by reviewing progress providing a focus to the remaining therapy session. The RT shifted the focus of the session from the family's strengths and brought attention back to continued areas of difficulty to suggest ways that these could be explored.

During the later stages of therapy, the RT reviewed the families' progress and directed the family regarding areas for further development. The RT made reference to changes made by the families' and to their achievements to re-emphasise their progress. They also identified areas of continued risk and concern, particularly in relation to the family communication and relationships. As indicted in the literature, relationships and communication with parents are central to the prevention and management of self-harm risk. The RT's adaptation therefore appeared appropriate, empowering and helpful to the overall therapeutic process.

CHAPTER FIVE: DISCUSSION

The aim of the current research was to explore the influence of the RT on the co-construction of meaning-making with families in therapy with particular attention to;

1. How family members construct and position themselves in relation to one another and the problems brought to therapy
2. The storylines and positions developed by the RT
3. The discursive strategies utilised by the RT
4. The impact the RT has on subsequent family discussions.

To address the research aims, I will begin by providing a summary of the main research findings from the previous chapter. I will go on to discuss these within the context of relevant literature with consideration of the implications for clinical practice. Reflections on the strengths and limitations of the research will then be discussed with suggestions for future research. I will conclude this chapter by reflecting on the strengths and limitations of my position as a researcher and how this may have influenced the analysis. As the focus of the study is on the influence of the RT, this chapter underlines the RT's strategies and impact on the family's storylines and positions. I will also consider the implications of this for the process of therapy.

Summary of Findings

Key findings across cases included the following;

- Collaboration: Collaborative positioning and the use of pronouns
- Negotiation: Open communication and the RT's expert position
- Resilience: Recovery orientated narratives
- Responsivity to the stage of therapy.

Positions demonstrated by the RT included collaborative positioning by use of terms 'we' and 'us' which served to unite the family therapy team and overcome areas of conflict and competition. The RT also used tentative language and adopted a 'not-knowing' position to minimise their expert status, instead positioning themselves as collaborative partners to facilitate more open communication and a shared purpose between all members of the therapy team and the family. Important qualitative shifts were noted in the content and nature of family narratives and

positioning across cases. The family narratives included an increased sense of hope, connectedness, acceptance and the potential for change. Families also demonstrated new understandings of their situations as they shared their individual perspectives and co-constructed new meanings. Family members also changed their interactional patterns as they shifted from positions which were more representative of individualism and blame to collectivism and a shared responsibility for understanding and change. Following input from the RT, families communicated more openly together, and engaged in difficult conversations to renegotiate positions and reconsider their perspectives. Overall, the families' pre RT narratives were considerably more problem-focused in comparison to the post RT discussions; post RT discussions were generally more positive or recovery orientated. This shift from pre to post RT is influenced by the involvement of the RT which was also facilitated by intervention from the therapist.

Collaboration: Collaborative Positioning and the Use of Pronouns

Following input from the RT, family members positioned themselves more collaboratively in their relationships with each other. There was also a sense of problems being positioned as shared family concerns which could be overcome together as opposed to being individual difficulties. The RT influenced this shift by the use of collective pronouns which collaboratively positioned family members together as a united force. The shift in family positioning indicates an increased sense of collaboration and togetherness within the family unit. This change was associated with the RT's use of collective pronouns and co-positioning which brought the family together and overcame prior conflict and blame. For Jasmine this resulted in a reduced sense of personal responsibility for the family problems during the therapy session as the family came to understand both their individual and shared responsibilities and also recognised the need to overcome the problem together as a family.

Findings from the current research suggest an increased sense of togetherness and interconnectedness across all cases. Storylines of togetherness and agreeableness are considered helpful for families to overcome challenges and make positive changes (Roach, Keady, Bee, & Williams, 2014). Agreeing storylines are representative of moral coherence and resilience within the family unit. Such positioning is essential for overcoming challenges and preventing the negative influence of conflict, incoherence, and inconsistency which are inherent within family storylines of colluding, conflicting, fabricating and protecting which were common within the pre RT discussions (Roach et al., 2014). Within the current study, this observable shift in family

positioning overcame prior issues of conflict, blame and collusion which are considered problematic for family progress (Roach et al., 2014).

Shifts in family positioning from 'I' to 'we' suggest a therapeutic change in the construction of problems from intra-personnel to interpersonal during the therapy sessions which is consistent with findings from previous family therapy research (Coulehan, Friedlander, & Heatherington, 1998; Sluzki, 1992). Such changes indicate the reparation of an impasse (Strong et al., 2008) with in session changes also potentially leading to changes in the content and dynamics of participants' communications outside of the therapeutic context. A shift from individualism to collectivism indicates a helpful and hopeful change for the families involved. Considered within the context of identity construction, this change is particularly important for the referred young people as they are seen to shift from positioning themselves in terms of loneliness, isolation and rejection to a collective sense of belonging within the family (Yuval-Davis, 2010).

In addition to promoting inter-relationships and inter-connectedness within the family unit, the RT's use of collective pronouns and co-positioning also appears to have facilitated the therapeutic alliance (Roach et al., 2014). Within the present study, the RT used collective pronouns such as 'we 'and 'us' in reference to themselves and the family across cases which facilitated a sense of togetherness and collaboration. The RT also made only minimal reference to singular pronouns such as 'I' and 'me'. This complemented and reinforced the impact of using collective pronouns and further developed the therapeutic alliance. By positioning themselves alongside the family, the RT seemed to build a sense of cohesiveness, resilience and increased hope between all members of the therapy team. This sense of collaboration and cohesion within the therapy room created a sense of all members working together to overcome the problem. Subsequently, the families seemed more able to consider their collective responsibility for change.

The collaboration and co-positioning demonstrated by the RT is consistent with past research findings (Berge & Danielsson, 2013; Roach et al., 2014). Similar to the findings of Martin-Beltran (2013), the co-positioning of family members as united partners with a common purpose appears to have facilitated more open communication and negotiation between family members. Additionally, the co-positioning of family members with the therapy team shifted the expert positioning of the RT and the positioning of family members from help seekers to experts of their experiences which facilitated change within the therapeutic dynamic, whereby family members

were empowered to act as their own therapists. RT input within the present study therefore prevented family members from seeing themselves as passive recipients of therapeutic intervention as they were encouraged to take an active role in constructing meaning with the therapy team. These findings are consistent with other family therapy studies which highlight the potential of the RT to influence therapeutic relations (Mitchell et al., 2014). Perceptions of progress have been linked to collaboration and alliance within the family, for example, both therapists' and clients' perceptions of progress have been linked to a sense of shared purpose (Escudero, Freidlander, Varele, & Abascal, 2008).

The therapeutic relationship is both an outcome and pre-requisite for effective RT processes. The RT appears to facilitate the establishment of therapeutic alliance. The therapeutic alliance is considered to be an essential component of effective therapy and central to therapeutic change (Norcross & Wampold, 2011). The RT therefore appears to be both a mediator and moderator of therapeutic change within Systemic Family Therapy (Green & Latchford, 2012).The current research suggests that a collaborative RT approach may be a useful and valuable resource within family therapy as it appears to be beneficial for establishing an effective therapeutic alliance between the family and the therapist and therapy team more generally. This finding is similar to the research by O'Connor et al. (1997) and Mitchell et al. (2014) which indicated that family members appreciated the collaborative approach offered by the RT.

Findings from the current study also challenge prior research which suggested that RT intervention may not be effective during early therapy sessions (Smith et al., 1994). Existing literature suggests that the RT may be anxiety provoking for families, and some may find this process strange and overwhelming (Mitchell et al., 2014; O'Connor et al. 1997). However, when considered from an alternative perspective as highlighted within the current research, the RT's collaborative approach may be a useful resource in earlier sessions in order to help ease the family's anxieties and enable the process to become more natural. Collaboration between the family therapy team may also facilitate a more respectful, non-judgemental, accepting and equal relationship between family members as the RT model these skills and the family have the opportunity to experience this way of relating within the space of the therapeutic relationship (Mitchell et al., 2014; Jenkins, 1996).

As previously outlined, findings from the current study challenge Smith et al.'s (1994) suggestion regarding the use and effectiveness of RT's in early therapy sessions. Contrary to these earlier

statements, when considered within the context of therapeutic change, the current study provides some support for Smith et al.'s position as the RT seems to have a different influence in the earlier stages of therapy as opposed to later stages. For instance, the RT appears to promote collaboration and therapeutic alliance '*with*' the family in the earlier stages of therapy. In contrast, the RT appear to focus more on promoting collaboration and alliance '*between*' family members in the later stages of therapy. The RT may therefore be more influential on the family's therapeutic outcomes during the later stages. This hypothesis is consistent with past research which indicates: 'engagement in the therapeutic process', 'emotional connection with the therapist', and 'safety within the therapeutic system' during the early stages of therapy, are associated with successful therapeutic outcomes (Escudero et al., 2008). Whereas, within the later therapy sessions, a 'shared sense of purpose within the family' is associated with successful therapeutic outcomes (Escudero et al., 2008).

Negotiation: Open Communication and the Reflecting Team's Expert Position

In addition to the RT adopting a collaborative position, at times they also position themselves as the experts. RT's expert positioning appeared to initiate more problem-talk regarding issues of risk and concern within the family. This was particularly important for Sandra and Carly within family two where relationship issues were continuing to position Carly at risk of further self-harm. Through the open discussion of difficult issues within the family, family members were able to negotiate problems together. This also led to an increased sense of collaboration and shared meaning-making as family members co-constructed new possibilities.

The expert positioning of the RT was most prominent in families two and three. This is likely to be representative of the stage of therapy. Family one was at an earlier stage in the therapeutic process where the focus was likely to be more concentrated on establishing the alliance. However, families two and three were at a mid to end point of therapy and therefore issues of risk and continuing concern were more of a priority (Boston et al., 2009). Being at a later stage of therapy, it is likely that family two was also at a later stage in relation to therapeutic change (Escudero et al., 2008). During the later stages of therapy when alliances have been established, it may be necessary for the RT to adopt a more expert position to challenge and encourage more change within the family system, or to direct the focus of therapy.

As indicated in the introduction, the SHIFT guidelines (see Appendix B) state that reflections from the RT should hold a tentative and curious stance. Other cautionary notes and guidelines for reflective processes include Andersen's assertion that "the team must remain positive, discreet, respectful, sensitive, imaginative and creatively free" (Andersen, 1987, p.9). On the whole, the RT within the current study appeared to adhere to the guidelines proposed by Andersen, however, there were occasions when they stepped away from the tentative and curious stance proposed within SHIFT guidelines as they provided directive statements to the families in relation to issues of risk. The practice of RT observed within the current study could be considered an adaptation of RT practice and advancement of current RT theory in response to issues of risk. The expert position taken by the RT is consistent with the broader SHIFT guidelines which state that "there will be times when there may be greater need for therapists to take an overtly 'expert position' e.g. when assessing risk" (Boston et al., 2009, p.20).

The RT practice within the current study seems to shadow aspects of the Milan systemic approach (Tomm, 1984), whereby a more directive, expert advisory position is adopted by the Family Therapist when there are reasons for concern. This approach is a step away from a purely narrative, post-modern approach to therapy where multiple interpretations are possible and held to be equally valid (O'Connor et al., 2004). There is an inherent tension and dilemma between risk management and the intended function of the RT to overcoming the power differential between clients and therapists and generate multiple perspectives. As discussed previously, operating from an expert position, the therapist may be considered to hold specialist knowledge and skills which can be utilised to resolve or repair the client's problems thus disempowering the client (Proctor, 2002). Dialogical and narrative therapies generally seek to minimise the power imbalance by taking a more collaborative stance within the therapeutic relationship (Malinen, Cooper, & Thomas, 2012). However, such collaboration could be disadvantageous where there are issues of risk as this necessitates a more pro-active mode of power to ensure safety and protection (Tew, 2006). When issues of risk and safeguarding are raised in therapy, the RT and therapy team more broadly are required to utilise such directive approaches in order to promote and protect the wellbeing and safety of the child (Children Act, 1989; DfE 2015).

The Department of Health Best Practice in Managing Risk Guidelines (DoH, 2007), which are utilised to inform risk management strategies within local CAMHS, recommend the collaborative management of risk. It therefore seems appropriate for the RT to take an expert position in

relation to issues of risk and continuing concern with families whilst also adopting a collaborative positioning for the remaining part of their reflections. The RT's positioning appears to strike a helpful balance between the management and assessment of risk whilst also considering the process of therapeutic change which parallels the use of solution-focused strategies documented within the literature (Sharry, Darmody, & Madden, 2002). Rather than explicitly directing or instructing the family, the RT appeared to lead the family "from one step behind" (Cantwell & Holmes, 1994, pp.17-26) as one "taps on the shoulder" (Berg & Dolan, 2001, p.3) of the individual or family member enabling them to consider a different direction (cited in de Shazer et al., 2007, p.4). As indicated by Hoffman (1985) "nonneutral, 'linear' attitudes and actions are often 1) necessary, 2) appropriate, 3) what you are being paid for... particularly when fragile bodies must be protected from harm…. the first order of priority is protecting human life and rights. The only rule is to be clear about which hat one is wearing, a social control hat or a systemic change hat" (Hoffman, 1985, p.394).

Consistent with collaborative therapy theories (Anderson & Goolishan, 1988), the RT positioned themselves as 'conversational partners' (Anderson, 2008) when they were not discussing issues related to risk. From this position, the RT were more speculative through the use of tentative questions and wonderings as opposed to be directive or expertly positioned (Malinen et al., 2012; Nolan & Moreland, 2014). Nevertheless, in relation to issues of risk, and indirectly related areas such as the issue of parental conflict, relationships and communication between the parent and child subsystems, the RT made some advisory statements and emphasised parent's responsibilities. The RT's reference to parental responsibility resembled the influence of Minuchin and strategic therapies in with an emphasis on the hierarchy and boundaries between the parent and child sub-systems (Minuchen, 1974; Minuchin & Laplin, 2011).

Typically, RT's have been discouraged from making 'pronouncements', 'interpretations', or 'supervisory remarks' (Andersen 1987, 1991), 'strategising', 'problem-solving', 'teaching', 'role-modelling', 'perturbing', or 'advising' (White, 1995). Andersen's later writing on RT practice made reference to "ideas of intervention" whereby RT members take a more directive approach and offer suggestions for intervention. However, such offerings are intended to be collaborative, with team members not adopting a strategic 'expert' position (Lax, 1995).

The SHIFT manual cautions Family Therapist's and the RT to be mindful of the potential for an expert position to 'reinforcing dependency' and minimise the recognition of family strengths and resources (Boston et al., 2009). However, Boston (2000) also cautions against a rigid, non-expert positioning of the therapist in post-modernist approaches to family therapy. It could be considered by some families as "unsettling or disrespectful", particularly families who are looking for "simple, straightforward expert advice" (Boston, 2000, p.456). In taking a responsive approach to families presenting needs, the therapist and RT members would be best placed drawing from both modernist and post-modernist approaches to take positions of 'not-knowing' and 'expert' knowledge depending on the situation and context.

Resilience: Recovery Orientated Narratives

Within the current study, the RT reframed problem saturated narratives by reference to past, present and future tense which led to the development of more recovery orientated narratives. Reframing involved describing or explaining a problem from an alternative perspective which encouraged new understandings, meanings and possibilities. The RT also focused a large proportion of their reflections on family strengths, skills and resources which are consistent with solution-focused therapies (Sharry et al., 2002). The family were therefore re-positioned by the RT as resourceful and resilient. Exploring possible exceptions to the family's problem encourages the creation of new narratives by uncovering times when the problem has been successfully challenged or overcome (Sluzki, 1992).

Within the current study, the RT's use of past and future tense was also influential on the re-authoring of problem saturated narratives by situating these as historical events which have now been overcome. This use of the past tense enables problems to be acknowledged whilst also minimising the potentially disabling narratives. By focusing attention on the family's strengths, resiliencies and past solutions, the RT seem to be empowering the family and enabling a client- led approach to resolving their own issues. The family are then, in effect, encouraged to become their own therapists, implementing skills in problem resolution which they may go on to utilise within future interactions and also in response to future problems. This is consistent with literature which suggests that client-led solutions are most likely to be successful (Hubble, Duncan, and Miller, 1999). Focusing on strengths and resiliencies also results in an amplification of the family's potential for change (Hawley, 2000). This was particularly evident and important within family

three in which the RT recognised and encouraged the positive reinforcement observed between family members.

The RT's promotion of resilience in the current study is an important finding. Resilience was historically conceptualised as an individual construct of competence in spite of significant adversity (Egeland, Carlson, & Sroufe, 1993). However, more recently resilience has been conceptualised as a relational construct (Focht-Birkerts & Beardslee, 2000), with 'reparative potential' and 'relational resilience' being suggested as key family resiliency constructs (Walsh, 1996, 2015). In addition to open communication, factors including cohesion, mutual support, a positive belief system and problem solving capacity are central to family resilience (Walsh, 2015) and the protection against the risk of self-harm (Borowsky, Ireland, & Resnick, 2001; Compton, Thompson, & Kaslow, 2005; Resnick et al. 1997). Whilst self-harm is not the primary focus of this study, it was a central concern of the SHIFT trial from which the cases were extracted. As indicated in the literature review, past research highlights the importance of family relationships, particularly parent and family cohesion, a shared sense of purpose and open communication as central protective factors which mitigate against the risk of self-harm during adolescence (Borowsky, Ireland, & Resnick, 2001; Compton, Thompson, & Kaslow, 2005; Resnick et al. 1997).

Young people's 'emotional fluidity' and ability to openly discuss difficulties is suggested to be a key aspect of resiliency (Focht-Birkerts & Beardslee, 2000). This sense of openness has also been associated with an improvement in the familial relationship, potentially as a result of greater understanding and validation between the parent and child (Focht-Birkerts & Beardslee, 2000; Walsh, 2015). Intervention from the RT within the current study led to a similar result, with family members indicating an increased sense of openness and consideration of communication within their relationships which are considered to be central components of family resilience (Focht-Birkerts & Beardslee, 2000; Walsh, 2015).

As suggested by O'Connor et al. (1997), recognition of family strengths, resiliencies and change are likely to be appreciated by family members. The discursive strategies and techniques utilised by the RT appear consistent with the study of couples experiences of the RT by Egeli et al. (2013) in which 'identifying strengths', 'normalising difficulties', 'presenting inspiring possibilities', 'support' and 'highlighting personal growth' were experienced as instilling a sense of hope. Attending to clients sense of hope is considered central to the process of therapeutic change and to more

favourable mental and physical health outcomes (Snyder, 2002). Discussing problems in the context of past solutions also leads to the reframing of problem focused to more recovery orientated narratives and an increased sense of hope. In addition, framing such events in the past enables the construction of more positive and productive narratives within the therapy room which may be adopted into future family narratives.

The increased sense of hopefulness for change and participation of family members during therapy is consistent with Karver, Handelsman, Fields and Bickman's (2005, 2006) model of therapeutic relationship variables which are considered to be partly determinant of successful or unsuccessful outcomes. Such input from the RT as observed within the current study can therefore be considered conducive to the change process and potentially also to an improved sense of emotional wellbeing within the family. Whilst the RT most often encouraged recovery orientated narratives, they also made space to consider continuing problems by acknowledging areas of risk and concern in addition to encouraging open communication about difficult issues. This balanced position from the RT ensured that problems were not overlooked but instead were considered openly in order to address pertinent issues.

Reflecting Team Influence - A Shift to the Family Meaning System

Through the process of therapy, family narratives appear to have shifted as a result of input from the RT. Considering family therapy as a process of identity re-construction and self-development (Bamberg, 2004, 2008; Bamberg & Georgakopoulou, 2008; McLean et al., 2007) individual and family identities negotiated in the unfolding therapeutic discussions indicate shifts to more positive, helpful and hopeful constructions. The reframing and re-storying of difficult past events which occurred as a result of the RT intervention may lead to a change in the individual's self-concept and their overall life story. For example, the pre-RT storyline of Helen's anxiety and her related self-concept of being an anxious person was re-positioned as a past event and reframed as resilience in the moment which creates the potential for a new self-concept to emerge. Helen may therefore undertake future challenges with this new conceptualisation of herself as resilient and capable of overcoming problems. Changes to the family's narratives and positions indicate the emergence of desired, preferred and future selves (McAdams, 2008), and are considered representative of personal growth, integration and maturity (McAdams & Olson, 2010). The transformation of stories is a key indicator of therapeutic change (McLean et al., 2007) and suggests the creation of a new family meaning system influenced by the RT.

The current research suggests that the co-creation of meaning-making is facilitated by the RT. As a result of this input, family members indicated an improvement in their relationships, considering their shared responsibilities and strategies which they could utilise in order to overcome problems as a family unit. The families also demonstrated change in their communication patterns as they were more open and engaged in difficult conversations within the family. This increased openness between family members also enabled further co-construction of meaning through shared understanding and appreciation of one another's individual perspectives.

Changes in the family's constructions were indicated by a shift to more recovery orientated storylines and positions which suggests that the RT are influential in generating a sense of resilience. Overall therefore, this RT appears to have a positive influence on promoting family resilience through a range of processes which include the promotion of interconnectedness, open communication and recovery orientated narratives. Input from the RT subsequently led to the recognition and acknowledgement of unhelpful positions and enabled the renegotiation of priorities and family relationships.

Previous research exploring RT practice has focused on the therapeutic process more generally and did not make use of direct observational data which could be analysed in detail such as that undertaken in the current study. The current research adds to the literature by increasing our understanding of how a RT operates within the process of therapeutic practice within the SHIFT trial. The RT under investigation had a noteworthy influence on the process of meaning-making across all three families. The RT can therefore be considered a useful addition to therapeutic practice within the context and parameters of the current study.

Research Appraisal

The nature of research projects requires there to be a sense of coherence, logical structure and a flowing narrative to the analytical findings. However, by presenting the data in a structured and ordered manner, inevitably some of the complexities may have been lost.

During the analysis it became apparent that it was difficult to fully isolate the RT from the influence of the therapist. The positions, storylines and discursive strategies proposed by the RT appeared to have implications for the family members and the therapist. This is to be expected, as

all people present in room and involved in the therapeutic conversations are implicated in reflections upon this process. The RT's influence on the therapist's action is likely to have an influence on the family meaning system in a way which is indirect but is worthy of further attention. In addition to consideration of the RT's influence on the family meaning system, closer consideration of the RT's influence on the therapist's action may provide more information on the operation and influencing potential of the RT. It may therefore be helpful to consider the therapy team as a whole in addition to the contributions of the therapist and the RT individually in future research.

Due to the infancy of PA and a lack of prior research which combines PA with DP, a number of challenges arose whilst undertaking the current research. The absence of a clear strategy to progress the analysis during the early phases of the research was perplexing. The trial and error approach to the research was also very time-consuming. Through perseverance and the creative synthesis of various approaches, an innovative method and approach to the analysis has been established. Whilst it is acknowledged that the methodological procedure may require additional refinement for future use, it is hoped that the current study will actively progress current research in family therapy, psychology and related fields.

There is currently limited research which focuses specifically on the process and practice of the RT. Through the use of recorded therapy sessions, the current research was able to observe and analyse the RT in action during live family therapy. This is a novel approach which benefits by being a direct analysis of live therapy. Using this approach, it was also possible to isolate the influence of the RT from other extraneous influences. Selecting therapy sessions from the same therapy team enabled an in-depth analysis of the RT in action with different families. This enabled identification of commonalities and discrepancies in the RT's approach and practice across different families in order to begin hypothesising about potential reasons for any variability observed.

For the current research, a small and specific sample was selected from the SHIFT trial. This sampling strategy provided the opportunity to undertake a detailed analysis of the practice of one RT within various family contexts provided by within the SHIFT trial. The small size and specificity of the sample limits the applicability of the conclusions to other contexts as findings may only be representative of this particular RT. Selecting a small sample was justified for an exploratory study

and it is understood that further research will be required to establish the transferability of these findings (Yin, 2013). However, this particular RT was practicing as part of a national RCT which involved strict recruitment, training, supervision, reporting protocols and measures of treatment integrity (Masterson et al., 2016). Due to the rigorous procedures undertaken by the SHIFT trial to ensure that appropriate standards of therapeutic practice were upheld, the practice of the RT within the current study and therefore also the findings from this research should be considered of significant value, worthy of recognition and applicable to future research.

The multiple case study design utilised within the current study enabled a thorough analysis and understanding of a RT within the SHIFT trial. By studying the RT across different family contexts, and triangulating the data through cross-case comparison, adaptations to RT theory and practice have been identified in response to risk related issues. The current study suggests that when issues of risk occur within therapy, the RT can facilitate safeguarding and risk management strategies through the provision of direct feedback to the family and/or therapist which has an influence on subsequent therapy discussions and the process of therapy. As the RT response to risk was consistent across all three cases, this can be considered a credible finding (Merriam, 1988; Yin, 2013). Further research will be required to further establish the transferability of this finding to other therapy teams, populations, and risk issues in various contexts, however, the RT practice identified within the current study could be considered a necessary and appropriate response to the presentation of risk.

Data for the current study was drawn from the SHIFT trial which implemented a manualised approach to therapy designed specifically for the treatment of adolescent self-harm. The therapeutic activity observed within the current study was therefore bound within the context of the trial. There is a possibility that the therapeutic process and practice of the RT may differ from that which takes place in typical family therapy with different populations and also different presenting problems. As the SHIFT trial is primarily focused upon adolescent self-harm, the initial discussions and problems which arose during therapy were therefore directly or indirectly related to the act of self-harm. One of the main goals of these family therapy sessions is therefore to reduce the frequency and severity of self-harm incidents. The therapist's position includes an inherent responsibility to recognise and respond to indications of ongoing self-harm and associated risks. Whilst all therapists have a responsibility to monitor and manage risks, the prevalence of self-harm risk within the SHIFT trial may have resulted in a more risk focused and

managed approach from the RT. The practice of the RT within the current study may not therefore represent that which is typical of RTs more generally. Further research will be needed to see whether there are commonalities with other families, therapists and RTs more generally.

Findings from the current study indicate how a RT is likely to operate and adapt practices in accordance with the specific needs of adolescents and their families during the process of undertaking therapy where there is a risk; on this occasion, the risk of self-harm. Whilst not directly transferable to other settings, these findings will be relevant to many other settings where risk issues arise during therapy. Issues of risk management are central to many therapeutic contexts, particularly with children and adolescents where high risk behaviours such as eating disorders, substance misuse, offending behaviour, and issues of child protection and safeguarding are commonly presented (Collishaw, 2015). Risk management is central to healthcare practice within the National Health Service (NHS, 2015). Findings from the current research could therefore be taken as a starting point to amending and updating existing RT theory for the management and negotiation of risk within family therapy more generally.

The current research focuses specifically on the individual sessions and this restricts interpretations to within-session findings. As the current research involved secondary data analysis, there were also restrictions on the use of follow-up questionnaires and further explorations with therapists and clients. Interpretations are specific to the data that was available and observed during the session as captured on the recordings. Any additional information such as conversations from previous therapy sessions has not been considered as part of the analyses. No definitive claims can therefore be made regarding long-term implications of the RT intervention for families within the current study. However, as the focus of the research was to explore the immediate influence of the RT in practice, the current focus on in session changes was considered important in order to identify some of the subtle nuances of RT practice and influence during the process of therapy.

The analysis of the RT influence is limited to the reflections spoken by the RT within the therapy room. As indicted in the SHIFT guidelines (Appendix B), the themes suggested by the RT may have also been used to form the basis of a letter to the family, or as an opening summary at the next therapy session. While some consideration was made to the use of the therapeutic letter in one of the sessions, the current research did not consider all aspects of RT intervention such as input via

the telephone. The full impact of the RT cannot therefore be captured within the design of the current study as such influences may become apparent in subsequent sessions. Further longitudinal studies and feedback from families may be required to gain a comprehensive understanding of these wider implications of RT practice.

The current research is a starting point for process research into the work and influence of the RT in action. It provides an initial insight into the operation of a RT in practice which is able to consider and highlight any consistencies and contradictions apparent between existing theory and practice. Generally, the RT demonstrated a reasonable degree of adherence to the principles outlined within the guidelines proposed by Anderson, the SHIFT trial and the wider literature. The RT were observed adhering to the following principles: the reflections were generally respectful, tentative and curious, unless considering risk-related issues. Whilst the RT did not offer individual perspectives, this promoted collaboration and is likely to have been a response to the conflictual dynamics and positions presented by the families. The RT's reflections were connected to the ideas of the previous contributor, and the language used by the family. There was also a sense that the number of themes discussed, and the duration of these discussions were well managed. Following the RT, the therapist monitored the effect of the team reflections on the family by asking for thoughts and reactions from family members, and linking statements back to the content of the RT's comments.

Recommendations for Future Research
There are many possibilities for future researchers to build on the findings and methodology utilised in the current study. For example, a further avenue of study would be to directly explore the relational dynamics, negotiations and processes occurring within academic and clinical supervision utilising DP, PA and the semantic polarities model. The analytical strategy utilised in the current study could also be applied to other areas such as supervisory and consultative practices with professionals at an organisational level.

A logical next step within the field of family therapy research would be to explore the influence of the RT in a longitudinal study which maps the discursive strategies utilised by the RT, and tracks the progression of the family narratives for the full duration of therapy sessions. Such research may indicate key change points which influence the family narratives and positions to become more harmonious, attuned and integrated. This protracted period of analysis would also establish

a greater sense of the RT's overall impact on the therapeutic process, by noting the occurrence and recurrence of topics and themes over the duration of therapy. Such research would also indicate how the RT influences the therapist by tracking how the therapist makes use of ideas offered by the RT in subsequent sessions. Further research could also be undertaken which compares the practice of this particular RT with other RT's within the SHIFT trial and various other contexts to establish whether there are similarities in the influence and practice of the RT, particularly in response to issues of risk. Such research may involve different populations, clinical problems and settings such as routine clinical practice and other clinical trials. It would also be warranted to investigate the influence of teams of varying sizes and compositions which include variations in personal characteristics such as gender and ethnicity.

Future studies could also gather direct feedback on participant's experience of the RT. Such data may provide additional insight into the RT's overall influence. A more comprehensive account of changes to the families' narratives could also be offered by the inclusion of quantitative research strategies such as narrative coding systems, self-assessments and further qualitative, narrative based interviews (Barker, Pistrang, & Elliott, 2002; Bartunek & Seo, 2002; Smith, 2000).

An avenue for future research would be to investigate the influence of the RT through a process of multi-level modelling (Baldwin, Imel, Braithwaite & Atkins, 2014; Sexton, Ridley, & Kleiner, 2004). Comprehensive multi-level models of change which take into account: theoretical, research and practice components, mechanisms and processes, are considered critical for progressing our understanding of therapeutic change (Sexton & Alexander, 2004). Such research could be utilised to determine the extent of the RT's influence on outcomes and to identify factors involved in the RT's impact. Multi-level models would allow comparison of within-RT and between-RT treatment effects over time with different clinical populations, clinical risks and problem severity. Ranking of the therapy teams relative effectiveness whilst also considering the severity of client presentation and other contextual factors would enable patterns of variability in RT practice and influence to be discovered and compared. Further information regarding RT influence could also be gathered by comparing the process and outcomes of therapy teams with and without the use of a RT.

An additional avenue for further research is the use of therapeutic letters, particularly in relation to how they link to the influence of the RT. Therapeutic letters are frequently used yet under researched aspect of therapy (Fishel, Ablon, & Craver, 2010; Hoffman, Hinkle, & Kress, 2010;

White & Epston, 1990). As therapeutic letters were a core component of family therapy in the SHIFT trial (Boston et al., 2009) their use and potential influence on the process of therapy became apparent within the current study. The use and influence of therapeutic letters therefore warrants further investigation.

Conclusion

Within the current study, the RT appears to have an important influence on the process of meaning-making within family therapy. There are three central processes through which this influence occurred within the current case studies. Firstly, the RT's collaborative co-positioning and use of pronouns facilitated the establishment and maintenance of the therapeutic and family alliance. Secondly, the RT acted as a supervisory resource as they adopted an expert position which was influential in the management of risk within the therapy and family system. This was achieved by increasing family awareness of the impact of individual behaviour on inter-relations within the wider family system and the related risk of self-harm. Thirdly, the RT shifting positions and reframing storylines to create new narratives of resilience and recovery to instil a sense of hope and generate change.

This combination of expert positioning with collaborative and narrative approaches is consistent with the historical and theoretical underpinnings of family therapy and the RT (de Shazer et al., 2007; Minuchin, 1974; Minuchin & Laplin, 2011; Trepper et al., 2008). This includes the dialogical and collaborative influence of Tom Andersen (1987, 1991), the narrative influence of Michael White (1995, 2004), and the expert-model influence of the Milan team (Selvini et al., 1980). RT practice within the current study is also consistent with the SHIFT key theoretical and therapeutic principles and interventions which include; attention to dialogue, narratives and the use of language, collaborative working, highlighting the family's strengths and possibilities, and the systemic management of risk (Boston et al., 2009).

As indicated in the literature review, the therapeutic intentions of the RT included the creation of hope, overcoming therapeutic impasse and the generation of multiple perspectives (Egeli et al., 2011; Smith, Winton, & Yoshioka, 1992; Jenkins, 1996). Within the current study, the collaborative practice and recovery orientated narratives indicated were consistent with the original theoretical principles. The promotion of multiple perspectives were not as prevalent as anticipated, however,

this did not appear to be the main priority for this particular RT within the SHIFT trial due to the risks of repeated self-harm which required a more directive response.

Clinical Implications

Although it is not possible to make claims of effectiveness from only three cases, the findings from the current study clearly indicate that this particular RT was influential on the process of meaning-making within the observed family therapy sessions. In all three cases the RT had a positive influence on the families' narratives and positioning as they developed a shared understanding and appreciation of their inter-relationships which were considered within the context of risk management. Changes were also noted in the families' communication patterns and the way in which family members related to one another. The RT appeared to influence change through a range of discursive strategies which included: collaborative co-positioning of the family and therapy team; adopting an expert position regarding risks and areas of continuing concern; emphasising and reinforcing family strengths, progress and resilience. In addition, the use of pronouns, past and future tense were influential strategies utilised by the RT.

Through the use of generic therapeutic skills the therapeutic alliance was established and maintained. The influence of the RT was also mediated by input from the therapist. It appears to be the collaborative influence of the therapist and RT combined which has significantly influenced the overall changes observed. However, the RT did not appear to be as influential upon the generation of multiple alternative perspectives as theorised within the literature (Lax, 1995; Paré, 1999; Janowsky, Dickerson, & Zimmerman, 1995). This suggests a potential to progress existing RT theory and guidelines to incorporate the adaptations required when working with high levels of risk.

Findings of the present study suggest that the RT is a worthwhile and useful resource for the process of family therapy. The RT was instrumental in guiding and reinforcing the therapist's influence, acting as a consultative team, a supervisory resource and a collaborative partner. The RT was therefore a valuable addition to therapy as they had a significant influence on many aspects of the therapeutic process including: the establishment and maintenance of the therapeutic alliance, meaning-making, change, and the influence of the therapist which far exceeded that which could have been undertaken with a lone therapist. The RT are also valuable in terms of providing an alternative position and perspective to that offered by the lone therapist which also minimises the

potential for over identification with individual family members. Consequently, this research supports the continued allocation of resources for the provision of RTs within family therapy, and for further research to be undertaken to improve our understanding of this process with other populations and presentations.

Recommendations for the future use of RT's include;

1) The potential benefits of utilising the RT at all stages of therapy which includes; to establish and enhance the development of the therapeutic alliance during the initial and early stages of therapy, to review and focus the remaining therapy during the mid-therapy stages, and to review progress and identify areas for further development in the later stages.

2) The RT adapting their approach in response to the specific needs of the family, such as the value of being direct to manage risk and a united, collaborative positioning of the team in response to family conflicts.

3) Consider utilising a diverse, multi-ethnic, multicultural, and mixed gendered RT as this may open up more discussions around contentious issues. This may also facilitate the construction of meanings that are varied and not too aligned or distant from those of the individual family members.

4) The importance of implementing interpersonal and generic therapeutic skills in order to influence change (Jordan, Cowan & Roberts, 1995).

Final Reflections

Undertaking the current study has influenced my personal and professional development in a number of ways. Through the close observation and analysis of therapy sessions, I have become more aware of systemic theories, techniques and the process of positioning in interactions. I am also more aware of my influential position during the process of meaning-making within therapy with clients, and the importance of reflective and supervisory processes for enhancing and monitoring my use of self within clinical settings.

As the current study progressed, I became more aware of factors influencing my interpretations and analysis; this included my personal, family and professional experiences. For example, having had first-hand experience of family conflict, I was aware of my tendency to identify with the

position of the young person in family one. I was also aware that my personal and professional interest in promoting children's rights and welfare had the potential to influence my reactions to the data and my interpretation of negotiations within the therapy session. However, as the research progressed, I became more aware and mindful of my position and the potential for this to influence my interpretations. As the research process was circular, this enabled me to re-visit, question and re-phrase some of my earlier interpretations in line with participants words, grounding these in the data to minimise the level of personal bias.

During the analysis of family three, I also became aware that gaps in my knowledge and experience of various Indian cultures, traditions and religions within western society and the UK may have limited my understanding and analysis of the case. This may have resulted in a degree of caution regarding how I interpreted some of the family discussions and behaviours within the family who were of a race, religion, culture and ethnicity which differed from that of my own. Some of the family discussions involved assumptions about gender roles and power relations within the family, in addition to concerns about marrying others outside of one's own religion. These issues appeared to be linked to segregation within the wider family and there were indications that this was an area that the family found difficult to discuss openly within the therapy session. This may have posed a challenge to the therapy team in dealing with a delicate and potentially volatile topic during therapy which involved wider cultural and systemic issues. Additionally, this raised a further question regarding the different ethnic background of the therapists and the family members which could have been a barrier to engaging openly with these contentious topics. Reflecting on such issues and influences during supervision and within my reflective diary enabled me to become more aware of potential biases and to consider alternative hypotheses and interpretations by drawing upon and expanding my existing knowledge.

'Paralysis by analysis' captures my experience of undertaking the research, with over-thinking, caution and a lack of confidence debilitating progress. I felt at times that I had too many ideas regarding the direction of the research which hindered my progress. As time elapsed, the importance of clear, simple questions and a systematic model to guide the process of undertaking and writing up the research became increasingly evident. I also recognised that the chosen method is only a means to an end which also facilitates the research process. While recognising the importance of having a guiding framework for systematising the research, with close attention to method and procedure, there is a risk that energy can be exhausted and rigidity can inhibit

progress and creativity. Over the course of undertaking the research I have come to realise that "it is in the spaces between ideas that our creativity is most fertile" (Burck, Barratt, & Kavner, 2013, p.xxiii).

There were inherent difficulties when undertaking the current study as it involved developing a new procedure for data analysis whilst also interpreting the new data. Consequently it was difficult to take a meta-perspective and develop multiple or alternative understandings and interpretations of the therapy data. The development of alternative interpretations and perspectives may require greater degree of separation from the data. This may be possible in subsequent revisions of the material contained within the current thesis.

Theoretical concepts central to the RT including reflexivity, dialogical processes, meaning systems, instructive interaction, conditions of safety, maintaining ones integrity, and the difference that makes a difference, were all central to my personal experience and the process of undertaking the current thesis. I became very aware of my gruelling and relentless approach to learning and personal development in addition to feelings of incompetence within academia. In the absence of a clear guiding framework, coupled with many competing demands, my attempts to amalgamate ideas and concepts from a wide range of sources stretched my personal constructs and meaning system to a point which led at times to confusion and incoherence. This was particularly evident in my original transcript. It has taken much time and patience for my ideas to become comprehensible and for these to be communicated to others through the written word.

Parallels between therapeutic and supervisory relationships were also evident, with relationships being central to the negotiation, joint meaning-making and shared understandings which occur throughout therapeutic and supervisory processes. Supervising doctoral research is a complex, multifaceted relational task influenced by various factors including models and understandings of supervision pedagogy (McCallin & Nayar, 2012) and the differing needs and expectations of supervisors and supervisees (Gill & Burnard, 2008). A further avenue for research may be to look at how meaning is negotiated within the supervisory process. The approach to such research may draw upon the use of positioning theory and sematic polarities such as that undertaken within the current study.

Whilst the research was not a simple endeavour, it is hoped that findings from the current study have made a worthwhile contribution to our understanding of RT processes and also to inform future research methodology. In summary, the process of undertaking the current research has been challenging and character building. I hope that this experience will enable me to undertake future research, therapy, supervision and consultative work with more confidence so as to be more effective and efficient in these endeavours.

ABBREVIATIONS

ASBOs	Antisocial Behaviour Orders
BPS:	British Psychological Society
CA:	Conversation Analysis
CAMHS:	Child and Adolescent Mental Health Services
DA:	Discourse Analysis
DP:	Discursive Psychology
LAC:	Looked After Children
MRI:	Mental Research Institute
NHS:	National Health Service
NICE:	National Institute of Clinical Excellence
PA:	Positioning Analysis
RCT:	Randomised Controlled Trial
RT:	Reflecting Team
SHIFT:	Self-harm Intervention Family Therapy
SFBT:	Solution Focused Brief Therapy
SFT:	Systemic Family Therapy
UK:	United Kingdom

REFERENCES

Allen, R. E. S. (2011). *Childless older people and support: positioning experiences and expectations*. Retrieved from https://researchspace.auckland.ac.nz/handle/2292/6622

Allen, J. M., & Faigley, L. (1995). Discursive strategies for social change: An alternative rhetoric of argument. *Rhetoric Review*, *14*, 142-172.

Allen, R. E., & Wiles, J. L. (2013). The utility of positioning theory to the study of ageing: Examples from research with childless older people. *Journal of Aging Studies*, 27, 175-187.

Andersen, T. (1987). The reflecting team: dialogue and meta-dialogue in clinical work. *Family Process*, *26,* 4, 415-428.

Andersen, T. (1991). *The reflecting team: Dialogues and dialogues about the dialogues*. London, W.W. Norton & Company, Ltd.

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 27, 371-393.

Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In. S. McNamee & K. Gergen (Eds.), Therapy as social construction (pp. 25-39). Newbury Park, CA: Sage.

Anderson, H., & Jensen, P. (2007). Innovations in the reflecting process. London: Karnac Books.

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online*. Retrieved from http://www.distans.hkr.se/anders/transana_workshop/antakibilligedwardspotter.pdf

Aristotle (1996). *Aristotle's Metaphysics* (H.G.Apostle, Trans.). Bloomington: Indiana University Press.

Asen, E. (2002). Outcome Research in Family Therapy. *Advances in Psychiatric Treatment.* 8, 230-238.

Avdi, E., & Georgaca, E. (2007). Narrative research in psychotherapy: A critical review. *Psychology and Psychotherapy: Theory, Research and Practice*, 80, 407-419.

Bakhtin, M., & Emerson, C. (1984). *Problems of Dostoevsky's poetics*. University of Minnesota Press.

Baldwin, S. A., Imel, Z. E., Braithwaite, S. R., & Atkins, D. C. (2014). Analyzing multiple outcomes in clinical research using multivariate multilevel models. *Journal of Consulting and Clinical Psychology*, *82*, 5, 920.

Bamberg, M. (1999). Is there anything behind discourse? Narrative and the local accomplishment of identities. In W., Maiers, B., Bayer, B., Esgalhado, R., Jorna, & E., Schraube. (Eds.). *Challenges to Theoretical Psychology*, (pp.220-227). North York, Ontario, Captus Press.

Bamberg, M. (2004). Talk, Small Stories, and Adolescent Identities. *Human Development*, 47, 366-369.

Bamberg, M. (2008). Selves and identities in the making: The study of microgenetic processes in interactive practices. In U. Müller, J. Carpendale, N. Budwig, & B. Sokol. (Eds.), *Social Life and Social Knowledge*: Toward a Process Account of Development (pp. 205–224). New York: Erlbaum/Taylor & Francis.

Bamberg, M., & Georgeakopoulos, A. (2008). Small stories as a new perspective in narrative and identity analysis. *An Interdisciplinary Journal of Language, Discourse Communication Studies*, 28, 377-396.

Berger, R. (2000). The goodness of fit between the reflecting team approach and stepfamilies' problems and issues. *Journal of Systemic Therapies*, *19,* 2, 43.

Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in clinical psychology*. London: Wiley.

Bartlett, T. (2008). *Wheels within wheels, or triangles within triangles: Time and context in positioning theory.* In Global conflict resolution through positioning analysis (pp. 169-187). New York: Springer.

Bartunek, J. M., & Seo, M. G. (2002). Qualitative research can add new meanings to quantitative research. *Journal of Organizational Behavior*, 23, 237-242.

Bateson, G. (1972). *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology*. University of Chicago Press.

Beaudoin, M. N. (2008). Therapeutic movement and stuckness in Family Therapy. *Journal of Systemic Therapies*, 27, 76-91.

Berg, I., & Dolan, Y. (2001). *Tales of solutions: A collection of hope-inspiring stories*. New York, NY: Norton.

Berge, M., and Danielsson, A. T. (2013). Characterising learning interactions: a study of university students solving physics problems in groups. *Research in Science Education*, 43, 1177-1196.

Besley, A. C. (2002). Foucault and the turn to narrative therapy. *British Journal of Guidance and Counselling*, *30*, 2, 125-143.

Biever, J. L., & Gardner, G. T. (1995). The use of reflecting teams in social constructionist training. *Journal of Systemic Therapies.* Vol 14, 3, 47-56

Bogdan, J. L. (1984). Family organization as an ecology of ideas: An alternative to the reification of family systems. *Family Process*, *23*, 375-388.

Borowsky, I. W., Ireland, M., & Resnick, M. D. (2001). Adolescent suicide attempts: risks and protectors. *Pediatrics*, 107, 485-493.

Boston, P. (2000). Systemic family therapy and the influence of post-modernism. *Advances in Psychiatric Treatment*, *6*, 450-457.

Boston, P., Eisler, I., & Cottrell, D. (2009). *Systemic Family Therapy Manual for Adolescents Self-Harm; SHIFT Self Harm Intervention Family Therapy*. Retrieved from http://medhealth.leeds.ac.uk/SHIFTManual

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101.

Brent, D. A., & Mann, J. J. (2006). Familial pathways to suicidal behavior—understanding and preventing suicide among adolescents. *New England Journal of Medicine*, *355*, 2719-2721.

Brown, Philippa Hannah (2014). *People with learning disabilities and the interpersonal construction of self-determination*. (Unpublished doctoral thesis). University of Leeds. Retrieved from http://etheses.whiterose.ac.uk/

Brownlee, K., Vis, J. A., & McKenna, A. (2009). Review of the reflecting team process: Strengths, challenges, and clinical implications. *The Family Journal*, *17*, 139-145.

Bruner, J. (1986). Two modes of thought. *Actual minds, possible worlds*, London, Harvard University Press

Bruner, J. (1997). A narrative model of self-construction. *Annals of the New York Academy of Sciences*, 818, 145-161.

Burck, C. (2005). Comparing qualitative research methodologies for systemic research: The use of grounded theory, discourse analysis and narrative analysis. *Journal of Family Therapy*, *27*, 237-262.

Burck, C., Barratt, S., and Kavner, E. (2013). *Positions and polarities in contemporary systemic practice: The Legacy of David Campbell*. London; Karnac Books Ltd.

Burnham, J., Alvis Palma, D., and Whitehouse, L. (2008). Learning as a context for differences and differences as a context for learning. *Journal of Family Therapy*, 30, 529-542.

Byrne, S., Morgan, S., Fitzpatrick, C., Boylan, C., Crowley, S., Gahan, H., & Guerin, S. (2008). Deliberate self-harm in children and adolescents: a qualitative study exploring the needs of parents and carers. *Clinical Child Psychology and Psychiatry*, *13*, 493-504.

Campbell, D. (2003). Fundamentals of theory and practice revisited; The mutiny and the bounty: The place of Milan ideas today. *Australian and New Zealand Journal of Family Therapy*, *24*, 15-25.

Campbell, D., Ayo, Y. & Grønbæk, M. (2009). *Positioning theory applied to systemic practice.* Retrieved from https://www.youtube.com/watch?v=Ifo-DU830kg

Campbell, D., & Grønbæk, M. (2006). *Taking positions in the organization*. Karnac Books.

Cantwell, P., & Holmes, S. (1994). Social construction: A paradigm shift for systemic therapy and training. *Australian and New Zealand Journal of Family Therapy*, *15*, 17-26.

Carlsson, G., Hantilsson, U., and Nyström, M. (2014). Reflective team–a clinical intervention for sustainable care improvement. *Reflective Practice*, *15*, 378-389.

Carr, A. (1998). Michael White's narrative therapy. *Contemporary Family Therapy*, *20*, 485-503.

Carr, A. (2000a). Evidence-based practice in family therapy and systemic consultation I: Child focused problems. *Journal of Family Therapy*, 22, 29-60.

Carr, A. (2000b). Evidence-based practice in family therapy and systemic consultation II: Adult focused problems. *Journal of Family Therapy*, 22, 273-295.

Carr, A. (2006). Thematic review of family therapy journals in 2005. *Journal of Family Therapy*, *28*, 420-439.

Chang, J. (2010). The reflecting Tteam. A training method for family counsellors. *The Family Journal: Counselling and Therapy for Couples and Families*, 18, 36-44.

Children Act (1989). Retrieved from http://www.legislation.gov.uk/ukpga/1989/41/contents

Collishaw, S. (2015). Annual research review: secular trends in child and adolescent mental health. *Journal of Child Psychology and Psychiatry*, 56, 370-393.

Cooper, W. O., Callahan, S. T., Shintani, A., Fuchs, D. C., Shelton, R. C., Dudley, J. A., Graves, W.A. & Ray, W. A. (2014). Antidepressants and suicide attempts in children. *Pediatrics*, *133,* 2, 204-210.

Compton, M. T., Thompson, N. J., & Kaslow, N. J. (2005). Social environment factors associated with suicide attempt among low-income African Americans: The protective role of family relationships and social support. *Social Psychiatry and Psychiatric Epidemiology*, 40, 175-185.

Cottrell, D., & Boston, P. (2002). Practitioner review: The effectiveness of systemic family therapy for children and adolescents. *Journal of Child Psychology and Psychiatry*, 43, 573-586.

Coulehan, R., Friedlander, M. L., and Heatherington, L. (1998). Transforming narratives: A change event in constructivist family therapy. *Family Process*, *37,* 1, 17-33.

Cox, J. A., Bañez, L., Hawley, L. D., & Mostade, J. (2003). Use of the reflecting team process in the training of group workers. *Journal for Specialists in Group Work*, *28*, 89-105.

Data Protection Act (1998). Retrieved from http://www.legislation.gov.uk/ukpga/1998/29

Davidson, C. R. (2009). Transcription: Imperatives for qualitative research. *International Journal of Qualitative Methods*, 8, 35-52.

Davies, B., & Harré, R. (1990). Positioning and personhood. In: R. Harré & L.V.Langenhove (Eds.), *Positioning Theory*, (pp.32-52). Oxford: Blackwell.

Davies, B., & Harré, R. (2001). Positioning: The Discursive Production of Selves, In Wetherell, M., Taylor, S., & Yates, S. J. (2001). *Discourse Theory and Practice: A Reader,* (pp.261-271). London: Sage.

de Barbaro, B., Drożdżowicz, L., Janusz, B., Gdowska, K., Dembińska, E., Kołbik, I., & Furgał, M. (2008). Multi-Couple Reflecting Team: Preliminary Report. *Journal of Marital and Family Therapy*, *34*, 287-297.

de Oliveira, A. S. B. (2003). An "Appropriated Unusual" Reflecting Team: Inviting Parents to Be on the Team. *Journal of Family Psychotherapy*, *14*, 85-88.

de Shazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. *Family Process,* 25, 2, 207-221.

de Shazer, S., Dolan, Y., Korman, H., McCollum, E., Trepper, T., & Berg, I. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. NY US: Haworth Press

DfE, (2015). Working together to safeguard children. *A guide to inter-agency working to safeguard and promote the welfare of children.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Diorinou, M., & Tseliou, E. (2014). Studying circular questioning "in situ": Discourse analysis of a first systemic family therapy session. *Journal of Marital and Family Therapy*, *40*, 106-121.

DoH, (2007). The department of health best practice in managing risk guidelines. *Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*. Retrieved from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf

Dsharrie Shazer, S., Insoo, K., Lipchik, E., Nunnally, A., Wallace, G. & Weiner-Davis, M. (1986) Brief therapy: Focused solution development. *Family Process,* 25, 207-221.

Edley, N. (2001). Analysing masculinity: Interpretative repertoires, ideological dilemmas and subject positions. In M. Wetherell, S., Taylor, & S.J. Yates, (Eds.). *Discourse as data: A guide for analysis*, (pp.189-228). London, Sage.

Egeland, B., Carlson, E., & Sroufe, L. A. (1993). Resilience as process. *Development and Psychopathology*, *5*, 517-528.

Egeli, N., Brar, N., Larsen, D., & Yohani, S. (2014a). Couples' experiences of hope when participating in the reflecting team process: A case study. *Contemporary Family Therapy*, *36*, 93-107.

Egeli, N., Brar, N., Larsen, D., and Yohani, S. (2014b). Couples' experiences of vulnerability when participating in the reflecting team process: A case study. *Canadian Journal of Counselling and Psychotherapy*, 48, 4, 20-39.

Egeli, N., Brar, N., Larsen, D., and Yohani, S. (2014c). Intersections between hope and vulnerability in couples' experiences of the reflecting team process. *Journal of Couple & Relationship Therapy*, *13*, 3, 198-218.

Eisler, I., Dare, C., & Szmukler, G. I. (1988). What's happened to family interaction research? An historical account and a family systems viewpoint. *Journal of Marital and Family Therapy*, *14*, 45-65.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*, 215-229.

Escudero, V., Friedlander, M. L., Varela, N., & Abascal, A. (2008). Observing the therapeutic alliance in family therapy: Associations with participants' perceptions and therapeutic outcomes. *Journal of Family Therapy*, 30, 194-214.

Eubanks, R. A. (2002). The MRI reflecting team: An integrated approach. *Journal of Systemic Therapies*, *21*, 1, 10.

Evans, E., Hawton, K., & Rodham, K. (2005). In what ways are adolescents who engage in self-harm or experience thoughts of self-harm different in terms of help-seeking, communication and coping strategies? *Journal of Adolescence*, *28*, 573-587.

Firestone, W. A. (1993). Alternative arguments for generalizing from data as applied to qualitative research. *Educational Researcher*, *22*, 16-23.

Fishel, A. K., Ablon, J. S., & Craver, J. C. (2010). The couple's reflecting team: How spoken and written reflections, gender, and stage of therapy impact perceived helpfulness. *Journal of Couple & Relationship Therapy*, *9*, 344-359.

Fishel, A. K., Buchs, T., McSheffrey, C., & Murphy, C. (2001). Adding written reflections to the reflecting team. *Journal of Family Psychotherapy*, *12*, 81-88.

Fisher, H. L., Moffitt, T. E., Houts, R. M., Belsky, D. W., Arseneault, L., & Caspi, A. (2012). Bullying victimisation and risk of self-harm in early adolescence: longitudinal cohort study. *British Medical Journal, 344, e2683, 1-9.* Retrieved from *http://www.bmj.com/content/bmj/344/bmj.e2683.full.pdf*

Fleuridas, C., Nelson, T. S., & Rosenthal, D. M. (1986). The evolution of circular questions: Training Family Therapists. *Journal of Marital and Family Therapy*, *12*, 113-127.

Fliege, H., Lee, J. R., Grimm, A., & Klapp, B. F. (2009). Risk factors and correlates of deliberate self-harm behavior: A systematic review. *Journal of psychosomatic research*, *66*, 477-493.

Focht-Birkerts, L., & Beardslee, W. R. (2000). A Child's Experience of Parental Depression: Encouraging Relational Resilience in Families with Affective Illness. *Family Process*, 39, 417-434.

Foucault, M. (1982). The subject and power. *Critical inquiry*, *8*, 4, 777-795.

Friedman, S. E. (1995). *The reflecting team in action: Collaborative practice in family therapy*. New York, Guilford Press.

Frigerio, A., Montali, L., and Fine, M. (2013). Attention deficit/hyperactivity disorder blame game: A study on the positioning of professionals, teachers and parents. *Health,* 17, 584-604.

Gale, J. (2010). Discursive analysis: A research approach for studying the moment-to-moment construction of meaning in systemic practice. *Human Systems: The Journal of Therapy, Consultation & Training*, *21*, 7-37.

Garcia, A. G., & Guevara, L. (2007). Voicing Voices. . In H., Anderson, & P., Jensen. (Eds.). *Innovations in the reflecting process*. (pp.58-73). London, Karnac Books.

Garrido-Fernández, M., Jaén-Rincón, P., & Garcia-Martínez, J. (2011). Evaluating a reflecting-team couples approach to problem gambling. *Journal of Constructivist Psychology*, *24*, 1-29.

Garven, R. (2011). Creating dialogic contexts for multidisciplinary clinical reviews: The reflecting team process. *Australian and New Zealand Journal of Family Therapy*, *32*, 283-299.

Gehart, D. (2013). Philosophical foundations of family therapy theories. In mastering competencies in family therapy: A practical approach to theory and clinical case documentation. (2nd Eds). California State University, Cengage Learning.

Gehart, D. (2014). *MRI and Milan: Systemic family therapies part I. Mastering Competencies Series*. Retrieved from https://www.youtube.com/watch?v=QRBjvCxeBeg

Gergen, K. J. (2001). *Social construction in context*. London: Sage.

Gergen, K. J. (2009*). Realities and relationships: Soundings in social construction*. Harvard University Press.

Ghosten, C. D. (2012*). Analyzing conflict in organizations with positioning theory: A narrative Inquiry.* Retrieved from http://trace.tennessee.edu/utk_graddiss/1295/

Gill, P., & Burnard, P. (2008). The student-supervisor relationship in the PhD/Doctoral process. *British Journal of Nursing*, *17*, 668-672.

Grandesso, M. A. (1996). The reflecting team: An analysis from the construction-of-meaning point of view. *Journal of Constructivist Psychology*, *9*, 303-309.

Gratz, K. L. (2003). Risk factors for and functions of deliberate Self-Harm: An empirical and conceptual review. *Clinical Psychology: Science and Practice*, *10*, 192-205.

Green, B. (2015). *How do therapists and families negotiate meaning and family relating during family therapy for self-harm?* (Unpublished doctoral thesis). University of Leeds. Retrieved from http://etheses.whiterose.ac.uk/

Green, D., & Latchford, G. (2012). *Maximising the benefits of psychotherapy: A practice-based evidence approach*. West Sussex. John Wiley & Sons.

Greenberg, L. S. (1991). Research on the process of change. *Psychotherapy Research*, *1*, 3-16.

Griffith, J. L., & Griffith, M. E. (1992). Speaking the unspeakable: Use of the reflecting position in therapies for somatic symptoms. *Family Systems Medicine*, *10*, 41-51

Griffith, J. L., Griffith, M. E., Krejmas, N., McLain, M., Mittal, D., Rains, J., & Tingle, C. (1992). Reflecting team consultations and their impact upon family therapy for somatic symptoms as coded by structural analysis of social behavior (SASB). *Family Systems Medicine*, *10,* 1, 53.

Griffith, W. (1999). The reflecting team as an alternative case teaching model a narrative, Conversational approach. *Management Learning*, *30*, 343-362.

Guerreiro, D. F., Cruz, D., Frasquilho, D., Santos, J. C., Figueira, M. L., & Sampaio, D. (2013). Association between deliberate self-harm and coping in adolescents: a critical review of the last 10 years' literature. *Archives of Suicide Research*, 17, 91-105.

Harré, R., & Moghaddam, F. M. (2008). *Intrapersonal conflict. In global conflict resolution through positioning analysis* (pp. 65-78). New York: Springer.

Harré, R., & Moghaddam, F. M. (Eds.). (2003). *The Self and others: Positioning Individuals and Groups in Personal, Political, and Cultural Contexts*. Greenwood Publishing Group.

Harré, R., Moghaddam, F. M., Cairnie, T. P., Rothbart, D., & Sabat, S. R. (2009). Recent advances in positioning theory. *Theory & Psychology*, 19, 5-31.

Harré, R., & Slocum, N. (2003). Disputes as complex social events: On the uses of positioning theory. *Common Knowledge*, 9, 100-118.

Harper, D. J. (2003). Poverty and discourse. In *Poverty and Psychology* (pp. 185-203). US; Springer.

Hawley, D. R. (2000). Clinical implications of family resilience. *American Journal of Family Therapy*, *28*, 2, 101-116.

Hawton, K., Rodham, K., Evans, E., & Wetherall, R. (2002). Deliberate self-harm in adolescents: self-report survey in schools in England. *British Medical Journal*, *325*, 1207-1211.

Hawton, K., Zahl, D., & Weatherall, R. (2003). Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. *The British Journal of Psychiatry*, *182*, 6, 537-542.

Henriksen, T. D. (2008). Liquidating roles and crystallising positions: Investigating the road between role and positioning theory. In Moghaddam, F. M., Harré, R., & Lee, N. (Eds.). *Global Conflict Resolution through Positioning Analysis* (pp. 41-64). Springer New York.

Hoffman, L. (1988). A constructivist position for family therapy. *The Irish Journal of Psychology*, *9* ,1, 110-129.

Hoffman, L. (1985). Beyond power and control: Toward a "second order" family systems therapy. *Family Systems Medicine*, *3*, 4, 381-396

Hoffman, L. (2007). Practising "withness": A human art. In H., Anderson, & P., Jensen, (Eds.). *Innovations in the reflecting process*. (pp.3-15). London, Karnac Books.

Hoffman, R., Hinkle, M. G., & Kress, V. W. (2010). Letter writing as an intervention in family therapy with adolescents who engage in nonsuicidal self-injury. *The Family Journal*, *18*, 24-30.

Höger, C., & Temme, M. (1995). Systemic therapy with a reflecting team: Processes and outcomes. [German]. Systemische Therapie mit einem reflektierenden Team. Eine Annaherung an Wirksamkeit und Wirkungsweise. *System Familie, 8*, 1, 51-61.

Höger, C., Temme, M., & Geiken, G. (1994). Who benefits from systemic therapy with a reflecting team? *Zeitschrift fur Kinder-und Jugendpsychiatrie*, *22*, 16-22.

Höger, C., Temme, M., Reiter, L., & Steiner, E. (1994). The reflecting team approach: convergent results of two exploratory studies. *Journal of Family Therapy*, *16*, 427-437.

Hopkins, C., & Reed, A. (2008). Accent, dialect, and vocabulary in the reflective process: A question of ethics. *Journal of Systemic Therapies*, *27,* 2, 50-59.

Hoyt, M. F. (2013). *Some stories are better than others: Doing what works in brief therapy and managed care.* Philadelphia: Routledge.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change.* Washington, DC: American Psychological Association.

Jackson, D. D. (1956). The question of family homeostasis. *The Psychiatric Quarterly. Supplement*, *31*, 79-90.

Janowsky, Z. Dickerson, V. & Zimmerman, J. (1995). Through Susan's eyes: Reflections on a

    reflecting team experience. In S., E., Friedman (Ed.). *The reflecting team in action:*

    Collaborative practice in family therapy. New York, Guilford Press, 167-183

Jefferson, G. (1985). *An exercise in the transcription and analysis of laughter*. In T. Van Dijk (Ed.).

    Handbook of discourse analysis, Vol. 3: discourse and dialogue (pp.25-34). London, UK:

    Academic Press.

Jenkins, D. (1996). A Reflecting Team Approach to Family Therapy: a Delphi Study. *Journal of*

    Marital and Family Therapy, 22, 219-238.

Johnson, C., Waters, M., Webster, D., & Goldman, J. (1997). What do you think about what the

    team said? The solution-focused reflecting team as a virtual therapeutic community.

    Contemporary Family Therapy, *19*, 1, 49-62.

Jordan, E., Cowan, A., & Roberts, J. (1995). Knowing the rules: Discursive strategies in young

    children's power struggles. *Early Childhood Research Quarterly*, *10*, 3, 339-358.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: past, present, and future. *Clinical*

    Psychology: Science and Practice, *10*, 144-156.

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005). A theoretical model of common

    process factors in youth and family therapy. *Mental Health Services Research*, *7*, 35-51.

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic

    relationship variables in youth and family therapy: The evidence for different relationship

    variables in the child and adolescent treatment outcome literature. *Clinical Psychology*

    Review, *26*, 50-65.

Kelly, G. A. (1955). The psychology of personal constructs, Volume one: *A theory of personality*. WW

    Norton and Company.

Kjellberg, E., Edwardsson, M., Niemela, B. J., & Oberg, T. (1995). Using the reflecting process with families stuck in violence and child abuse. In Friedman, S. E. *The reflecting team in action*, New York, Guilford Press, 38-61.

Klonsky, E. D. (2009). The functions of self-injury in young adults who cut themselves: Clarifying the evidence for affect-regulation. *Psychiatry Research*, *166*, 260-268.

Klonsky, E. D., & Glenn, C. R. (2009). Assessing the functions of non-suicidal self-injury: Psychometric properties of the Inventory of Statements About Self-injury (ISAS). *Journal of Psychopathology and Behavioral Assessment*, *31*, 215-219.

Kogan, S. M. (1998). The politics of making meaning: Discourse Analysis of a 'postmodern' interview. *Journal of Family Therapy*, 20, 229-251.

Korobov, N. (2001). Reconciling Theory with Method: From Conversation Analysis and Critical Discourse Analysis to Positioning Analysis. *In Forum: Qualitative Social Research*, 2, 3, 1-36.

Kuenzli-Monard, F., & Kuenzli, A. (1999). Une différence fait-elle la différence? Le reflecting team comme partie intégrante d'un processus psychothérapeutique. *Thérapie familiale*, *20,* 1, 23-37.

Landis, L. & Young, M. (1994). The Reflecting Team in Counsellor Education. *Counsellor Education and Supervision*, 33, 210-280.

Lange, R. (2010). The Family as its Own Reflecting Team: A Family Therapy Method. *Journal of Family Therapy*, 32, 398-408.

Lax, W. (1995). Offering Reflections; Some Theoretical and Practical Considerations. In Friedman, S. E. *The reflecting team in action: Collaborative practice in family therapy*. New York, Guilford Press, 145-166

Levant, R. F. (2005). *Report of the 2005 Presidential Task Force on Evidence-Based Practice*. Washington DC : American Psychological Association.

Lever, H., & Gmeiner, A. (2000). Families leaving family therapy after one or two sessions: A multiple descriptive case study. *Contemporary Family Therapy*, *22*, 39-65.

Liddle, H. A. (1995). Conceptual and clinical dimensions of a multidimensional, multi-systems engagement strategy in family-based adolescent treatment. *Psychotherapy: Theory, Research, Practice, Training*, *32*, 39-58

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. New York, Guilford Press.

Löwenborg, C. (2001). Inspiration Across Cultures: Reflecting Teams among the Métis in Canada. *Australian and New Zealand Journal of Family Therapy*, *22*, 25-27.

Lucas, U., & Tan, P. L. (2007). Developing a reflective capacity within undergraduate education: the role of work-based placement learning. *Higher Education*, 2, 2005-2007.

Luft, J. & Ingham, H. (1955). *The Johari Window: a graphic model for interpersonal relations*. Los Angeles: University of California Western Training Lab.

Madge, N., Hawton, K., McMahon, E. M., Corcoran, P., De Leo, D., de Wilde, E. J., Fekete, S., van Heeringen, K., Ystgaard, M., & Arensman, E. (2011). Psychological characteristics, stressful life events and deliberate self-harm: findings from the Child & Adolescent Self-harm in Europe (CASE) Study. *European Child & Adolescent Psychiatry*, *20*, 499-508.

Malinen, T., Cooper, S. J., & Thomas, F. N. (2012). *Masters of narrative and collaborative therapies: the voices of Andersen, Anderson, and White*. New York: Routledge.

Martin-Beltran, M. (2013). "I don't feel as embarrassed because we're all learning": Discursive positioning among adolescents becoming multilingual. *International Journal of Educational Research*, *62*, 152-161.

Masterson, C., Barker, C., Jackson, D., & Boston, P. (2016). Constructing a SHIFT adherence measure (SAM): the development of a family therapy integrity measure for the SHIFT trial. *Journal of Family Therapy*. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/1467-6427.12104/abstract

Maturana, H. R., & Varela, F. J. (1987). *The tree of knowledge: The biological roots of human understanding*. Boston: New Science Library.

McAdams, D.P. (2008). Personal narratives and the life story. In John, O., Robins, R., and Pervin, L. A. *Handbook of personality: Theory and research*. (pp.241-261). Guilford Press. Retrieved from http://www.redemptiveself.northwestern.edu/mcadams/

McAdams, D. P., & Olson, B. D. (2010). Personality Development: Continuity and Change Over the Life Course. *Annual Review of Psychology*, 61, 517-542.

McCallin, A., & Nayar, S. (2012). Postgraduate research supervision: A critical review of current practice. *Teaching in Higher Education*, *17*, 63-74.

McCrea, S. M. (2010). Intuition, insight and the right hemisphere: emergence of higher sociocognitive functions. *Psychology Research and Behavior Management*, *3*, 1-39.

McDonald, G., O'Brien, L., & Jackson, D. (2007). Guilt and shame: experiences of parents of self-harming adolescents. *Journal of Child Health Care*, *11*, 298-310.

McLean, K. C., Pasupathi, M., & Pals, J. L. (2007). Selves Creating Stories Creating Selves: A Process Model of Self-Development. *Personality and Social Psychology Review*, 11, 262-278.

McNamee, S., & Gergen, K. J. (1992). *Therapy as social construction*. London, Sage.

Merriam, S. B. (1988). *Case study research in education: A qualitative approach*. San Francisco, Jossey-Bass.

Miermont, J. (1995). *The Dictionary of Family Therapy*. Blackwell Publishing. Retrieved from
http://www.blackwellreference.com/public/book?id=g9780631170488_9780631170488

Miller, D., & Lax, W. D. (1988). Interrupting deadly struggles: A reflecting team model for working with couples. *Journal of Systemic Therapies*, *7,* 3, 16.

Minuchin, S. (1974). *Families and family therapy*. Harvard University Press.

Minuchin, S., and Fishman, H. C. (1981). *Family therapy techniques*. UK: Harvard University Press.

Minuchin, S., and Laplin, J. (2011). Salvador Minuchin on Family Therapy. Retrieved from
https://www.psychotherapy.net/data/uploads/5113e45715ce5.pdf.

Minuchin, S. (2012). Salvador Minuchin. Marlborough Family Service, London. MCF. The Philadelphia Child and Family Therapy Training Center. Association for Family Therapy and Systemic Practice. Retrieved from https://www.youtube.com/watch?v=eSE1_k7gD6Y.

Mirkin, M. P. E. (1990). *The social and political contexts of family therapy*. Allyn & Bacon.

Mitchell, P., Rhodes, P., Wallis, A., & Wilson, V. (2014). A Comparison of Two Systemic Family Therapy Reflecting Team Interventions. *Journal of Family Therapy*, 36, 237-254.

Monk, G., & Gehart, D. R. (2003). Socio-Political Activist or Conversational Partner? Distinguishing the Position of the therapist in Narrative and Collaborative Therapies. *Family Process*, 42, 19-30.

Moon, S. M., Dillon, D. R., & Sprenkle, D. H. (1990). Family Therapy and Qualitative Research. *Journal of Marital and Family Therapy, 16,* 357-373.

Munro, L., Knox, M., & Lowe, R. (2008). Exploring the potential of constructionist therapy: deaf clients, hearing therapists and a reflecting team. *Journal of deaf studies and deaf education*, *13*, 307-323.

Myerhoff, B. (1986). *Life not death in Venice: Its second life*. In V. Turner, & E. Bruner. The Anthropology of Experience. Chicago: University of Illinois Press.

NHS. (2015). Risk management policy and process guide, NHS England. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2012/11/risk-man-strat.pdf

NICE. (2004). *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. Retrieved from www.nice.org.uk/CG16

Nolan, A., & Moreland, N. (2014). The process of psychological consultation. *Educational Psychology in Practice*, 30, 63-77.

Norcross, John C., and Bruce E. Wampold. (2011). "Evidence-based therapy relationships: Research conclusions and clinical practices." *Psychotherapy,* 48, 98-102.

Norris, S. (2002). The implication of visual research for discourse analysis: Transcription beyond language. *Visual Communication*, 1, 97–121.

O'Brien, P. J. (1994). The uses of an observation team with a parent support group. *International Journal of Group Psychotherapy*, *44*, 233-238.

O'Connor, R. C., Rasmussen, S., Miles, J., & Hawton, K. (2009). Self-harm in adolescents: Self-report survey in schools in Scotland. *The British Journal of Psychiatry*, *194*, 68-72.

O'Connor, T. S. J., Davis, A., Meakes, E., Pickering, R., & Schuman, M. (2004). Narrative therapy using a reflecting team: An ethnographic study of therapists' experiences. *Contemporary Family Therapy*, 26, 23-39.

O'Connor, T. S. J., Meakes, E., Pickering, M. R., & Schuman, M. (1997). On the right track: Client experience of narrative therapy. *Contemporary Family Therapy*, 19, 479-495.

Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm. *The British Journal of Psychiatry*, *181*, 193-199.

Papp, P. (1980). The Greek chorus and other techniques of paradoxical therapy. *Family process*, *19, 1*, 45-57.

Paré, D. A. (1999). Using reflecting teams in clinical training. *Canadian Journal of Counselling*, *33*, 293-306.

Parker, I. (2004). Criteria for qualitative research in psychology. *Qualitative Research in Psychology*, 1, 95-106.

Parker, N., & O'Reilly, M. (2013). Reflections from behind the screen avoiding therapeutic rupture when utilizing reflecting teams. *The Family Journal*, 21, 170-179.

Pender, R.L., & Stinchfield, T. (2012). A reflective look at reflecting teams. *The Family Journal; Counselling and Therapy for Couples and Families*, 20, 117-112.

Pender, R. L., & Stinchfield, T. (2014). Making meaning a couple's perspective of the reflecting team process. *The Family Journal*, *22,* 3, 273-281.

Perlesz, A., Young, J., Patersorr, R., & Bridge, S. (1994). The reflecting team as a reflection of second order therapeutic ideals. *Australian and New Zealand Journal of Family Therapy*, *15,* 3, 117-127.

Pote, H., Stratton, P., Cottrell, D., Boston, P., Shapiro, D., and Hanks, H. (2000). *Systemic family therapy manual*. University of Leeds: Leeds Family Therapy Research Centre, School of Psychology

Pote, H., Stratton, P., Cottrell, D., Shapiro, D & Boston, P. (2003). Systemic family therapy can be manualised: Research process and findings. *Journal of Family Therapy*. 25, 236-262.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London. Sage.

Potter, J. (2001). Wittgenstein and Austin. *Discourse Theory and Practice*, 39-48.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, *2*, 281-307.

Prest, L. A., Darden, E. C., and Keller, J. F. (1990). "The fly on the wall" reflecting team supervision. *Journal of Marital and Family Therapy*, *16*, 265-273.

Proctor, G. (2002). *The dynamics of power in counselling and psychotherapy: Ethics, politics and practice*. Herefordshire. United Kingdom. PCCS Books.

Reichelt, S., & Skjerve, J. (2013). The reflecting team model used for clinical group supervision without clients present. *Journal of Marital and Family Therapy*, *39*, 244-255.

Reiter, L., Steiner, E., Ahlers, C., Vogel, R. M., and Wagner, H. (1993): Das reflektierende Team als therapeutische Methode. *System Familie*, 6, 10-20.

Resnick M.D., Bearman, P.S., Blum, R.W., Bauman, K.E., Harris, K.M., Jones, J., Tabor, J., Beuhrin, T., Sieving, R.E., Shew, M., Ireland, M., Bearinger, L.H., & Udry, J.R. (1997). *Protecting adolescents from harm: Findings from the national longitudinal study on adolescent health*. Jama, 278, 823-832.

Rhodes, P., Whatson, L., Mora, L., Hansson, A., Brearley, K., & Dikian, J. (2011). Systemic hypothesising for challenging behaviour in intellectual disabilities: a reflecting team approach. *Australian and New Zealand Journal of Family Therapy*, *32*, 70-82.

Roach, P., Keady, J., Bee, P., & Williams, S. (2014). 'We can't keep going on like this': Identifying family storylines in Young onset dementia. *Ageing and Society*, 34, 8, 1397-1426.

Roberts, M., Caesar, L., Perryclear, B., & Phillips, D. (1989). Reflecting team consultations. *Journal of Systemic Therapies*, *8,* 2-3, 38-46.

Robertson, S., Bagnall, A. & M. Walker. (2015). Evidence for a gender-based approach to mental health programmes: Identifying the key considerations associated with "being male". Project Report. The Movember Foundation. Retrieved from http://eprints.leedsbeckett.ac.uk/1773/

Schegloff, E. A. (1999). 'Schegloff's texts' as' Billig's data': A critical reply. *Discourse & Society*, *10*, 558-572.

Scoliers, G., Portzky, G., Madge, N., Hewitt, A., Hawton, K., De Wilde, E. J., & Van Heeringen, K. (2009). Reasons for adolescent deliberate self-harm: a cry of pain and/or a cry for help? *Social Psychiatry and Psychiatric Epidemiology*, 44, 601-607.

Seikkula, J., & Olson, M. E. (2003). The open dialogue approach to acute psychosis: Its poetics and micropolitics. *Family Process*, *42*, 403-418.

Sells, S. P., Smith, T. E., Coe, M. J., Yoshioka, M., & Robbins, J. (1994). An ethnography of couple and therapist experiences in reflecting team practice. *Journal of Marital and Family Therapy*, *20*, 247-266.

Selvini, M. P., Boscolo, L., Cecchin, G., & Prata, G. (1980). Hypothesizing—circularity—neutrality: Three guidelines for the conductor of the session. *Family Process*, *19*, 3-12.

Sexton, T. L., & Alexander, J. F. (2004). *Functional family therapy clinical training manual*. Baltimore, MD: Annie E. Casey Foundation.

Sexton, T. L., Kinser, J. C., & Hanes, C. W. (2008). Beyond a single standard: Levels of evidence approach for evaluating marriage and family therapy research and practice. *Journal of Family Therapy*, 30, 386-398.

Sexton, T. L., Ridley, C. R., & Kleiner, A. J. (2004). Beyond common factors: multilevel-process models of therapeutic change in marriage and family therapy. *Journal of Marital and Family Therapy*, 30, 131-149.

Shadish, W. R., & Baldwin, S. A. (2003). Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy,* 29, 547-557.

Sharry, J., Darmody, M., & Madden, B. (2002). A solution-focused approach to working with clients who are suicidal. *British Journal of Guidance and Counselling*, 30, 383-399.

Sheinberg, M. (1985). The debate: A strategic technique. *Family Process*, 24, 259-271.

Shilts, L., Rudes, J., & Madigan, S. (1993). The use of a solution-focused interview with a reflecting team format: Evolving thoughts from clinical practice. *Journal of Systemic Therapies*, *12,* 1, 1.

Shotter, J. (1993). *The cultural politics of everyday life*. Toronto: University of Toronto Press

Shotter, J., & Katz, A. (2007). Reflecting talk. inner talk," and" outer talk": Tom Andersen's way of being. In H. Anderson & P. Jensen (Eds.), *Innovations in the reflecting process*, (pp.16-32). London, Karnac Books.

Shurts, W., Cashwell, C., Epurgeon, S., Degges-White, S. Barrio, C., and Kardatzke, K. (2006). Preparing counsellors in training to work with couples: Using role-plays reflecting teams. *The Family Journal*, 14, 151-157.

Skegg, K., Nada-Raja, S., Dickson, N., Paul, C., & Williams, S. (2003). Sexual orientation and self-harm in men and women. *American Journal of Psychiatry*. 160, 541-546

Sluzki, C. E. (1992). Transformations: A Blueprint for narrative changes in therapy. *Family Process*, 31, 217-230.

Smith, C. P. (2000). Content analysis and narrative analysis. In H. T. Reis & C. M. Judd

   (Eds.). *Handbook of research methods in social and personality psychology*, (pp.313-335).

   New York: Cambridge University Press.

Smith, J. A., Harré, R., & Van Langenhove, L. (Eds.). (1995). *Rethinking methods in psychology*.

   London, Sage.

Smith, T. E., Jenkins, D., & Sells, S.P. (1995). Reflecting teams: voices of diversity. *Journal of Family*

   Psychotherapy. 6, 2, 49-70.

Smith, T.E., Sells, S.P. & Clevenger, T. (1994). Ethnographic content analysis of couple and therapist

   perceptions in a reflecting team setting. *Journal of Marital and Family Therapy*, *20*, 267-286.

Smith, T.E.., Winton, M. & Yoshioka, (1992). A qualitative understanding of reflective teams II:

   therapists perspectives. *Contemporary Family Therapy*, 14, 5, 419-432.

Smith, T. E., Yoshioka, M., & Winton, M. (1993). A qualitative understanding of reflecting teams I:

   Client perspectives. *Journal of Systemic Therapies*, *12*, 3, 28-43.

Smith, T. Sells, S., Pereira, M., Todahl, J. & Papagianiss, G. (1995). Pilot process research of reflecting

   conversations. Qualitative studies in family psychotherapy. *Journal of Family Psychotherapy*,

   6, 3, 71-89

Snyder, C. R. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry*, 13, 249-275.

Sparks, J., Ariel, J., Coffey, E. P., & Tabachnik, S. (2011). A fugue in four voices: sounding themes and

   variations on the reflecting team. *Family Process*, *50*, 115-128.

Stake, R. E. (2006). *Multiple case study analysis.* New York: The Guilford Press

Stinchfield, T. A., Hill, N. R., & Kleist, D. M. (2007). The reflective model of triadic supervision:

   Defining an emerging modality. *Counselor Education and Supervision*, *46*, 172-183.

Stratton, P. (2010). *The evidence base of systemic family therapy and couples therapy*. Association for Family Therapy, UK. Retrieved from www.aft.org.uk

Stratton, P. (2007). Enhancing family therapy's relationships with research. Australian and New Zealand. *Journal of Family Therapy,* 28, 177-184.

Strong, T., Busch, R., & Couture, S. (2008). Conversational evidence in therapeutic dialogue. *Journal of Marital and Family Therapy*, 34, 388-405.

Swim, S. E., Priest, A., & Mikawa, T. (2012). A Sea of Ideas on the Reflecting Process: Reflective Techniques in Community Engagement: A Collaborative Recovery Model. In Rambo, A., West, C., Schooley, A., & Boyd, T. V. (Eds.). *Family therapy review: Contrasting contemporary models*. (pp.176-180). East Sussex: Routledge

Tew, J. (2006). Understanding power and powerlessness towards a framework for emancipatory practice in social work. *Journal of Social Work*, 6, 33-51.

Thorne, A., & McLean, K. C. (2003). Telling traumatic events in adolescence: A study of master narrative positioning. *Connecting culture and memory: The development of an autobiographical self*. Mahwah, NJ: Lawrence Erlbaum.

Tirado, F., & Gálvez, A. (2008). Positioning theory and discourse analysis: some tools for social interaction analysis. *Historical Social Research/Historische Sozialforschung*, 8, 2, 224-251.

Tomm, K. (1984). One perspective on the Milan Systemic Approach: Part I. Overview of development, theory, and practice. *Journal of Marital and Family Therapy*, 10, 113-25.

Tomm, K. (1989). Externalizing the problem and internalizing personal agency. *Journal of Strategic and Systemic Therapies*, 8, 1. 1-8. Retrieved from http://reauthoringteaching.com/wp-content/uploads/2013/10/externalize_-the_prob-2.pdf

Treacher, A. (1988). The Milan method—a preliminary critique*. *Journal of Family Therapy*, 10, 1-8.

Trepper, T. S., McCollum, E. E., De Jong, P., Korman, H., Gingerich, W., & Franklin, C. (2008). Solution focused therapy treatment manual for working with individuals research committee of the solution focused brief therapy association, 1-8. Retrieved from http://static1.squarespace.com/static/5613390ae4b0a31f22111bed/t/5622d773e4b0501d4068c507/1445123955104/SFBT+research.pdf

Tulloch, A. L., Blizzard, L., & Pinkus, Z. (1997). Adolescent-parent communication in self-harm. *Journal of Adolescent Health*, *21*, 267-275.

Ugazio, V. (1998). Storie permesse e storie proibite. Turin; Bollati Boringhieri

Vaz, K. M. (2005). Reflecting team group therapy and its congruence with feminist principles: A focus on African American women. *Women & Therapy*, *28*, 65-75.

Von Bertalanffy, L. (1972). The history and status of general systems theory. *Academy of Management Journal*, 15, 407-426.

Wagner, J. (2007). Conversation, language and the written word. In H. Anderson, & P. Jensen, (Eds.). (2007). *Innovations in the reflecting process*. (pp.86-102). London, Karnac Books.

Wahlström, J. (2006). Narrative transformations and externalizing talk in a reflecting team consultation. *Qualitative Social Work*, *5*, 313-332.

Walsh, F. (1996). The concept of family resilience: Crisis and challenge. *Family Process*, 35, 261-281

Walsh, F. (2015). *Strengthening family resilience*. (3rd ed.). London, Guilford Publications.

Walther, S., & Fox, H. (2012). Narrative therapy and outsider witness practice: Teachers as a community of acknowledgement. *Educational and Child Psychology*, *29*, 10, 8-17.

Watts, R. E., & Trusty, J. (2003). Using imaginary team members in reflecting" as if". *Journal of Constructivist Psychology*, *16*, 335-340.

Watson, C. (2007). Small stories, positioning analysis, and the doing of professional identities in learning to teach. *Narrative Inquiry*, 17, 371-389.

Watzlawick, P., Weakland, J., & Fish, R. (1974). *Change: Principles of problem resolution and problem formation*. New York; Norton.

Weakland, J. H., Fisch, R., Watzlawick, P., and Bodin, A. M. (1974). Brief therapy: Focused problem resolution. *Family Process*, *13*, 141-168.

Webb, L. (2002). Deliberate self-harm in adolescence: a systematic review of psychological and psychosocial factors. *Journal of Advanced Nursing*, *38*, 235-244.

Whitaker, C. A., and Keith, D. V. (1981). Symbolic-experiential family therapy. *Handbook of family therapy*, *1*, 187-225.

White, M., and Epston, D. (1990). *Narrative means to therapeutic ends*. New York: WW Norton & Company.

White, M. (1995). *Re-authoring lives: interviews and essays. Adelaide: Dulwich Centre Publications*,

White, M. (2004). Re-authoring conversations: from a single-storied to a multi-storied existence. *International Journal of Narrative Therapy & Community Work*, 1, 60-76

Willig, C. (2008). Introducing qualitative research methods in psychology. *Maidenhead: McGraw Hill*.

Willott, S., Hatton, T., and Oyebode, J. (2012). Reflecting team processes in family therapy: A search for research. *Journal of Family Therapy*, 34, 180-203.

Wittgenstein, L. (1953). *Philosophical Investigations*. Oxford, UK: Blackwell.

Wright-Hughes, A., Graham, E., Farrin, A., Collinson, M., Boston, P., Eisler, I., Fortine, S., Green, J., House, A., Owens, D., Simic, M., Tubeuf, S., Nixon, J., McCabe, C., Kerfoot, M. & Cottrell, D.

(2015). Self-Harm Intervention: Family Therapy (SHIFT), a study protocol for a randomised controlled trial of family therapy versus treatment as usual for young people seen after a second or subsequent episode of self-harm. *Trials*, *16*, 501. Retrieved from https://www.researchgate.net/profile/David_Owens11/publication/283526434_Self-Harm_Intervention_Family_Therapy_SHIFT_a_study_protocol_for_a_randomised_controlled_trial_of_family_therapy_versus_treatment_as_usual_for_young_people_seen_after_a_second_or_subsequent_episode_of/links/564da10d08ae1ef9296aba2b.pdf

Yin, R. K. (2013). *Case study research: Design and methods*. London, Sage publications.

Young Minds (2011). Talking self-harm. Talking taboos. Cello group. Retrieved from http://www.cellogroup.com/pdfs/talking_self_harm.pdf

Young, J., Saunders, F., Prentice, G., Macri-Riseley, D., Fitch, R., & Pati-Tasca, C. (1997). Three journeys toward the reflecting team. *Australian and New Zealand Journal of Family Therapy*, *18*, 27-37.

Yuval-Davis, N. (2010). Theorizing identity: Beyond the 'us' and 'them' dichotomy. *Patterns of Prejudice*, 44, 261-280.

Zainal, Z. (2007). Case study as a research method. *Jurnal Kemanusiaan*, *9*. Retrieved from http://www.management.utm.my/jurnalkemanusiaan/attachments/article/163/JK9_163.pdf

Zarski, J.J., Sterling, A.L., & Parr, P.E. (1998). The reflecting position: theoretical, counsellor, and client perspectives. Social construction in couple and family counselling. Alexandria, Va: *American Counseling Association*, 79-100.

Zelle, G. (2009). Exploring the Application of Positioning Theory to the Analysis of Organisational Change. *Faculty of Commerce Papers*, University of Wollongong.

Zevallos, R., and Chong, N. (2007). Open conversations that weave changes in contexts of poverty or

wealth. In H. Anderson, & P. Jensen (Eds.). *Innovations in the reflecting process*, (pp.74-85).

London, Karnac Books.

APPENDICES

Appendix A: Literature Search Strategy

As there were very few empirical studies of RT practice and process issues, during the course of undertaking the thesis it was necessary to carry out a number of formal literature searches to keep up-to-date with any new developments. Additional papers of interest were located using a 'snowball' method which involved looking at references in the identified papers and further papers sourced via the internet and through reading in related areas.

A final literature search was undertaken in May 2016 using the words 'reflecting team'. This search included the following databases; OVID MEDLINE (1946 to May 2016), PsycARTICLES Full text, PsycINFO (1806 to May 2016), Leeds University Library's Journals@Ovid and Leeds University Library's Books. A total of two-hundred and seventy results were located, ninety-two of which were identified as being of potential relevance to the use of a RT within family therapy. Of those selected, eight were duplications and nine were unpublished dissertations.

There were also two relatively recent reviews of the RT literature (Pender & Stinchfield, 2012; Willott, Hatton, & Oyebode, 2012), two critical reviews of the RT process (Brownlee, Vis & McKenna, 2009; Perlesz, Young, Patersorr & Bridge, 1994), an expert opinion poll – Delphi study (Jenkins, 1996), five descriptive case studies (Berger, 2000; Eubanks, 2002; Johnson, Waters, Webster & Goldman, 2007; Roberts, Caesar, Perryclear & Phillips, 1989; Shilts, Rudes & Madigan, 1993) and four relevant theoretical papers (Andersen, 1987, 1991; Shotter & Katz, 2007; Grandesso, 1996).

A further eleven papers were qualitative studies of participants experiences or perceptions of the RT; six of the clients' experience (Egeli, Brar, Larsen & Yohani, 2014a, b; c; Pender & Stinchfield, 2014; Smith, Jenkins & Sells, 1995; Smith, Yoshioka & Winton, 1993) one of the therapists' experience (O'Connor, et al., 2004), one of RT members experience (Smith, Winton & Yoshioka, 1992), one of the clients' and therapists' experience (Sells, Smith, Coe, Yoshioka, Robbins, 1994) and one of their perceptions (Smith, Sells & Clevenger, 1994) in addition to one which explored clients', therapists' and RT members' experience (Young et al., 1997).

Fifteen other papers explored the application of RTs across various cultures (Löwenborg, 2001; Vaz, 2005), abilities (Munro, Knox & Lowe, 2008; Rhodes et al., 2011) and contexts such as couples therapy (de Barbaro et al., 2008; Garrido-Fernández, Jaén-Rincón & Garcia-Martínez, 2011), single session consultation (Wahlström, 2006), parent support groups (O'Brien, 1994), parental interpersonal trauma (Gardner, Loya & Hyman, 2014) multidisciplinary review meetings (Garven, 2011; Rhodes et al., 2011), organisational development (Carlsson, Hantilsson & Nyström, 2014), supervision (Prest, Darden & Keller, 1990), with the family acting as their own team (Lange, 2010; Watts & Trusty, 2003) and the addition of written reflections (Fishel, Buchs, McSheffrey & Murphy, 2001). An additional two descriptive papers (de Oliveira, 2003; Lax, 1989) and two single case studies (Fredman, Christie & Bear, 2007; Sori, 2010) outlined creative RT practices specific to therapy with children and families.

Four of the papers were not written in English (Höger, Temme & Geiken, 1994; Höger & Temme, 1995; Kuenzli-Monard & Kuenzli, 1999; Reiter, Steiner, Ahlers, Vogel & Wagner, 1993); five were descriptive theoretical papers (Hopkins & Reed, 2008; Miller & Lax, 1988; Sparks et al., 2011; Swim, Priest & Mikawa, 2012; Zarski, Sterling & Parr, 1998) and four were descriptive book chapters (Friedman, 1995).

Appendix B: SHIFT Manual & SAM Adherence Measure Extracts

Key Components of the SHIFT Manual

Theoretical principles	Therapeutic principles	Intervention
• Systems Focus	• Collaborative working	• Linear Questioning
• Circularity	• Context	• Circular
• Connections and	• Reflexive abilities	Questioning
patterns	• Strengths and	• Statements
• Constructivism	possibilities	• Reflecting Team
• Social constructionism	• Ethical practice	• Child Focused
• Dialogue		• Systemic Risk
• Narratives and		Management
language		

Guidance for the reflecting team

Within the trial, Family Therapists' are guided in their use of the RT by the SHIFT manual which states:

'The reflections should be respectful of the family, therapist and team members, hold a tentative and curious stance, stay connected to the ideas of the previous contributor, stay connected with the language used by the family, use age appropriate language, and restrict the number of themes and length of time.

The therapist should take responsibility for monitoring the effect of the team reflections on the family by asking for thoughts/reactions from family members after the team intervention and observe any changes in subsequent conversations that appear linked to the content of the reflecting team. Direct and indirect feedback needs to be considered, as some families will only protest through a lack of responsiveness. Normally, there would be time for the family to respond to the team reflections but it may also be the case that the full impact may not appear until a subsequent session. It may be that the themes offered in the reflecting team form the basis of a letter or a reminder at the beginning of the next session' (p36-37).

SHIFT manual guidance for family therapist's on risk assessment and risk management from a systemic perspective

At times during therapy it will be necessary to consider the risk which one or more member of the family poses in relation to their own well being or the well being of a family member. In the context of the SHIFT study, self-harm and the possible risk of suicide will always be an important consideration. Therapists should bring their concerns into the discussion with the family to hear their views of the risks. It is important that the therapist's and family's concerns are identified, in a manner which opens up communication and leads to the establishment of contingency plans to monitor or prevent further risks. Risk and responsibility need to be understood as a relational process, where the increase of risk activates carers and professionals into positions of greater responsibility.

Therapists will have to balance the need for opening up communication within the family about risk with the need to provide separate space for the young person to talk about their concerns. In the early stages of engaging the family in treatment, the latter may need to take precedence, as the therapist may not be in a position to fully judge the extent of the adolescent's willingness to talk about suicidal ideation in front of the family. However, the therapist needs to be mindful of the effect of assessing risk with the adolescent individually rather than in the family context; e.g. reinforcing beliefs that professionals have a more important role in assessing/managing risky behaviours than parents, the avoidance of discussing difficult or painful issues etc. In general, any individual conversations of risk should include a discussion of how the issues raised can be brought back into the family context.

While issues of safety will have to be uppermost in the therapist's mind when considering risk, an important consideration is to maintain an awareness of the context and manner in which it is being presented. Just as self-harming behaviour may have become a means of communication within the family, it can also develop a similar role in the therapy system. Where risk becomes the dominant issue, therapists may need to be explicit that they are putting aside their therapeutic role as they have serious concerns about the risks to the young person or another family member. This may include a request for a psychiatric risk assessment and discussions with the family of the possibility of hospital admission. However, therapists need to keep in mind that there is no absolute dividing line between conversations with risk management intent and conversations with a therapeutic intent. Paradoxically, an explicit statement about setting aside one's therapeutic role in order to

deal with issues of safety may itself be of therapeutic value by showing care and concern and by using the opportunity of "safety talk" to open up new possibilities for the family. This might include discussions about who the young person would talk to if they were feeling suicidal, what concerns they might have about how people would respond to this and what kind of response they would feel would be most helpful. Over the course of the treatment therapists will be addressing issues of risk both from a safety point of view and also as an important part of the therapeutic conversations about how self-harm organizes families. The overlap between these two areas will raise dilemmas for therapists and the therapy team (balancing safety and therapeutic needs, addressing issues of dependence/independence, perceptions of who has what responsibility etc) but these are a reflection of the problems families have to deal with and provide important therapeutic opportunities.

The conversation in the initial phase will inevitably include discussion related to risk as well as more detailed exploration of the family's understanding of the self-harm and will be outlined in greater detail in that section. But it may well arise at other periods in the treatment and will be dealt with using the same principles. The type and amount of risk assessment questions will depend on the information from the referral and the responses in the meeting.

Risk & Reflecting Team Components of the SHIFT Adherence Measure (SAM)

4) Risk issues appropriately considered / attended to

Risk issues explored
In first session - Automatic referral to expert rater if no exploration of risk is evident or if risk is inappropriately addressed.

Safety plans agreed
If risk is not discussed in second or subsequent sessions, refer to an expert rater to ensure that there is a safety plan in place.

'Expert' position taken if required re: risk management
Where risk issues arise the therapist should employ a more directive approach to ensure that the client is kept safe and that the family and professionals involved are aware of what is required or agreed in relation to the safety plan.

5) Reflecting team offered & adherent

The reflecting team is offered to the family and this forms a significant part of the therapeutic work. The reflecting team conversations may follow different formats, but generally, this will be a conversation between team members related to themes or dilemmas discussed in the session. Families will listen to the reflecting team conversation and then be invited to comment on the fit and usefulness of the ideas.

The timing of team reflections can vary and may be used in early, mid-session point or near the end. The reflecting team may consist of some or all of the therapy team as seems appropriate relative to the size of the team and wishes of the family. The team may join the family or switch places from observation room to therapy room.

Appendix C: SHIFT Trial & IRAS Ethical Letter of Approval

NHS
Health Research Authority

National Research Ethics Service

NRES Committee West Midlands - The Black Country

3rd Floor, Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7816
Fax: 0161 625 7299

07 October 2014

Miss Christina M I Barker
38 Avenue Hill
Leeds
LS8 4EY

Dear Miss Barker

Study title:	**Exploring the infleunce of the reflecting team on the family meaning system in family therapy.**
REC reference:	**14/WM/1179**
Protocol number:	**N/A**
IRAS project ID:	**135797**

The Proportionate Review Sub-committee of the NRES Committee West Midlands - The Black Country reviewed the above application on 06 October 2014.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager Miss Shehnaz Ishaq, nrescommittee.westmidlands-blackcountry@nhs.net.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

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

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

A Research Ethics Committee established by the Health Research Authority

UNIVERSITY OF LEEDS

Christina Barker
Clinical Psychologist in Training
University of Leeds

18 September 2014

Dear Christina

Re: Exploring the influence of the reflecting team on the family meaning system in family therapy

I write to confirm, on behalf of the SHIFT Trial Management Group, that we are happy for your project to go ahead.

We understand that this will involve your access to SHIFT trial participants' recorded family therapy session data, and will make this available in accordance with the consent already provided by SHIFT trial families (i.e. providing data for only those who have consented to their data being used for other research projects).

This study supports the main trial's objectives of understanding how family therapy works, and will be supervised by applicants from the core SHIFT team. As such it will assist us in delivering the core objectives of the study and we look forward to seeing the outcome of your work.

Yours sincerely

Professor David Cottrell
Professor of Child & Adolescent Psychiatry
SHIFT Chief Investigator

1

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

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

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

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

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion").

Summary of discussion at the meeting

Consider and confirm the suitability of the summary of the study.

The Committee felt the summary should be re-written to make more intelligible to the lay person.

Approved documents

The documents reviewed and approved were:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]	1	19 September 2013
IRAS Checklist XML [Checklist_03092014]		03 September 2014
Letter Of Intention To Appeal [email correspondence]		26 September 2014
Letter Of Intention To Appeal		24 September 2014
Other [ShHIFT Trial Letter of Support]		18 September 2014
Other [Unfavourable Opinion letter from London Hampstead]		08 September 2014

Other [Supervisors CV]	1	01 September 2014
REC Application Form [REC_Form_03092014]		03 September 2014
Research protocol or project proposal [Research Protocol 1]	1	21 July 2014
Summary CV for Chief Investigator (CI) [CV]	1	21 July 2014
Summary CV for supervisor (student research) [Lead Supervisor CV]	1	01 September 2014

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

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

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

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

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

Yours sincerely

DM Cattrall
pp

Signed on behalf of:
Dr Hiliary Paniagua
Chair

Enclosures: List of names and professions of members who took part in the review

                       "After ethical review – guidance for researchers"

Copy to: Faculty Research Ethics and Governance Admin

                   Anne Gowing, Leeds Teaching Hospitals NHS Trust

Appendix D: Transcription Protocol

(…)   Denotes a pause in speech

[*]   Speech unclear or omitted

[sometimes]   Suggested word indicated where the speech is unclear or inaudible

[laughs at T]   Gestures and para-verbal utterances relevant to meaning of text

hhh   Audible intake or exhalation of breath

hmm, erm, uh-huh   Represents non-verbal utterances

Appendix E: Transcript extracts

Stage One

Initial notes 00546_2013.03.14_05

Pre RT discussions: YP not feeling heard, mum multitasking – laptop barrier, angry with school and education system, dad not having good education, impact on employment, yp expresses hope for qualifications and employment.

RT:

- Relationship with dad improving,
- Laptop and work as barrier for mum to communicate with daughter,
- Boundaries when working from home,
- Queried when mum decides to spend time with daughter
- Importance of spending time with parents – protective factor for self harm
- Risk and protective factors with self-harm,
- Recognised both talking about things outside their relationship – speculate as to whether it may be hard for them to talk about their relationship,
- Laptop has been mentioned before – RT wonders whether that will that change and whether they need to be worried
- Discussed difficulties when boss works so hard – expectations as an employee to do the same
- Considered whether mum would need support to consider boundaries with employer.
- yp speaking to others, laptop stopping relationship growing, yp safety, protection and closeness to mum. How would mum change balance and what would she say to work. Risk issue, importance of relationship with parents. YP changing, feelings of alones – yp becoming different with aloneness, maturing, happiness with independence. What is changing in yp, encouraging independence.

Post RT: Not aloneness - being ignored difficult, Mum comments on business, yp comments on mums long working hours, mums nature - 'committed' to work, flexible boss, balance between yp and job, T notes protective factors – environment-activities -relationships –talking to parents, self harm secretive, yp being able to talk about emotions at home. Yp acknowledges excitement as never go out together. Shared interests. Hotel shared room / own room own space. Yp likes when parents take interest in her activities. Yp wanting mums full attention at times..

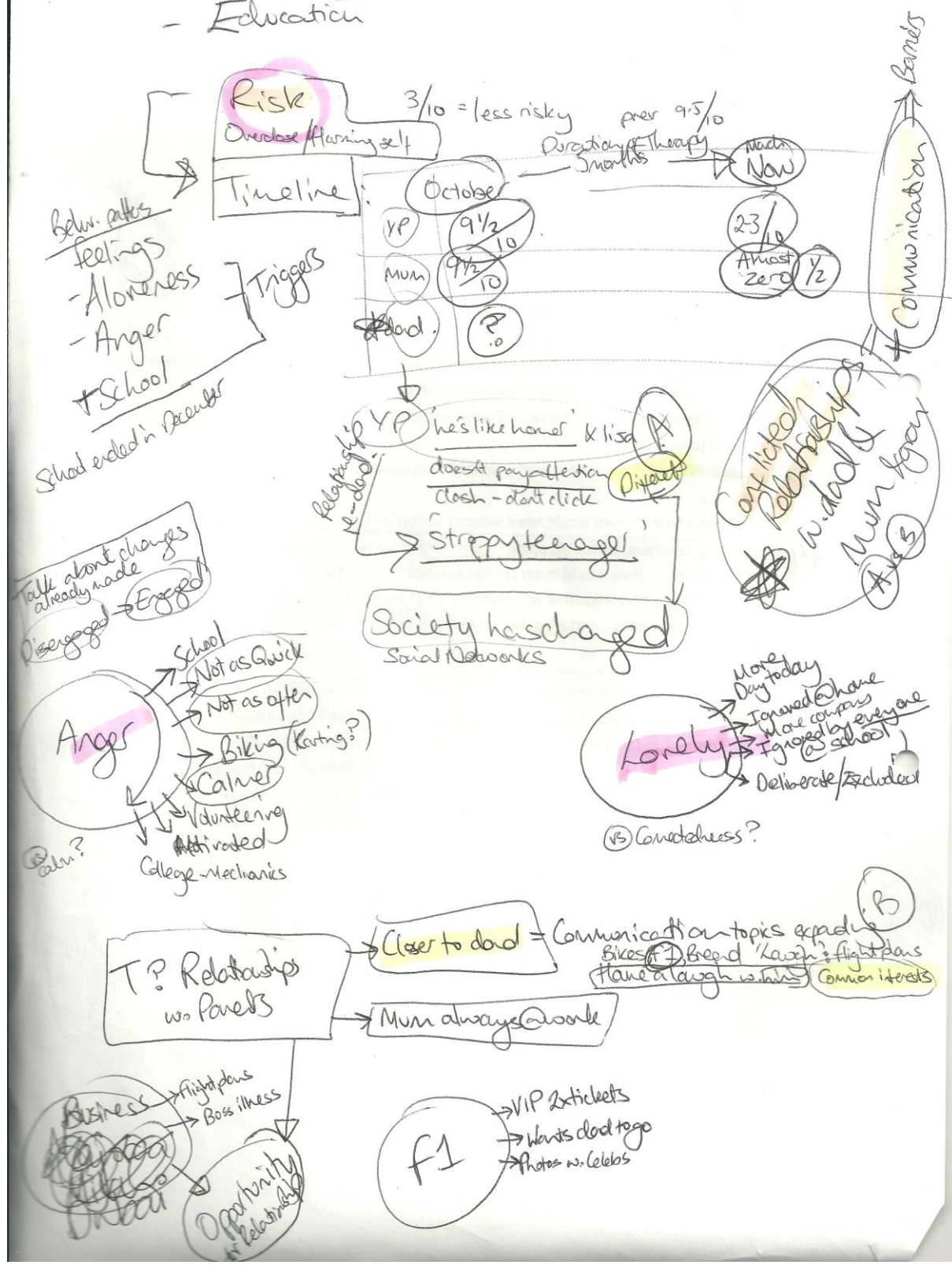Identifying key topics |PRERT| May 2015

- Reviewing progress + planning future sessions
- Education

Risk
3/10 = less risky   prev 9.5/10
Overdose / Harming self
Duration of Therapy 3 months → March Now

Timeline: October   23/
YP   9½/10   Almost zero ½
Mum   9½/10
✗dad   ?.0

Bands
Communication

Behav. attitudes
feelings
- Aloneness
- Anger
+ School   } Triggers

School ended in December

YP   'he's like home' K lisa A.
relationship re-dad?   doesn't pay attention   Divorced
    clash - don't click
    'Stroppy teenager'

    Society has changed
    Social Networks

Conflicted Relationships
w. dad &
Mum together   ✗A + B

Talk about changes
already made → Engaged
Disengaged

Anger
→ School
→ Not as Quick
→ Not as often
→ Biking (Karting?)
→ Calmer
→ Volunteering
→ Motivated
College - Mechanics
Calm?

Lonely
→ More
Day today
→ Ignored @ home
→ More company
→ Ignored by everyone
@ school
→ Deliberate/Excluded

vs Connectedness?

T? Relationships
w. Parents → Closer to dad = Communication topics expand   B
    Bikes, D. Breed 'Laugh', flight plans
    Have a laugh with him   Common interests
→ Mum always @ work

Business → Flight plans
→ Boss illness

Opportunity
+ Relationship

F1
→ VIP 2 tickets
→ Wants dad to go
→ Photos w. Celebs

Family Relationships and Barriers to Communication

Pre RT Dialogue

Carly likens her relationship with her father to that of the Simpsons characters 'Homer and Lisa' who have different personalities and a conflicted relationship. Carly initially positions her father Brian as an <u>inattentive</u> parent who is not fully aware of Carly's risk of self-harming. In contrast, Sandra positions Brian as a <u>concerned and protective</u> parent who takes action to minimise the risk of self-harm. Carly doubts her mother's account of her father's actions, instead positioning her mother as the one who is <u>concerned and protective</u>. Sandra goes on to position herself as a <u>protective parent</u> as she discusses her plans to defend Carly in response to Brian's criticism of her.

Line 100-134

> T: What do you think your dad would say if he was here?
> C: I haven't got a clue.
> T: Guess
> C: It's not that he doesn't care, he just doesn't pay attention to it.
> T: Ah ha.
> S: He does, he just doesn't let you know that he's paying attention to it.
> C: It doesn't look like it crosses his mind, he's just like Homer.
> S: He doesn't outwardly show... feelings.
> T: In some ways he does take some notice doesn't he because I know you said last time. I think it was last time that you said, actually the tablets had been moved but he hasn't said anything about it but you had noticed that he'd actually moved them.
> C: [looks to mum] I think you actually told him to move them.
> S: I didn't.
> C: You will have done.
> S: I didn't tell him.
> T: So that's interesting, so your mum didn't tell him but he did it out of...
> C: It's kind of a coincidence how she had said it and then they disappeared the next day.
> S: It wasn't the next day.
> C: Well the same day.
> S: No it wasn't', it was a short while after.
> T: So he's obviously thinking or being concerned and done something about it.
> C: It's just like Homer and Lisa, they don't really click, it's it'... just clash. [mum laughs at this likening].
> T: So if he was here, what do you think he would say? I know you don't know and it's a bit of a guess.
> C: I don't know, I don't really think he thinks about what goes through my mind and what's going on in my mind. (Pause) To me, from his point of view he probably just thinks I'm just a stroppy teenager. I think that's just what he thinks it is.
> S: He does relate to you a lot because the other day when you were out, he said, when you were out he said to me, he said 'well I was never at home when I was that age', so he gets it, he gets all this stuff. And I have a plan actually, next time he starts you know sort of moaning about whatever you're doing and I'll say well at least she isn't doing what you were doing, because he was being a bad boy when he was your age. [Carly laughs – mum then laughs] A police bad boy when he was your age, so at least you're not doing that so.
> C: Exactly!
> S: You've got a bit of...

1

C: I'm not as bad as you think, you know.

Although Carly perceives that her father positions her as a stroppy teenager, she goes on to acknowledge the recent developments in their relationship. Carly positions her father as being more available and approachable which she contrasts to the positioning of her mother as unavailable and unapproachable. Carly suggest that she values her father's time and attention and the increased closeness of their relationship, even though he often talks about topics which are of no interest to her. In contrast, Carly positions her relationship with her mother as blocked and distant as she reports feeling unable to communicate with her due to her work which is a physical barrier to their communication.

Line 258-278

C: He's always making bread, I come downstairs and I've just woken up I'm like oh what you doing? He's like baking bread, you do this, this, this and this and I'm like dad I really don't care. He'll spend half an hour watching all these things and it'll just go in one ear and straight the other, I just don't care about it but he's still talking to me so I'm not bothered.
S: He's just trying to teach you how to make bread.
T: So how has your relationship with your mum and dad changed in the last few months?
C: I'm closer to my dad because like he'll come home and he'll talk to me, but not really with my mum sorry (looks to mum)… [S: Why?] because you're working, I can't really talk to you whilst you're working.
S: You can still come and talk to me.
C: Well last time I did that you made me right loads of names on malaria boxes.
S: Laughs. Ye we are supposed to be taking Malaria tablets, remind me we need to take them.
T: So I'm hearing that you're closer to your dad?
C: Yeah
T: Tell me about that, because that's… that's a surprise to me.
C: Before…. all we used to talk about before was bikes and cars
T: And radio-control things wasn't it?
C: Yeah, radio ham, ham , ham ham haha, I don't know what that stands for, but like now we talk about bread which is like another step, (laughs)I don't even like bread but…
T: What else do you talk to your dad about?
C: Not much really.

Early on in the session Carly indicates that feelings of aloneness are key to her risk of self harming. She goes on to position herself as invisible and a reject as she recalls being ignored by her peers in school which links to her feelings of anger and aloneness. *"What wound me up when I was at school is when people were ignoring me and that's one thing that sets me off, I can't stand ignorant people [...]. That ticks me off really bad, that's one of the worst things"* (line 633-636). Carly also discusses being rejected by her parents but does not take this personally as she does not perceive it to be intentional. Instead she attributes this to her father's personality, continuing to position him as inattentive.

Line 232-

2

C: I'm a lot more alone on, I'm a lot more lonely day to day.

T: Yeah I would imagine, because we touched on that a little bit last time didn't we, that when you were at home, you were in less contact with people, you were in your room quite a bit because we talked about when you're busy (looks at mum) and contact and so on. So tell me a little bit more about that because there's something about what you do with these feeling, really.

C: I feel more... like I've got more company than I did at school, because at home I do get ignored. But I don't get ignored that much. Whilst I was at school, I am only getting ignored by two people at home, but when I were at school I were getting ignored by everyone. It's like I was invisible, I used to get pushed and shoved about and... like if I talked to someone they'd just ignore me and... It's like I were alone yet in a room full of people.

S: I would say that it was being alone in a room full of people.

T: So it felt like that was even more concentrated or more highlighted at school?

C: Yeah it's like it was more... like deliberate to me, but... at home I know it's not deliberate because my dad's just selective hearing to me [mum laughs]

S: He has selective hearing to me aswell, I have conversations and he just doesn't answer you.

In the pre-RT discussion, both Carly and Sandra indicate that they would like to have a closer relationship with each other. However there appears to be an inconsistency in both Carly and Sandra's desired and demonstrated /current positioning.

By initially positioning herself as un-talkative, Carly attributes her lack of communication with her mother to an aspect of her personality. However, Carly contradicts this positioning by positioning herself as talkative with friends. She also demonstrates that she is talkative during the session by interrupting the therapist on a number of occasions. The therapist then struggles to interject back into the conversation.

Sandra continues to position herself as a protective parent and expresses a desire to help her daughter whilst positioning Carly as resistant to receiving her support. However, Sandra's capacity to be available and responsive to her daughters needs appears to be compromised by her busy work-life. Carly positions Sandra as distant and unavailable suggesting that her work and the time she spend on her laptop are barriers to their communication which impacts on the overall closeness of their relationship.

Line 542-601

T: I'm aware we've been talking quite a bit about your dad and right at the start you said something about your relationship with your mum, you said you're not as close... because your mums busy.

C: It's not-not as close, it's just same.

T: So what changes have happened do you think between the two of you?

C: None (laughs)

T: What do you think Sandra?

S: I don't know to be honest

C: None really

S: You still don't talk to me about stuff that's bothering you.

C: I'm just not a talkative person.

S: I don't know, I don't think you believe I can help, because it's been a long time since I was a teenager.

T: So I'm hearing Sandra from you, correct me if I'm wrong but you're saying that when Carly's struggling with something and she doesn't come to you, she doesn't talk to you about those things and is that something you'd like to be different?

S: I'd like that to be different because then I can help you.

C: It's like one of the things, like I prefer to speak to someone my age, like Sarah because when I speak to her, she's fifteen soon, and I'm not here and she's so angry at me... (C laughs then C laughs). And it's like I prefer to talk to her about something because she's intelligent, she always knows what to do, she's a brainiac... and it's like she my age, so she understands. But it's like you (points to mum) when you were my age, you didn't have a phone, social networks weren't about.

S: Oh yeah it was different...

T: There's a lot of differences but...

C : It's so much different.

S: ...but there's a lot of similarities.

C: Kind of.

T: What prevents you, I mean I hear this a lot with mums and daughters, you know, sometimes they really want to talk and sometimes not so I suppose I'm interested, obviously there are differences, in your mum didn't certain things and wasn't in the same situations as you Carly, but, what else prevents you from taking any difficulties to your mum? ....If you like...

C: I don't like speaking to you when you're behind your laptop.

S: Ok

T: Right, so laptop, physically a laptop is a barrier yeah.

C: 'Cause I feel like, physically as well, I can see her, but...

T: You haven't got her attention.

C: It's a distraction, it's like when you try and talk to me and I'm on my phone. 'Cause like I get it with Sarah, when I'm sat next to Sarah and I'm talking for forty-five minutes constant... and I'll look at her and she's like... [S: she's going to say what] 'what?' Grrrrrr (angry tone).

T: So there are things like phones and laptops, they are a complete barrier aren't they? Cause the one... (T interrupted by C).

C: Yeah so when I try and talk to dad and he's on his laptop and even though it's at the side of him there, and I'm there. [T: For instance... can I just share...] I say dad and he just turns and says what?

T: Can I just share something... (T then struggling to interject C).

C: Ye. Course.

T: I often think when we're talking is that you like eye contact.

C: Do I?

T: Because I think when we're talking, and I'm conscious now I'm looking at you know, but when we're talking we will look at each other quite a bit, and I think that is quite important sometimes to actually communicate that you're listening, you're heard. And I remember in another session once you said something about, it's really important to you to be listened to and that somebody is noticing.

C: [looks to mum] Yeah and it winds me up sometimes when I'm trying to talk to you whilst you're working, because I know your full concentration is not on me... it sounds a bit greedy.

S: No my full concentration probably isn't, but I can multitask really quite well because I am a PA and that is what I do.

[Carly and mum laugh]

4

C: I know and it sounds awful to say that your full concentration is not on me, I am not trying to be attention seeking, but it's like... if I'm trying to talk to you and you don't catch something then, [looks to the therapist] that's another thing, if you don't understand me then it winds me up.

S: You do get yeah, quite snappy on that because she will say something, and I don't understand what she's said.

Carly continue to talk of her growing relationship with her father, positioning them as <u>friends</u> as she discusses a number of shared interests, shared humour and their potential to 'have a laugh' together. Conversely, Carly continues to contrast her relationship with her father to that with her mother which she positions as <u>distant, d</u>espite wanting them to be close.

Line 375-394

T: So how does it feel going on holiday with your dad as well?

C: Quite good cause when we're on holiday I have a laugh with him. It's going to be even better because I think one suitcase is just going to be full of sandwiches because you don't like curry (looks at mum)

S: No I don't like curry

C: Cause all they eat is curry, it's like I know my dad and in Thailand there are street stalls and stuff and they sell like really dodgy things like fried flies and stuff (laughs) and my dad wants me to try em but I really don't wanna.

T: So you've got opportunity, so I'm just thinking about, kind of you know one of your things at the start of therapy was wanting to be closer to your mum and dad.

C: Yeah it's good though because like me and my dad both like curry, but its like when we used to go to Bradford me and my dad would have curry. It's about the only time I can have it.

S: You can have it, I can eat something else. You do occasionally.

C: You're always like uurrgh, I don't like it (mimics mum) taking the mick all the time.

T: So it sounds like there's opportunity here for you know this ten days in Thailand all together to have more opportunity to be close and get to know your dad in different ways, him to get to know you in different ways.

C: Yeah it's like one thing aswell about why I want to go to the gala with dad instead of you (looks at mum) no offence on you, is because he's more pushy than you, so he can push me to the front near the driver's seat and say 'go get a picture'.

==Throughout the pre RT discussion, a sense of competition appears to emerge in Carly's relational positioning of her two parents who are counter positioned in terms of their availability, attentiveness, ability to protect and their friendship in relation to Carly.==

Despite appearing to position her relationship with her father more positively than that with her mother, Carly also acknowledges some tension and ambivalence in their relationship. As the session progresses, Carly re-positions her father as <u>insensitive and aggressive</u> as she discusses times when their relationship is conflicted. Carly describes the negative impact this can have on her emotional wellbeing. Sandra also positions herself as <u>caring, protective and supportive</u> of Carly in times of need as she discusses her responsiveness to emotional distress, and the humour they have shared in their relationship at these times.

Line 503-525

5

Appendix F: Discursive Strategies Utilised by the Reflecting Team

Table 2: Within Case Analysis of Discursive Strategies Utilised by the Reflecting Team

Family / Case One	Family / Case Two	Family / Case Three
Empathising	Strengths focused and promoting personal agency	Emphasising and reinforcing family strengths and resiliencies
Normalising	Focusing on areas for development / improvement	Collaboration: sharing ownership and minimising the power differential – use of pronouns
Strengths and solution focus	Identifying barriers to change	Focusing on inter-relational and circular processes
Use of tense	Taking a more 'expert' instructional position re-risk	Identifying, prioritising and negotiating the focus of therapy
Collaboration and use of pronouns	Expressing concern	
Tentative use of questioning	Encouraging alternative explanations and exceptions	
Expert supervisory position regarding concern	Collaboration	
Promoting a multiverse position / encouraging alternative perspectives	Generic therapeutic skills: acknowledgement, acceptance, normalising empathising, validation and understanding	

Appendix G: Table 3: Cross Case Analysis of Discursive Strategies Utilised by the Reflecting Team

Discursive concepts	Case One	Case Two	Case Three
Empathising, normalising, non-threatening	3	2	0
Alternative perspectives	3	2	0
Strengths	1	2	3
Collaboration	2	1	3
Inter-relational focus	0	0	3
Expert - directive	1	3	2