A DISCOURSE ANALYSIS OF HOW PARTICIPANTS IN A FINAL FAMILY THERAPY SESSION NEGOTIATE THEIR UNDERSTANDING OF THE THERAPY PROCESS AND ITS OUTCOME

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

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Abstract

Introduction:

Meaning making has been shown to be beneficial to family wellbeing and has been explored in terms of problem construction at the beginning of therapy. However, there have been no studies which have looked at how meaning of change is negotiated at the end of family therapy. The final session is a pivotal point for these meanings to be discussed and these will be the understandings that the family take with them after therapy. This thesis aims to address this gap in the literature base by exploring how the participants in a final family therapy session negotiate their understanding of the therapy process and its outcome.

Method:

Video recordings of six final family therapy sessions were analysed using a discursive psychology method. The data were selected from a pre-existing database from the Self Harm in Family Therapy (SHIFT) trial, which studied family therapy for adolescents who self-harm. Each transcript was analysed using a protocol based on the guiding principles of discursive psychology and then extracts were selected as significant examples of how the therapy process and outcomes were discussed in the session.

Results:

The analysis found that the outcomes of therapy that were constructed were; increased family resilience and functioning, changes in problem meaning and a reduction in stress. Two interpretative repertoires were drawn upon for constructing agency in the therapy process; change comes from the family system and change comes from the therapists and the therapy forum. This analysis found that of the six families, four worked collaboratively together to develop a shared understanding of the therapy and two families resisted the

therapeutic process and a shared understanding did not appear to have been reached.

Discussion:

Different actions were taken by the various stakeholders in the session, which seemed to either support or hinder the shared meaning making process at the end of therapy. The therapists supported the collaborative process by attempting to maintain alliances through neutrality, empowering individuals as well as the family as a whole and by fostering 'realistic' hope for the future. The parents, as well as the therapists, acknowledged the developmental stage of the young person and this appeared to have different outcomes based on the young person's perspective on this. Finally, the young people seemed to take one of two courses of action in the final session; either to participate in the session and collaborate with the others in the room or they took the action of protesting and not engaging with the session.

Table of Contents

List of Abbreviations

SFCT: Systemic Family and Couple Therapy

SOFTA: System of Observing Family Therapy Alliance

CBT: Cognitive Behavioural Therapy

MCA: Membership Categorisation Analysis

MCD: Membership Categorisation Device

SHIFT: Self-Harm in Family Therapy

RCT: Randomised Controlled Trial

CAMHS: Child and Adolescent Mental Health Service

NHS: National Health Service

GT: Grounded Theory

FDA: Foucauldian Discourse Analysis

DP: Discursive Psychology

IR: Interpretative Repertoire

CTRU: Clinical Trials Research Unit

FAAR: Family Adjustment and Adaptation Response

IPR: Interpersonal Recall

List of Tables

List of Figures

Introduction Chapter

Family therapy aims to generate new, less problem focused meanings to ultimately reduce distress; yet, *how* this is done in practice is an under researched area for the field. Our understanding of family therapy process and outcome often relies on the use of objective measures such as questionnaires or quantities of problems or symptoms, which do not allow for an exploration of how these new meanings are constructed. These realist research methods focus on measurable outcomes e.g. number of hospital admissions and they do not assess changes in meaning or understanding. Thus, our knowledge of process and outcome in family therapy can often be based on methods that are not in line with the theoretical underpinnings of the current practice of family therapy. Furthermore, there are no research studies to date which have looked at how meaning is negotiated at the end of therapy when discussing change and outcome, yet this is a key task for the final sessions. The end of therapy is when the final meanings of change and outcome are negotiated and these will be the meanings the family take away with them after therapy. This study addresses this gap in the evidence base with the hope that this will encourage other researchers in the field to develop our understanding of process and outcome that is in line with the epistemology of family therapy.

This chapter will begin with a review of the current context of family therapy and will provide an overview of the changes and shifts that have occurred within family therapy and the research base to provide context for this research. Research studies which have used a discursive method will be discussed and then the current study will be situated within this. The chapter will close with a rationale for this study, alongside the research questions I hope to address.

Current Context of Family Therapy

Systemic therapy has evolved into many different forms and models to meet the needs of the variety of people who come for therapy (Stratton, 2016).

Systemic Family and Couples Therapies (SFCT) all share the same approach to helping people with psychological difficulties, by focusing on relationships and seeing people in the broader context of the systems they are part of. The aim is not to 'cure' mental illness within an individual, but rather to use the strengths of their relationships to make the perceived difficulties less problematic (Stratton, 2016). Therapeutic gains are achieved in collaboration with the family; there is less importance given to understanding where a problem has come from and more space given to thinking about how the family can find an alternative (less problematic) meaning and how to take this into the future. Within the evidence base, family therapy has gained precedence as a beneficial and effective intervention for helping with various psychological and emotional difficulties (Sexton & Datchi, 2014; Sprenkle & Blow, 2004; von Sydow, Retzlaff, Beher, Haun, & Schweitzer, 2013).The majority of the research that has been conducted has looked at the efficacy of family therapy as a model either compared to other interventions or no treatment. In a review of the evidence base, Sexton and Datchi (2014) stated that family therapy interventions had better outcomes than other treatment modalities across different presenting problems and divergent schools of family therapy approaches. Shadish and Baldwin (2003) undertook a meta-analysis of 20 meta-analyses of couple and family therapy and reported that overall the average treated family fared better after therapy. They proposed that couple and family therapy is now an empirically supported therapy. Although there are many different forms of SFCT, there is evidence to suggest that systemic therapy is an effective and clinically useful treatment (Sexton & Datchi, 2014). New developments in family therapy research have investigated the processes and outcomes within systemic approaches so to better understand specific change mechanisms. I will review the process outcome literature for family therapy, but first I will discuss the epistemological shift towards a constructionist approach in current practice of family therapy, to contextualise the process research within this.

Epistemological Shifts within Family Therapy

Family therapy has undergone many different changes and developments in approaches, practices and assumptions over the years. Until the 1950s, family therapy had largely been informed by psychoanalytic traditions of family dynamics and sociological traditions in family research (Polkinghorne, 2004). Following this, there was an era of research which then moved the thinking towards viewing the family as a communication system and subsequently family therapy went through different phases. In his book 'Family Therapy: Concepts, Process and Practice', Alan Carr (2012) provides a comprehensive history of the developments and changes within family therapy. I will summarise this briefly to provide an understanding of the current epistemological stance. Carr (2012) states that the first phase of family therapy was a structural approach where the focus was on the homeostasis of the family system and the task of the therapist was to 'fix' the family by addressing the dysfunctional interactions to regain stability within the system. The next phase then evolved to view the therapist as part of the system rather than as an expert bystander. This meant that the therapist was no-longer seen as 'objective' and this was the first move towards seeing therapy as a co-constructive process between all those involved, including the therapist. However, the focus was still on the behaviour of the family and the aim of the intervention was to produce changes in these behaviours so the family was functional and stable. It was the introduction of the concept of reframing that propelled the next phase of family therapy. Reframing is the idea that people's behaviours are based on their interpretations of others behaviours or situations (Polkinghorne, 2004). Rather than behaviour being isolated to the individual, our actions are influenced by the meaning we attach to other's behaviour. In family therapy, reframing is used to think about how different interpretations may be influencing behaviour. It is then the role of the therapist to assist family members to re-evaluate and reinterpret the meaning they ascribe to a situation. This concept of action being informed by meaning is based on social constructionism principles and second order cybernetics, proposing that our experience of reality is constructed and shaped by the language we use and the meanings we both ascribe and interpret.

This move to a meaning-based approach is now the basis of current practice within systemic family therapy and there are four central elements to this. The first element is an emphasis on the family's strengths and capabilities, rather than pathologising the family and its members (Polkinghorne, 2004). There is a shift in the focus to look at what happens when the difficulty or problem is not there and what competencies there are within the system that facilitate this. The therapist views the family as a resource to be utilised, with strengths that need to be reinforced (Carr, 2012). The second element is seeing the therapist and the family as partners within the therapeutic process. This was a shift from the therapist previously being seen as an objective 'expert' who could observe the family from a detached position. Social constructionism ideas contradicted this and the therapist was then positioned as part of the system and therapeutic process. The introduction of the reflecting team approach has addressed this as it implies that the control and responsibility of the therapeutic work is shared between all involved, the therapists (the main therapist as well as those on the reflecting team) and the family members (Polkinghorne, 2004). The third element is a shift from the focus on an individual's behaviour to the meaning that events have for family members. There is an assumption within this that behaviour is a response to meaning and that this meaning is shaped and influenced by the social and cultural environment. This derives from a social constructionist position whereby meanings are seen as social rather than individual and that meaning is guided by the language that we use (Polkinghorne, 2004). The fourth and final element is the use of self-narratives and stories. The stories that people tell about themselves and others are understood to be the expression of that person's understandings of the meaning of events. Narratives are a form of discourse that represent time, linking and positioning events before, during and after other events. Systemic family therapy aims to revise the stories the family recount, to change the meanings attributed to life events and situations and ultimately change the feelings and behaviours in response to these events.

It is this change in meaning that underpins the current practice in family therapy. The value of this meaning making process has been demonstrated within the child stress and trauma evidence base. I will now review some of

this literature to illustrate the importance of this meaning making process for therapeutic interventions.

The Value of Meaning Making

Within child and family research, there is growing evidence of specific factors and characteristics that may be beneficial in response to stress, crisis and trauma (Gewirtz, Forgatch, & Wieling, 2008; Saltzman, Pynoos, Lester, Layne, & Beardslee, 2013; Wadsworth & Riggs, 2011). One of these factors is meaning making. The term meaning making is used in the literature to describe how families make sense of events and experiences such as trauma or loss (Park, 2013). Meaning is how we make sense or understand something and the process of meaning making is proposed to connect relationships and events (Park, 2010). There are different theories of meaning making; one commonly drawn upon in the family trauma and resilience literature is that distress comes from the discrepancy between global and situational meanings (Park, 2010). Global meanings are an individual's broad beliefs, goals and subjective feelings. They form the core schemas through which people interpret their experiences of the world (Mischel & Morf, 2003). Situational meanings refer to the meanings in the context of a particular event or experience. When people are confronted with a situational meaning that challenges their global meaning, this is proposed to cause distress from the discrepancy between these meanings. It is then through meaning making that an individual or a family can reduce the discrepancy, so to restore a sense of the world as meaningful (Park, 2010). In the literature, family meanings act as a mediator between family demands and family capabilities, facilitating the development of family resilience (Saltzman et al., 2013). Family meanings can include, the family's appraisal of the situation, their beliefs about who they are as a family, attributions of the event and beliefs about their control of the situation (Park, 2010). Thus, it is proposed that if the family can develop a shared meaning through a negotiated understanding then this will develop family resilience, where a crisis is seen as a shared family challenge and will preserve the family's sense of hope (Saltzman et al., 2013). Neimeyer, Baldwin, and Gillies (2006) looked into predictors of grief symptomatology and found that higher levels

of meaning making consistently predicted better outcomes on grief measures during the first two years of bereavement. They found that meaning reconstruction was a reliable predictor of both traumatic and separation distress even after controlling for the characteristics of the bereaved, the character of the relationship and the loss itself. Research has shown that when working with children who have experienced loss or trauma, the story or memory of these past events can be changed and adapted through the co-construction process (Alexander, Quas, & Goodman, 2002; Oppenheim, 2006). This is called extended encoding and provides the parent or caregiver with the tools to shape the child's beliefs about the self, others and the world that will then form the memory of this experience. It has then been shown that this has an influence on the child's later recollection and narrative (Oppenheim, Nir, Warren, & Emde, 1997). This can then be applied to the use of meaning making and developing negotiated meanings during the process of family therapy. The therapist takes the role of the 'caregiver' and during the therapeutic process facilitates the family to negotiate different perspectives of the difficulties they have faced. The therapist can then shape this by highlighting the family's strengths and successes.

Research has shown that the majority of parents who have had traumatic childhoods have incoherent narrative styles and then their children demonstrate insecure attachment styles (Byng-Hall, 1997). Main, Kaplan, and Cassidy (1985) did a series of investigations into this area and found that if a parent is able to tell a coherent story about their childhood, even with it being traumatic, their children are more likely to be securely attached. These findings imply the importance of helping people who have been through traumatic experiences to construct a coherent narrative, to not only help them but also their family. Waters and Fivush (2015) found that the ability to produce coherent autobiographical narratives in adolescence and young adulthood was related to psychological wellbeing. This research supported the evidence base which already demonstrated that the production of a coherent narrative supports positive self-identity (Blagov & Singer, 2004; McAdams, 1988) but also took it further to show it also

supported wellbeing in terms of purpose and meaning, and positive social relationships.

In the literature, it is conceptualised that it is through the process of meaning making that individuals and families gain a 'sense of coherence', where they feel they have an influence over events in their life and have trust in their abilities to overcome future obstacles. Thus, by therapists facilitating this negotiation of meaning and a shared understanding it develops positive belief structures that are part of resilience. This will then be the legacy of the therapeutic intervention, where a family has this shared narrative to call upon when another crisis or stressor is faced. Therefore it is important to understand how meaning is negotiated and shared within the therapeutic process and what it is that therapists do in order to facilitate this process. One of the tasks of the last sessions within family therapy is to evaluate the process and think about the future (Carr, 2012). Furthermore, the last session is the final chance for the therapist to support the shared meaning process and it is these final meanings that will be the ones the family take with them into the future as part of their resilience. Therefore, we need to look at the last session to understand how these change meanings are constructed and negotiated as a resource for the future and the family's wellbeing.

Now I have given an evidence based rationale for the value of meaning making and situated the current epistemological stance within family therapy practice, I will move on to review the therapy process research.

Therapy Process Research

Within the realm of individual therapies, there has been a shift from looking at therapeutic model efficacy to try and understand process variables in terms of outcome and change (Heatherington, Friedlander, & Greenberg, 2005). This shift is often reported as being catapulted by the meta-analysis done by Ahn and Wampold (2001) stating that common factors were more predictive of positive outcome in therapy than the therapeutic model. This shift of focus has been slower in the family and couple therapy evidence base, but is now gaining momentum as an important area for the field.

Change process research is deemed to be important because it goes beyond simply describing an intervention and predicting results, to allow researchers and theoreticians to explain how a particular set of interventions creates change in a particular therapeutic context (Johnson & Greenberg, 1988). I will now review the current evidence of process and outcome in family and couple therapy, leading on to how this research project fits within this.

Therapeutic Alliance

There have been various studies looking into process factors that influence outcome within family therapy. One of the most researched factors has been the therapeutic alliance. The System for Observing Family Therapy Alliances (SOFTA) is frequently used to analyse the effect of alliance on change process (Escudero, Friedlander, Varela, & Abascal, 2008; Friedlander et al., 2006). Escudero et al. (2008) looked at the positive and negative alliance behaviours within brief family therapy. They used the SOFTA to analyse videotapes of sessions with 37 families and found positive associations between in session behaviour and participants' perception of the alliance and improvement (positive change). Successful outcomes were defined as consensus by the therapist and all family members on general improvement and problem reduction. Hogue, Dauber, Stambaugh, Cecero, and Liddle (2006) compared the impact of the alliance in Cognitive Behavioural Therapy (CBT) and Family Therapy for adolescent substance abuse. Although they did not find any alliance effects in CBT, they did find that the alliance within family therapy influenced the outcome. They found that a stronger parent alliance predicted reduction in substance use and externalising behaviour (e.g. aggression) and those adolescents with weak alliance at the beginning that increased by the midpoint also showed significantly greater reductions in externalising behaviours than those where the alliance declined. These studies have all contributed to strengthening the idea that the alliance and process variables are of significant importance when researching the efficacy of family therapy. However, this has been criticised as being over-simplistic and Sexton and Datchi (2014) have suggested that this does not take into account the contribution of model-specific ingredients on common

factors such as alliance. Friedlander, Escudero, Heatherington, and Diamond (2011) conducted a meta-analysis of 17 family studies looking at alliance-retention/outcome and found different interactions and outcomes when looking at mediators and moderators of alliance for different forms of family therapy. This then supports the stance taken by Sexton and Datchi (2014), that the processes of the therapeutic alliance are treatment dependent. This then highlights the complexity and inter-connectedness of family therapy processes and a need for a more in depth exploration to understand processes within family therapy.

There have been advances made in looking at the complexity of the change mechanisms and therapeutic processes within family therapy, yet there are still questions raised about its impact on 'real' clinical practice (Sexton & Datchi, 2014). One difficulty with this research is that for the most part 'change' or outcome is measured using objective or quantitative methods. However, this can be seen as counter intuitive to the theoretical underpinnings of systemic family therapy. In family therapy, there is the social constructionist assumption that there is no one truth that can be measured and that there are different versions of reality at play at any one time. A version is influenced by the context and there is a dynamic construction of concepts and ideas that cannot be pinned down to one definition. Therefore, there is a need for more research that is congruent with the theoretical assumptions of the intervention, with an idiographic focus. We need to link research into therapeutic processes with measures of family change in order to produce a transactional rather than static account of therapeutic outcome (Frosh, Burck, Strickland—Clark, & Morgan, 1996).

Friedlander, Wildman, Heatherington, and Skowron (1994) reviewed the process evidence at the time and they concluded that the evidence base was still very much focused on objective analysis rather than a meaning based one and they called for greater focus on what the families 'do' in family therapy and to look at the interactional process that leads to change. Since that time, there is a now a growing evidence base on the interactional processes within family therapy. I will now review the current evidence base that has used discursive and narrative analytic techniques to explore the process of family therapy and situate this research study within this.

Discursive Studies of Family Therapy Process

Even though discourse is central to family therapy, surprisingly there is only a limited evidence base which looks at the narrative and discursive practices of family therapy. The initial studies that were carried out mainly focused on the range of discourses employed within the therapeutic process (Burck, Frosh, Strickland-Clark, & Morgan, 1998; Frosh et al., 1996). These studies found that there was a shift in the discourses being used during the therapeutic process, where the family moved from being firmly aligned to one discourse, to employing several discourses more flexibly by the end of therapy. This increase in discursive flexibility is regarded as indicative of positive change. Research then shifted to look more specifically at the processes within the therapy. I will now review the current evidence base, starting with the earlier studies looking at use of discourse in family therapy and then move on to review the studies that have looked at how language is used in family therapy process.

One of the first studies to use discursive techniques to explore process and change in family therapy was Frosh et al. (1996), where they used a discursive approach to look at how language is used to affect attitudes to change. They tracked the theme of 'how to deal with change' for one family, who were attending therapy after a marital separation. The family included parents Martin and Lucy and children Angela (14) and Ben (12) and they attended for 8 sessions of family therapy. Six of the eight sessions were transcribed and analysed. Using a discursive approach, informed by the principles of grounded theory, the transcripts were analysed for the theme of change. From this analysis, they identified two opposing parental discourses: change evolves versus change needs to be managed. Lucy was the instigator of attending therapy and within the therapy she most commonly drew upon the discourse of managed change, whereas Martin drew upon the discourse of change evolving naturally. At the beginning of the therapy, Lucy said that she wanted therapy to help them all effectively manage the change in their family situation (the marital separation); however Martin said that he thought they were attending therapy prematurely and they needed to just let the change happen, to allow issues to arise in their

own time rather than provoking them. Martin's philosophy of change may be construed as an opposing discourse to Lucy's and disengagement with therapy. Conversely, Lucy's proposal that change is something to be managed, can be construed as a way to control the imposed change of the separation in opposition to Martin. The analysis illustrates the subtle transition in attitude towards change held by members of the family, moving from a polarised adherence to different discursive attitudes towards greater flexibility. As the therapy progressed, Martin was seen to be more engaged and he started to talk about what he needed to do to help with the change in their family, following the separation. This indicates a more active approach to the change in his situation and recognition of the need for management of problems. During the therapy process, both parents (and children to a lesser extent) take up the opposed position to the one they are mainly associated with. By the final session, the discursive positions taken up by the family members have become considerably more fluid. Frosh et al. (1996) suggest that this flexibility indicates the growing capacity of the family to tolerate alternative discourses on change.

Burck et al. (1998) continued this work by looking at therapist interventions in the change process. They once again followed a similar process whereby they used grounded theory to analyse transcripts of a single case of a family therapy intervention. The research team decided to focus on the theme of control, as this was a significant theme in the family's relationship to the therapy and seemed likely to be an important indicator of therapeutic change. They identified changes in the discourses used by family members concerning control during the course of therapy. The family included parents Brenda and Miles and children, Mark (9), Donald (5) and Felicity (3) and they were attending therapy because of some general concerns of the parents regarding their children and their parenting. There were 30 sessions over the course of the therapy, all of the family attended for the initial sessions but the majority were attended just by the parents. The theme of control was not only relevant to the content of the therapy, but also to the process between the therapist and the family. The therapist uses a discourse of intentionality at the end of the first session to congratulate the parents for seeking help, suggesting that they were there to make things right for the children. In the

session, the family have illustrated their alignment with the discourse of being out of control, whereas the therapist using the discourse of intentionality positions the parents as having agency. Furthermore, the therapist uses her position as the expert to provide an alternative view on the way they have presented themselves, which opposes their discourse of being out of control. The therapist moves from the family's discourse of being out of control to one of being in charge by providing an alternative meaning. During the therapy and as the alliances build, the therapist starts to take more risks and challenge the family's discourse of being out of control. She uses the discourse of being in control in relation to their process of decision making, rather than the content of their parenting. This places the parents as in charge of their parenting and able to develop different choices. Burck et al. (1998) conclude that from their analysis, they have been able to trace how the therapist challenges participants thinking by introducing alternative discourses in relation to process, examining how their accounts are given as well as her own relationship with the family. The therapist can then engage the family in accepting a different position of being in charge. This study alongside the previous one from Frosh et al. (1996), both illustrate that positive change is linked with the family being able to use a wider range of discourses by the end of therapy.

Further to this, there have been a number of studies which have focused on the how the initial 'problem' is discussed and the negotiation of a pathological identity (Avdi, 2005; Dallos & Hamilton-Brown, 2000; Dallos, Neale, & Strouthos, 1997; O'Neill & LeCouteur, 2014). These studies highlight the positive aspects of shifting discourses away from a medical or pathological discourse towards a more flexible and less problem saturated discourse. Dallos et al. (1997) conducted a retrospective study to compare families where serious problems had arisen to those where difficulties had been managed in different ways. To do this they compared a clinical and non-clinical group; one where there had been a prolonged history of mental health interventions and the other where there had not been any such interventions. They found evidence that suggested that families may proceed along different pathways towards or away from pathology. They found that initial meanings that became attached to difficulties were

influential in shaping subsequent attempted solutions. Problem saturated initial meanings were linked with the use of the medical discourse, where problems were described as organic or signs of an illness. This then excluded alternative and non-pathological discourses. This study provided a rationale for looking at how problem meanings are constructed; however it was based on retrospective accounts and therefore did not provide an understanding of how these meanings are constructed. Consequently, a follow up study was conducted by Dallos and Hamilton-Brown (2000). This study aimed to look at how early difficulties are perceived in families and how the meanings related to the difficulties evolve. They recruited 9 families; 4 families who were reporting that their situation had improved and they were no longer in need of therapy (the spontaneous recovery (SR) group) and 5 families who reported that their problems were escalating and they required urgent help (the problems current (PC) group). There were no obvious differences between the two groups in terms of problem severity, length of time on the waiting list, family circumstances and age of children. The children's ages ranged from 2-14 and 5 were boys and 4 were girls. Semi-structured interviews were conducted with all of the families and then the interviews were transcribed and analysed using a combination of grounded theory, thematic analysis and discourse analysis. The analysis found that in the SR group, the accounts suggested that there had been a variety of significant positive inputs, such as seeing difficulties as transitory and as exemplifying normal developmental issues. The accounts indicated that positive inputs from friends, family and professionals could avoid the negative spiral. In the PC group, there was a lack of these positive inputs and instead the accounts offered a picture of the families being caught in a cycle of negative constructions of events and pathologising their child's actions. In these accounts, parents often did not have the emotional resources to reflect on their dynamics and the impacts of their relationships and the various stressors influencing the family. Therefore, pathologising and blaming tended to predominate the accounts. Dallos and Hamilton-Brown (2000) concluded that the initial presenting difficulties were no less extreme for the SR group and therefore the critical factor appeared to be the reactions and meanings ascribed to these difficulties rather than their

severity. This finding again emphasises the importance of meaning making in terms of wellbeing and positive outcomes. However, both studies do not look at how these meanings are negotiated within interactions or within the context of therapy.

Avdi (2005) also looked at the use of psychiatric diagnosis and suggested that an important task when working with a family is de-centering the dominant pathological maintaining account and facilitating the emergence of a wider range of less problematic discourses. This can also be seen in the research study by O'Neill and LeCouteur (2014), who as with the previous study, looked at a single case of family therapy where the family had a child with a diagnosis of autism. O'Neill and LeCouteur (2014) proposed that therapeutic change occurs from a discursive shift, by the family disengaging from the presenting problematic construction to an acceptable alternative account of events. They suggested that family therapy is a re-categorisation of the components of the presenting problem. They then used a single case of family therapy to explore this theory. The family comprised of parents John and Jane and children Paul (15) and Zac (13). Paul has a diagnosis of Autism and Inattentive-type attention deficit disorder (ADD) and the family were referred to therapy following Paul being threatened with exclusion from school because of behavioural problems. The family attended for 5 sessions over 2 months. The therapy sessions were recorded and transcribed and the transcripts were then analysed using the analytic framework of Membership Categorisation Analysis (MCA). MCA looks at how Membership Categorisation Devices (MCD) are used to assign category membership with the associated roles and expectations or that category. A MCD is a collection of categories into which members of a group can be assigned (e.g. the MCD religion produces the categories, Christian, Jew, Muslim). This analysis focused specifically on the consequences of invoking the Membership Categorisation Device (MCD) disability and the categorisation of autism in constructing a problem. The analysis illustrated that at the beginning of therapy the family were invoking the MCD disability to blame the school and to construct the parents in the 'carer' category. At the end of the first session, the therapist side-lines the use of the MCD disability and instead reframes the problem using the MCD of stages of life. The use of the

MCD stages of life brings into play other available developmental categories such as child, adolescent and adult. This is a family therapy technique called developmental reframing, that avoids pathologising children. The stages of life MCD is a higher order categorisation device than disability because everyone who is in the disability MCD is also in the stages of life MCD, but the converse is not true. Therefore, by invoking the stages of life MCD the therapist is not contradicting the family but offering an alternative view that can run alongside what the parents are saying, maintaining the therapeutic relationship. This shift towards using the stages of life MCD is then evident across the course of therapy. O'Neill and LeCouteur (2014) conclude that this study demonstrates how the de-centering of a problematic construction with a higher order MCD enables an alternative understanding that dissolves the original problem.

O'Reilly (2015) used a discursive psychology approach to look at how therapists interrupt their clients during family therapy sessions. She found that when the therapists interrupted the adults in the family, there was an orientation to the interruption as well as either an apology or acknowledgement of the interruption. However, when the therapists interrupted a child there was no orientation, acknowledgement or apology. O'Reilly suggests that this difference in approach constructs the child as having lower participation status than the adults in the room. Language is therefore vital in constructing and reinforcing these power discrepancies and it is not just the language that is used, but just as important that which is missed out. By not using these linguistic turns (apologising, acknowledgement) it constructs the child as inferior and powerless within therapy.

Patrika and Tseliou (2016) looked at how blame and responsibility are negotiated within the first two sessions of family therapy. They specifically wanted to understand family members' responses to the therapist's attempts to introduce a neutral and relational stance, through circular questioning. The sample consisted of 6 families with both their first and second family therapy sessions, available from a training programme in systemic family psychotherapy in Greece, which followed the Milan model. For the analysis they used the discursive action model (Horton-Salway, 2001), which shares

the same tenets of discursive psychology by focusing on the action orientation of talk. From the analysis, they found that when the therapist tried to introduce a relational perspective to the problem being discussed, this was often construed as an allocation of blame and responsibility to the family and then the family responded by further blaming the identified client. This highlights that language is not neutral as each person will interpret it based on their own assumptions and understandings. Our discursive practice is continually being shaped by our interactions and we need to acknowledge this to understand what meanings we are constructing and reinforcing.

Couture and Strong (2004) used a combined method using both conversational analysis as well as discourse analysis to look at 'forward moving conversations'. They were interested in looking at how families overcame *differends*, which they described as instances in the conversation where each family member is invested in his or her own way of understanding the topic and these differences become stuck. They wanted to investigate how new shared meanings and fresh connections between the therapist and the family members are created through dialogue. The study looked at how family members and therapists naturally made such discursive shifts, to move from a differend to a forward moving conversation. Adolescents and parents viewed videotapes of their recent therapy sessions and selected examples where they felt there was a forward moving conversation. The clinical example that they present is from a family therapy session, where the son 'Joe' has just been discharged from hospital following an incident of self-harm. In the therapy session, the differend is in relation to drawing up a contract regarding self-harm. The parents come from a position of certainty, saying that Joe needs to agree to the contract to not self-harm again, whereas, Joe is more ambivalent saying that he is unsure that he can fulfil this contract. Their positions left little room for dialogue on how they would collaborate on making Joe's safety a reality; the more Joe voiced his doubt, the more his parents entrenched themselves in their discursive position of certainty. Within this differend, the responsibility is being firmly placed with Joe. The therapist then helps the family shift to a forward moving conversation by offering a negotiation of responsibility within the family. The therapist suggests a two-way contract, which is taken on

board by Joe's father, who then illustrates his acceptance by using the term 'we' and showing this shared responsibility in the language he uses. Couture and Strong (2004) suggest that this illustrates how talk is use to accomplish as shift from incompatible discourses to a shared (more positive) discursive position. They state that change, from this perspective, is constructed within the immediacies of therapeutic conversation. Couture and Strong (2004) propose that discourse analysis methods are consistent with the theoretical stance of social constructionist family therapy and that discursive approaches allow us to understand how new meanings are constructed through therapeutic dialogue.

These studies all support the importance of understanding and analysing discourse to understand process within systemic family therapy. However, this evidence base is still very limited and often is based on the study of one or two cases. Meaning making is central to systemic approaches, yet the research that focuses on this is limited within the evidence base. Furthermore, the studies that do look at meaning tend to focus on the beginning of therapy (Dallos & Hamilton-Brown, 2000; Patrika & Tseliou, 2016) or take one single case of therapy (Avdi, 2005; Burck et al., 1998; Frosh et al., 1996) and from my review of the evidence, there do not seem to be any studies which focus on the end of therapy and how meaning is constructed with the story of therapy as part of the negotiation. The meaning making evidence base suggests that it is the shared meanings that a family takes away with them after the intervention that increases resilience and future wellbeing (Alexander et al., 2002; Oppenheim, 2006; Oppenheim et al., 1997). Therefore, it is important to understand how change meanings are negotiated in the final session, as these will be the meanings that the family will take with them into the future. This research seeks to address this gap and hopes to encourage others to build on this research to continue to develop our understanding of how meaning, in particular that relating to change, is not only constructed but negotiated within family therapy. Lastly, returning to what Friedlander et al. (1994) said, there needs to be a greater focus on what families 'do' in therapy and what are the effects of what is said. This reflects the dynamic interaction occurring in therapy and allows us to explore and understand the social action embedded in the language we

use. This research project aims to look at how change, outcome and the therapy process are spoken about within the last session of family therapy as well as exploring what happens because of this. I will now provide the context of the data set used in this study and put forward the research questions that will be addressed.

The Self Harm in Family Therapy (SHIFT) Project

The data used in this study comes from the Self Harm Intervention Family Therapy (SHIFT) project (Cottrell et al., 2018). The SHIFT project was a randomised control trial (RCT) comparing family therapy to treatment as usual for young people aged 11-17 who have engaged in self-harm on at least two occasions. For the family therapy arm, families were offered 6 months of a family therapy intervention. Qualified family therapists delivered the trial intervention using an adapted version of the Leeds Family Therapy and Research Centre Systemic Family Therapy Manual (Pote et al., 2001). All participants were identified from 40 Child and Adolescent Mental Health Services (CAMHS), within the National Health Service (NHS), located in one of three areas: Yorkshire, London and Greater Manchester. From 2009-2013, 832 young people consented to participate in the study and were randomly assigned to either family therapy (n=415) or treatment as usual (n=417). The primary measure of outcome of the trial was incidents of self-harm that led to hospital attendance during the 18 months after group assignment. The secondary outcomes that were recorded included; quality of life measures, cost-effectiveness (cost per self-harm event avoided), suicidal ideation, depression, overall mental health and emotional and behavioural difficulties and family functioning (Cottrell et al., 2018). All SHIFT family therapy sessions were recorded for assessing intervention fidelity and for use in future research.

The primary outcome data were available for 795 (96%) participants and found that there was no significant difference for rates of hospital admittance for repeat self-harm events between the two groups. However, they did find that for the secondary outcomes, young people and their caregivers in the family therapy group reported significantly better outcomes on several

elements of general emotional and behavioural difficulties, suggesting that family therapy had a significant positive effect on general mental health, even if this did not translate into a reduction in the incidents of self-harm (Cottrell et al., 2018).

As the SHIFT project is the largest RCT of family therapy to date, there is a wealth of recorded family therapy sessions available as a data set to be used by other research studies. Subsequent research has typically used the SHIFT data to look at the discursive practices used in family therapy. Green (2015) looked at how family therapists negotiate the meaning of self-harm over the course of therapy. Using grounded theory, he analysed two full cases of family therapy. From the analysis, he found that mutual engagement of key family members is crucial to starting the process of joint exploration of meaning and relating. He suggested that even though changes in meaning are important in and of themselves, the real significance is in the way they shape changes and interactions in the family. Barker (2016) looked at the influence of the reflecting team (RT) on the family meaning system, across three different families, using a discursive psychology approach. She found that the RT was instrumental in guiding and reinforcing the therapists influence, however that the RT may have a differential influence depending on the stage or context of therapy. Holliday (2017) used the SHIFT data to understand adolescents' experiences of self-harm and to explore their understandings of why they self-harmed, what their responses to self-harm were and how they ceased self-harm behaviour. This study used thematic analysis (with an inductive approach) to analyse session recordings from 22 participants. The research found that the young people described a number of reasons why they self-harmed, but that this was often a very difficult topic for them to discuss. Many of the participants reported self-harm as a way to manage feelings, but this again was expressed in a range of ways. Furthermore, the relationship between self-harm and suicidal ideation was described as complex and difficult to disentangle.

The End Sessions in Family Therapy

This research aims to understand how meaning is negotiated in the final session of family therapy. The SHIFT project used an adapted version of the Leeds Family Therapy Manual (Pote et al., 2001) to guide the intervention; therefore it is important to understand what is suggested by the manual to provide further context for this research. In the manual, guidance is provided generally for the 'ending' sessions, rather than specifically for the very final session. The recommended goals for the ending sessions are (Pote et al., 2001):

- Gather information and focus discussion
- Continue to work towards change at the levels of behaviours and beliefs
- Develop family understanding about behaviours and beliefs
- Secure collaborative decision re: ending
- Review the process of therapy

The manual explicitly recommends that therapists review the process of therapy with the family. It suggests that discussions should focus on what has been lost or gained for the family through therapy, the reasons for therapist's behaviours and procedures used and explore what the family might do differently if future difficulties arise. Thus, the final session seems optimum for looking at how meanings related to change, outcome and the therapy process are negotiated. Furthermore, it is these final meanings that the family will have once the therapy ends and they are likely to be the meanings that they may draw upon in the future.

The Role of Self-Harm in the Context of this Research

The data I will be using comes from the SHIFT project. Understandably as this was the primary reason for families attending therapy, discourses relating to self-harm are expected to be prominent in the data and therefore, will shape the analysis and discussion. Furthermore, the SHIFT version of family therapy placed great emphasis on families discussing self-harm and formulating strategies to deal with subsequent events (Cottrell et al., 2018). Therefore, although this study is not focusing on self-harm, it is important to

acknowledge this as the context for the data and to be aware of the potential role self-harm will play in this analysis. The commonality between all of the families will be that the adolescent has engaged in self-harm behaviour. Therefore, even if this is not a prominent discourse in itself in the last session, it will still be part of the context that will be shaping the discussions that are taking place. Furthermore, the families are attending therapy to 'do' something, so it will be vital to not only look at what is being said but what happens because of this talk; what are the different agendas in the room and how does self-harm influence these agendas. I will be considering the role and influence of self-harm in the analysis, discussion and any potential conclusions that I draw.

Rationale for the Study

Current practice of systemic therapy aims to support individuals and families to generate new or alternative meanings, to ultimately reduce distress (Carr, 2012). This generation and assimilation of meaning has been shown to have a positive effect on future wellbeing, particularly in the child trauma and loss evidence base (Neimeyer et al., 2006; Saltzman et al., 2013). However, there is limited evidence that looks at how these meanings are negotiated in sessions. Specifically for family therapy, how shared meanings of change are negotiated at the end of therapy, as this is when the final meanings are constructed that they will take with them after therapy. Over the last decade there has been a surge in process research to look at what impacts on 'change', yet this has mainly taken a realist approach with the use of outcome measures. This ignores the role of context on these versions of reality and misses out the dynamic construction of change through the language that we use. The descriptions used by someone provide us with information about the socially available ways of talking about change, which in turn continues to shape our 'reality' of whether changes have occurred and what this means (Potter & Wetherell, 1987). By looking at how meanings of outcome and the therapy itself are negotiated, we can understand the process by which these meanings are generated at the end of therapy for the family to take with them afterwards. The hope is that this research will provide a discussion about how the therapy process and any

outcome is negotiated in the final session of family therapy and how this is achieved by the different stakeholders involved.

Research Questions

Main Research Question

How do participants in the final session of family therapy negotiate their understanding of the therapy and its outcome?

Supporting Research Questions

1. How do the participants talk about the therapy process and any outcomes i.e. what has changed and how it has changed? What is *done* in the final session?

2. How is a shared understanding achieved (or hindered) in the final session?

3. What do the stakeholders do in the final session to try and develop a shared understanding?

Method Chapter

Within this chapter, I will present the theoretical and methodological rationale for this study and I will outline how my research questions led me to the chosen research method. Following this, I will outline the method that was undertaken, including the transcription process, data analysis and quality assurance measures.

Methodology

Pre-existing Data Set

The aim of this research is to look at how the participants in a final family therapy session negotiate their understanding of the therapy and its outcome. When this research question was chosen, I was aware of the SHIFT project and the wealth of recorded family therapy sessions that were collected as part of this trial. The SHIFT project was the largest randomised control trial of family therapy that has been conducted in the UK and all the families that took part in the SHIFT project consented to the data being used for secondary research purposes (Cottrell et al., 2018). Therefore, I requested to use the SHIFT data for this study, as it fitted with my research question and was available to be used. It was then once I had my research question and data set agreed, that I developed the rationale for using Discursive Psychology as the research method. I will now outline the process of this decision.

Selecting a Research Method

Qualitative methods allow for exploration and investigation of meaning and experience (Willig, 2013). In qualitative research, the aim is not to understand cause and effect but to gain a richer description and understanding of the phenomena being studied. Qualitative methods are suited to research questions related to process; exploring 'how' things are done or experienced (Willig, 2013). All research is interpretative and therefore is guided by beliefs, values and feelings about the world and how it

should be understood (Denzin & Lincoln, 1994). Qualitative research acknowledges this and is explicit about the researcher's position, how they may see the world and how they view knowledge (their epistemological stance) and thus how they may shape or influence the research. Qualitative research methods aim to provide a more complex understanding of the research findings and allow the researcher to illustrate any contextual factors to consider in relation to that particular study and the results and conclusions it presents. My research question seeks to understand how participants negotiate their understanding of the therapy process and its outcome and therefore is suited to a qualitative research method.

Within qualitative research, there are various methods that can be used which all have a different focus and purpose. With the chosen data set, a research method was required that would allow me to analyse naturally occurring talk. A potential research method was Grounded Theory (GT), which seeks to derive theory from the data. This method involves identifying categories from the data and then this provides an explanatory framework in which to understand the phenomenon being researched (Willig, 2013). GT is based on the principles of induction, where observations give rise to new theories. However, my research question aims to understand *how* meaning is negotiated between the participants in family therapy, rather than identifying different categories of meaning from the data. The focus on how meaning is negotiated meant that I needed a research method that would allow me to understand how language is used within interactions. In light of this, discourse analysis was viewed as the most appropriate fit for my research question.

Discourse Analysis

Discourse analysis is often referred to as the "turn to language" as it allows a researcher to analyse discourse in context (Potter & Wetherell, 1987). It is the study of how language is used in the world, not just to say things but to do things (Gee, 2010). Language is not seen as a neutral vehicle to label experience, rather it is seen as constitutive; it is the site where meanings are created and changed (Taylor, 2001). People use language as a form of social action; but from a discourse analysis perspective this function is not

just mechanical but is bound up in context (Potter & Wetherell, 1987). What we mean or intend by what we say is often subtle and indirect and it is the context that gives us a full understanding of the meaning that is being constructed (Taylor, 2001). People use language to construct versions of the social world; therefore a person's account will vary according to its function (Potter & Wetherell, 1987). A speaker can be seen as accomplishing a variety of social actions with what they say (Edley, 2001). Language makes things happen and discourse analysis is a way of showing how language constructs and creates meaning through social interactions and ultimately our social and psychological world (Potter & Wetherell, 1987).

Foucauldian Discourse Analysis (FDA) and Discursive Psychology (DP)

There are two different strands of Discourse Analysis (DA) that are most relevant to psychological research; Foucauldian Discourse Analysis (FDA) and Discursive Psychology (DP). Although both share the same assumption that language is constitutive in constructing meaning, they differ in their theoretical focus. I will now briefly explain both strands and provide a rationale for choosing DP as the research method for this study.

FDA was developed by Michael Foucault and as a method it specifically looks at language and its role in creating social and psychological life (Potter, 2004). FDA is based on the proposition that discourses both enable and constrain what can or can not be said and by whom (Willig, 2013). FDA pays attention to the relationship between discourses and institutions and focuses on power as a key component of how available a discourse is within a particular context (Potter, 2004). It takes a historical perspective and looks at how discourses have changed over time and the availability of certain discursive resources within a particular culture (Willig, 2013). FDA aims to produce knowledge about the 'discursive economy'; how it came to be that way over time and what it means for human subjectivity and experience (Willig, 2013). Therefore, it is best suited to questions, which want to explore the discursive worlds people live in and the power of discourse to construct objects, including the human self. For example, FDA has been used by feminist researchers to explore the power and discourse constructions

around sexuality (Van Ness, Miller, Negash, & Morgan, 2017) and also to explore the constructions of homosexuality and how the medicalised discourse has been used to pathologise this population (Drazenovich, 2012).

Discursive psychology (DP) is a strand of DA which is primarily concerned with how people use language to negotiate and construct meaning in everyday talk. In particular, it focuses on human agency within interactions (Edley, 2001). Discursive psychology has been specifically used to investigate 'institutional talk' (O'Reilly, 2008), where the talk has a distinct purpose with distinct roles within the conversation (e.g. between a doctor and a patient). Discursive psychology is well suited to this as it focuses on how discourse accomplishes and is part of social practice (Edwards & Potter, 1992). Discursive psychology focuses on how events are explained, how reports are constructed and the nature of reality. It specifically looks at these conversations within the context they are situated and the social action being achieved in the discourse (Edwards & Potter, 1992).

DP analyses the constructive and functional dimensions of language (Willig, 2013). To do this, researchers need to look at how people use language to construct objects and subjects and what consequences this has in the interaction. Potter and Wetherell (1987) state that patterns can be found when looking for the interpretative repertoires employed in talk. An interpretative repertoire (IR) is defined as "a register of terms and metaphors drawn upon to characterise and evaluate actions and events" (Potter & Wetherell, 1987, p. 128). The terms discourse and interpretative repertoire can often be used interchangeably but Edley (2001) describes that there is a theoretical difference suggesting that discourses relate to wider societal structures (medicine, politics) and IRs are smaller idiosyncratic discursive constructs. When the researcher has identified the various IRs that are being drawn upon in the talk, they can they look to see the consequence of this within the context of the interaction. The discursive devices used (blaming, justifying, empathising), then allow the researcher to focus on the action orientation of the talk.

DP can be criticised for over-emphasising accountability and stake and not taking into wider influences into account; i.e. culture and societal power

(Willig, 2013). The term stake is used in discourse analysis methods to describe the agenda or interest a person has in a particular course of action (Whittle & Mueller, 2011). FDA explicitly looks at these influences, whereas DP focuses more on action within an interaction. As I want to explore how understandings of therapy and its outcome are negotiated in the moment, DP seems to be the most suitable method to do this. However, I will take into consideration any potential wider contextual influences in the discussion of the findings. Potter and Edwards (2001) also emphasise the importance of using naturalistic data when using a discursive psychology approach. This is because discourse needs to be situated in the specific context of interest. Language is action-orientated according to the context and therefore only by looking at naturally occurring situations will you be able to be sure that it is applicable to that context. Thus, DP serves as the most appropriate method for this data set as it is of naturally occurring talk in therapy sessions.

Methodological Rationale

Discourse analysis was chosen as the most appropriate research method for this study for a number of reasons. The research question sits within a social constructionist understanding of knowledge as it seeks to understand how meaning is negotiated in the moment and within interactions. Further to this, the data set is of naturally occurring interactions in therapy sessions. Discourse analysts propose that meaning is constructed through the language used and is bound within the context and therefore it provides a suitable framework for the epistemological stance of this research question.

Discourse analysis also fits well with researching family therapy, because both approaches are based within language. Family therapy is a discursive practice which aims to generate new meanings, in the context of collaborative discourse (Avdi, 2005). It is based on the theoretical understanding that the emergence and treatment of psychological problems is within 'interactional terms' (Diorinou & Tseliou, 2014). Thus, if language is understood as the active tool in the therapy, then we need a method that allows us to analyse language as constructive.

Furthermore, when looking at the process of therapy, language based analysis proves well suited as both focus on meaning making through

language (Georgaca & Avdi, 2009). Linguistic tools allow for an exploration of how problems and solutions are mutually negotiated and constructed as well as acknowledging the role of cultural and contextual discourses (Georgaca & Avdi, 2009). Discourse analysis provides a method to look at how language is used in the context of family therapy. Discourse analysis allows the researcher to explore the therapeutic process and to try and make sense of it in light of the discursive context.

Method

SHIFT Data

The data used in this study came from the Self Harm Intervention Family Therapy project (SHIFT). Permission to use this data set was granted by the SHIFT research panel (see appendix 1).

Sample

There is very little published guidance on the appropriate sample size for qualitative research. It is often dependent on the research question itself and the method chosen. Previous published studies of family therapy that have used discourse analysis differ in their sample size; 1 family over 6 sessions (Frosh et al., 1996), 1 family over 30 sessions (Burck et al., 1998), 1 family over 12 sessions (Avdi, 2005) and 2 families over 6-8 sessions each (Green, 2015). (Potter & Wetherell, 1987) emphasise that the success of using DA is more dependent on the richness of the data set in relation to the research question, rather than the specific sample size number. It was decided in supervision that as I wanted to look at the entire final session and it was expected that the session would be rich in data related to my research questions that 6 family therapy sessions would provide an adequate data set to sufficiently answer the research question, within the limited time frame.

Selection

The inclusion criteria that were set were that the family gave consent for the recording of the session and for its use in secondary research (from the SHIFT project), the session needed to be a planned ending session (agreed with the family) and that the audio quality of the video was sufficient to be

able to transcribe. Based on these criteria, the data co-ordinator for the SHIFT project randomly allocated six family therapy cases from their database. To do this, the data co-ordinator filtered the database based on the first two inclusion criteria. This then left n=137 and of these 20 participants were randomly selected to allow six video tapes to be selected. This allowed for participants with tapes which could turn out to be problematic (due to visual, audio or upload problems). The SHIFT data co-ordinator within the CTRU then selected the first six participants for whom the recordings had already been uploaded on to the S drive. All of these recordings were satisfactory and this then provided the six families selected for this research.

Ethical Issues and Approval

Ethical approval for this study was granted by the School of Medicine Research Ethics Committee (MREC16-188) on 28th September 2017 (see appendix 2)

Data Protection and Confidentiality

The video recordings used for this study were stored on a hard drive that was held by the Clinical Research Trials Unit (CTRU). To access the recordings, I was allocated a secure room within the CTRU, where the screen was not visible to anyone else. One of the data co-ordinators from the trials unit would bring the hard drive to the room for me to use and then at the end of the day one of the data co-ordinators would collect it and it would be returned and securely stored within the CTRU. The recordings were transcribed by me and an internal transcriber who signed the confidentiality agreement and undertook the same process for accessing the videos with the CTRU. The internal transcriber has transcribed the SHIFT data for previous projects and therefore was familiar with the data set. The transcripts were stored on this hard drive and once fully anonymised the data co-ordinator would securely email the anonymised transcripts to my university email, so I could access them for the analysis. The transcripts were assigned a number to denote each family and pseudonyms were then assigned when writing up the results. Paper copies of the transcripts were

kept within a locked cabinet and electronic versions were stored on my password protected drive on the University of Leeds encrypted server.

Transcription

A simplified version of the Jefferson style transcription was used as a guide for the process, as suggested by Potter and Hepburn (2005). This method of transcription captures the words and some of the conversational features such as overlaps, intonation, pauses and emphasis (see table 1 below). However, it does not go into detail regarding the exact length of pauses and the more subtle elements of conversation such as non-verbal communication. Potter and Wetherell (1987) advocate this as adequate for discursive psychology because it allows the researcher to focus on the broader ideological content of the talk and means that they do not get side tracked by the minutiae of speech delivery and conversation. The transcripts were line-numbered to easily link back notes and comments to the transcript and to extract quotations for the analysis (Potter & Hepburn, 2005).

Symbol	Convention
[.]	Short pause
[…]	Long pause
(laugh)	Information on non-linguistic features
<u>**Text**</u>	Emphasised in speech
Speech **[Text]** **Speech**	Overlapping speech

Table 1: Transcription Conventions

Data Analysis

Before transcribing the session, I watched the session in its entirety so that I could observe the session as it would have happened and then I made some initial reflections about how I felt watching the session and what I was left

thinking and feeling in relation to my research questions, which was logged in my reflective journal. This allowed me to get a sense of the session and what I was bringing to the transcript before doing any analysis. I then transcribed the session, following the method described above. Once I had watched the final sessions, I also watched the first sessions for each family, to gain an understanding of the context of their journey in therapy. For the analysis, I took each transcript in turn and colour coded sections of text which seemed to relate to my research questions. I continued to familiarise myself with each transcript, re-reading it and taking time to go over my coding. I initially coded for each research aim and then organised the data into tables. This then allowed me to identify patterns and interpretative repertoires within the data. I have included a worked extract from one of the original transcripts to illustrate my working and analysis and this can be found in appendix 3. After this the analysis then focused on the action-orientation of the talk (Potter & Wetherell, 1987). The analysis looked at the context and function of the talk and which rhetorical devices were used to enact the interpretative repertoires. To guide this analysis, I developed a protocol, which was a list of questions based within DP principles to guide my analysis (see next page).

Figure 1: Protocol used for analysis (Edley, 2001; Edwards & Potter, 1992; Potter & Wetherell, 1987)

Stages of analysis

1. Identify patterns in the data: looking for both differences and consistency

Overall Questions:

- What is taken for granted as true or accurate descriptions of the world?
- Whose interests are best served by different discursive understandings/formulations?
- How are identities produced for particular occasions?
- How does history or culture impinge on/affect/impact on these performances?
- How does it structure both subjective experience and our sense of who we are?

For consistency look for Interpretative Repertoires (shared understandings):

- Look for people taking similar lines or making the same kinds of arguments
- What are the general assumptions being put forward?
- What are the patterns across different people's talk (images, metaphors, figures of speech)

For differences look for:

- Ideological dilemmas - look for 2 conflicting IR's of the same social object that are both held at the same time
- Also look for any exceptions to the regular pattern of accounting – what is different in these situations and then is there a pattern across the exceptions?

2. Identify functions and consequences of the talk

Look at the different IRs:

- What is the function of that IR in the room?
- What are the wider cultural implications of these ways of thinking?
- Why are people drawing on these IR's in this situation? What are they trying to achieve?

Look for the different subject positions conveyed:

- Who is implied by a particular IR? And what does this do?
- What does a given statement(s) say about the person that utters them? What consequence does this have?
- What are the different subject positions taken up by the various people in the room and what do they accomplish with this?
- What does the availability of these subject positions tell us about the broader ideological context in which such talk is done?

Once I developed hypotheses about the possible functions and consequences of the talk, I referred back to the transcripts to test and develop them and to find any supportive or contradictory examples that would refine the initial hypothesis. Analyses were frequently checked out with my supervisors as a quality assurance measure and to help develop and refine my hypotheses. In addition, I went back to watch the recordings after developing my initial hypotheses to refine them and to check the non-verbal communication to ensure that I was acknowledging the tone of the session and the context of what was being done and said. When writing up the analysis, sections of the transcripts were used as examples of the discursive practices being discussed.

Quality Assurance

To ensure that good practice is being conducted within qualitative research, there are a number of guidelines and practices that are recommended (Elliott, Fischer, & Rennie, 1999; Yardley, 2000). The importance of quality assurance in discourse analysis in particular is discussed by Leudar and Antaki (1996). They argue that discourse analysts need to ensure they are fully acknowledging their own footing in the research process and to not gloss over this by stating that using the participants own words is sufficient as a quality assurance measure. Leudar and Antaki (1996) stress that researchers using discourse analysis need to take as much care as other qualitative researchers to ensure they are providing the full context of the reported talk and providing the reader with an understanding of their own position throughout the research process. There are a number of steps I have taken to ensure the quality of this research, which have been informed by the guidelines produced by Elliott et al. (1999), also taking into account the specificities of using discourse analysis. I will now outline how I have incorporated these assurance measures into the research process:

- Owning my own perspective: Within the researcher reflexivity section (later in this chapter), I have described my theoretical orientation and I have discussed my own values and interests related to this research. I have reflected on how my own values and assumptions may impact the study throughout the research process and I have included these reflections both in the method chapter and the discussion chapter.

- Situating the sample: I have provided pen portraits for all of the families in this study, to provide the wider context for the reader.

- Grounding in examples: In the results chapter, I have used extracts from the transcripts to illustrate the discursive practices that I am commenting on. Furthermore, I have given clear descriptions of what was happening just before and then just after the extract to provide the full context of what was being and done in the session.

- Providing credibility checks: Throughout the analysis process, I met regularly with my supervisors to discuss and reflect my thoughts and

findings from the data. This gave me another perspective to ensure that my findings made sense in the context of their reading of the transcript and my explanation of the analysis. Furthermore, we were able to look at the extracts in the context of the whole session, which allowed for alternative ideas to be discussed.

Researcher Reflexivity

As a qualitative researcher, I am aware that I will bring my own values, experiences and assumptions to the research process. Elliott et al. (1999) emphasise the importance of the researcher owning their theoretical position and values in relation to the study, therefore I will now describe my own orientation and what influenced my decision to look at this particular research question. Prior to clinical training, I was working in the National and Specialist Child and Adolescent Eating Disorder Service at the Maudsley Hospital in London. The service had developed the 'Maudsley Model' as the predominant intervention and this was based within systemic family therapy practice. I was involved in family therapy sessions for a number of families over the two years I was there and it was these experiences that developed my keen interest in systemic ways of thinking and practicing. I had seen the positive impacts of systemic practice on how families communicate and interact with each other and this fuelled my interest in understanding the processes within family therapy. It was this that then influenced my decision in using this research to investigate the processes within family therapy. I was aware from the beginning that my interest in this area came from working as a clinician and that I would need to separate the role of being a clinician to the role of being a researcher within this project. This is something that I have used supervision to discuss and I have reflected on times during the research process, particularly the analysis where I may have been influenced by my role as a clinician. I noticed that at times I would focus on what I believed an individual was thinking about when they were saying something in the session and presuming what this may be based on my clinical experience. For example, for family 4 I considered how Tom was feeling as a step parent and whether he felt powerless in the family dynamics. I believe that my experience as a clinician has been beneficial in

helping me to understand the therapy process and what the therapist might be doing in the final session, but I had to ensure that I was focusing on what was happening in the session, rather than what I presumed an individual may be thinking.

Leudar and Antaki (1996) state that researcher reflexivity is imperative to the DP process so that the reader is not misled and to allow them to see the findings within the full context of the researcher's position. In light of this, I have kept a reflective journal, throughout this research process, to keep a record of my personal reflections at all stages of the study. I was then able to be aware of how my own values and assumptions may be impacting what I see in the data. An example of this has been how I have used my reflections to notice when I am being drawn into thinking as a clinician rather than as a researcher. When I watched the sessions initially, I was more invested in the families who spent more time explicitly talking about the changes they had noticed and the therapy process (e.g. family 1 and family 6). I found it more difficult to analyse the sessions for family 2 and family 5 because they were less co-operative with the process. I reflected on this in supervision and how I felt less sure of the changes for these families because they were not collaborating with the therapeutic process as the other families were. I realised that I was putting myself in the role of the therapist, trying to identify the changes for the family, when I actually needed to stay in my role as a researcher and focus on what was been *done* in the session. This reflection allowed me to take a step back and to re-look at the transcripts from the perspective of a researcher and I then used my protocol to focus on what was being achieved with the talk (or lack of talk) in the final session.

My Theoretical Position as a Researcher

During my time on clinical training, I have been drawn to social constructionist ways of thinking and seeing the world. This fits with my interest in family therapy and is often a theoretical position I hold in my clinical work. I will now describe my understanding of social constructionism, to give context to my theoretical orientation in this research.

Social constructionism derives from the epistemological stance that there is no one 'truth' to be discovered and described (Willig, 2013). Instead, it

proposes that there are different realities or understandings that are constructed within the social context. I particularly like that it encourages us to challenge our taken for granted assumptions and to take a more critical stance towards what we think we know by what we observe (Burr, 2015). So from my understanding, our knowledge of the world doesn't come from the nature of the world as it really is but that people construct it between them, through their interactions (Burr, 2015). Therefore, as a researcher I can look at the interactions between people to understand how meaning and knowledge is constructed.

From my perspective, language is not just a vehicle to describe reality but plays a key role in co-constructing reality. "Language provides us with a way of structuring our experience of the world and ourselves and that the concepts that we use do not pre-date language but are made possible by it" (Burr, 2015, p. 54). Analysing what people say, provides us with information about how socially available ways of talking about phenomena are used and what the consequences are for those involved (Willig, 2013). Social constructionism argues that the ways we understand the world, the categories and concepts we use are all culturally and historically bound (Burr, 2015). Therefore, from my perspective we cannot take language out of context as this is crucial for understanding the meaning and reality being produced. I believe that different versions of reality can be constructed through the language that is used, so to understand a concept or experience, we need to look at what is being said and then how it is being spoken about. This is a position I often hold in my clinical practice and informs the way I think about the people I work with and our experiences in the therapy room. Therefore, this will be a position that informs my role as a researcher within this study and will shape the analysis process. I will return to reflect on this later in the discussion chapter.

Results Chapter

I will start this chapter by giving an overview of the whole sample. Each family will initially be analysed separately, which will include a pen portrait presented alongside a brief overview of the first session. The story of the final session will then be presented using extracts from the transcripts. These extracts have been picked as being representative of how change was being discussed in this session; this then answers the first research question, **how do the participants talk about what has changed and how it has changed?** Following on from this individual analysis, the final part of this chapter will discuss the patterns and differences in the sample as a whole. This group analysis is broken down into the therapeutic tasks in a last session and answers **what is achieved in the final session?** Finally, the group analysis looks at the patterns of interaction in these sessions, to address the research question of **whether and how a shared understanding of the therapy process is negotiated.**

Overview of the sample

The sample consists of 6 families who all attended Family Therapy over 6 months. In four of the families, the mother was the only parent who attended all of sessions.

Family	Age of young person at the end of therapy	Sex of young person	Present in final session	How many sessions attended?
1	17	Female	Deborah (Mother)	8
			Peter (Father)	
			Emma (Young Person)	
			Julie (Therapist)	
2	14	Female	Tanya (Mother)	6
			Brooke (Young Person)	
			John (Therapist)	
3	13	Female	Lorraine (Mother)	9
			Isobel (Young Person)	
			John (Therapist)	
4	11	Male	Sarah (Mother)	8
			Tom (Step-Father)	
			Harry (Young Person)	
			Linda (Therapist)	
5	15	Female	Leanne (Mother)	7
			Lexi (Young Person)	
			John (Therapist)	
6	14	Female	Jane (Mother)	8
			Rachel (Young Person)	
			Karen (Therapist)	

Table 2: Characteristics of the Sample

Family 1

Pen Portrait

This family consists of Deborah (mother), Peter (father), Emma (17) and younger sister Lily. They attended for 8 sessions of Family Therapy over 6 months. The lead family therapist was Julie and there was a reflecting team of 2 other family therapists. Younger sister Lily attended for the first couple of sessions, but she was unable to attend further sessions due to school commitments. She was not present in the final session, but was mentioned in the discussion.

Referral and background context

The family were referred to the SHIFT project by their local CAMHS team. Emma had been struggling with low mood and feelings of anxiety and so she went to her GP to seek support. Her family were aware of her low mood and supported her to attend the GP appointment, but they were not aware of her self-harm at this point. The GP referred Emma to CAMHS, where she attended sessions with her parents and this was when her parents learnt that she had been cutting her arms to manage her low mood and anxiety. When Emma was referred to the SHIFT project, she had stopped self-harming by this point, but was still struggling with feelings of loneliness, anxiety and low self-esteem and was still having thoughts of hurting herself.

The first session

In the first session, Emma said that her family have been very supportive and she stated that they are able to be open and talk with each other. Both parents said that they wanted to understand the self-harm because it didn't make sense to them, especially as they believed Emma to be a very rational person. The family described how Emma experienced a very fast period of change in her development, particularly physically and they wondered if this was detrimental to her self-esteem and confidence. Emma agreed with this and commented on her physical appearance being a source of distress for her, because she believed she was bigger than other girls her age. She also

described a lot of anxiety about people not liking her and not having much self-confidence. The therapist recognised that although there was progress in terms of Emma not cutting herself, the thoughts were still there and that they would need to focus on understanding the difficult feelings and thoughts that had led her to use self-harm as a coping strategy.

The last session

At the start of the session, there is a discussion about Emma's recent experience of attending a festival over the summer. This is constructed as a positive change by all participants in the room because it was an experience where both parents had less control and Emma was able to be more independent and to practice how to get support from a distance. The family use this in the session as a way to talk about roles in the family and how they will adjust when Emma goes to university next year. There is a discussion about how Emma can balance getting support from the family, whilst also becoming more autonomous and standing on her own two feet. This is negotiated in the discussion, with Deborah and Peter holding different points of view, with Peter suggesting that she needs to learn to manage on her own, whilst Deborah reinforces that she will still have the support from them and is not alone. In this negotiation, parents are trying to communicate different things; Deborah wants to reassure Emma that they will still be there and care for her and Peter is trying to encourage her to plan for the future so she is able to be independent and has the skills to manage on her own. The therapist mentions that it is the final session and asks the family how they feel about the therapy ending. Deborah comments that she is relieved it is ending and there is then a disagreement between Deborah and Emma about this. Emma suggests that her mother is relieved because she doesn't like the stigma attached to attending therapy, whereas Deborah says that she thinks that they are now ok to manage on their own and that Emma is in a different place compared to the beginning of therapy. Peter supports Deborah, contesting that she has any negative views attached to attending therapy.

Extract 1

Following on from this, both parents start to reflect on how things are now and the changes that they have seen in Emma which mean that she is in a different place. They speak about the upcoming transition to university in about a year's time and state that Emma has been taking steps to prepare for the future e.g. by doing her personal statement for university and talking about getting a job. The conversation then leads on to talking about what changes they have noticed with Emma at home:

> *Peter: And it's strange to think that in the same breath that Emma is very positive and is taking steps now to sort of prepare herself for it, it's good to see*

> *Therapist: Yeah it really sounds as if __she__ is taking steps you're really seeing her [.] (switch focus from Peter to Emma) your dad has seen you doing your forms (Emma: nodding, eye contact with therapist) choosing your university and all those things you were saying [Peter: mmm] yeah [Deborah: learning to] [Therapist makes a hand gesture to carry on]*

> *Deborah: do jobs, cooking [Peter: cooking!] putting the washing on [Therapist: what are the jobs that are being done? (Inquisitive, excited tone]*

> *Emma: I did those anyway*

> *Deborah: Putting the washing on [Emma: I always used to put the washing on!]*

> *Peter: Emma has started to do things like cooking and things like that [Therapist: oh right!] which is good because it's preparing herself for when she has to do it on her own [Therapist: yeah]*

> *Therapist: Have you just sort of come to that yourself or? (directed at Emma)*

> *Emma: Yeah I guess so I mean it's just sort of like [.] I've always helped out (disagreeing tone) mum is making out like I just sit on my bum all the time*

> *Peter: We've never asked you to help out [Emma: I've always helped out!] (agreement and nodding) [.] but we purposefully never really asked because both you and your sister have always worked really hard at school and got stuck into your homework and me and your mum made a point of leaving you to get on with your work and things*

> *Emma: I always have helped out [Peter: I know you have] [.] I don't just sit there [Peter: only joking] but like I figured you've got to learn how to like cook and stuff eventually so I may as well cause like my cooking skills are absolutely atrocious*

In this extract, there is a disagreement when the conversation switches focus from preparing for university to Emma doing jobs around the house as examples of positive change. When the family are suggesting that one of the outcomes of therapy has been that Emma has been taking more responsibility for her future, there is agreement and collaboration between participants. Peter praises Emma for doing tasks to prepare for university and strengthens this praise when he says that "it is good to see" which suggests that it meets with his expectations and pleases him. The therapist then builds on this by responding with a complimentary affirming contribution. By putting stress on the word 'she', the therapist reinforces the significance of Emma taking responsibility and she also does this by switching focus from Peter to Emma, both physically by looking at her and by changing her language to directly address Emma. During this part of the session, Emma shows her agreement with what is being said by nodding and not contesting the changes that have been suggested by Peter and the therapist. However, this changes when Deborah switches the focus of the conversation to suggest that another positive outcome has been that Emma now does jobs around the house. Emma contests that this is a change by stating that she has always done household tasks. By contesting this, Emma is making a claim on a positive identity and refutes the construction that she was lazy or unhelpful before therapy. This can be seen when she criticises her mother for suggesting that this is a change. This conflict between Emma and Deborah can be seen at various points during this session and seems to be a theme within the therapy. In a different part of this final session, they speak about the difficulties in their relationship which stem from Emma's

sexuality and Deborah's difficulty in accepting this. Therefore, this issue of identity has been a reoccurring one in their family dynamics. Emma contests her mother's suggestion of change as a way of contesting the negative identity that she believes her mother has of her. In response to the disagreement between Deborah and Emma, Peter mediates by offering a more nuanced description of the change. He switches the focus to cooking, which means he can both support Deborah's claim that there are new jobs that Emma is doing, whilst also framing this in terms of preparing for university, which puts the change into context of the life transition ahead and moves away from the past. Peter also offers an acknowledgement of Emma's positive qualities, by saying that she is hard working. This acknowledgement and construction of her identity as a hard working person, then allows Emma to begin to concede her position and move towards the shared perspective of this being a positive change.

After this extract, Peter then brings the conversation back to preparing for university and he describes how as a family they have been having conversations about university courses and that Emma has been helping her younger sister look at her future options. The therapist then asks Emma to reflect on the changes that she thinks she has made and this is then broadened out to reflect on how they have changed as a family. One of the main themes of the last session is the change in how the family works together and relates to each other. Peter describes how therapy has helped them to take a step back in some ways but has also helped them to feel closer as they now understand each other more. In this they are negotiating the dilemma of how to maintain familial relationships and roles whilst also managing the transition from childhood to adulthood.

Extract 2

There is a strong theme of 'the future' present in this final session. When reflecting on what changes they have noticed, all the participants refer to how these changes will be beneficial in the future, particularly in relation to the transition to university and the change there will be in roles and relationships. Peter describes how they are 'closer but less hands on' and aligns this as positive for the future, when Emma will be further away from

them physically but that therapy has brought them closer together emotionally. Peter suggests that this emotional closeness has reassured him that in the future Emma will seek support from them when she is struggling and to try to not cope alone. This then prompts them to reflect on what problems are still present and how therapy has helped Emma to take a different position in relation to these difficulties:

Peter: I think that's the biggest thing I feel, that where we've come from till now cause ultimately the worries Emma has haven't really changed, you know she just reiterated it again there hasn't she saying that she doesn't want to be lonely and that was probably the biggest thing at the beginning wasn't it that you feel that sometimes you are alone

Therapist: But something around that has changed [Deborah & Peter: mmmm] and the sort of coping, the ways of living with that, it gives it a different meaning

Emma: I'm still just as lonely as I was, I just deal with it better I guess [.] like I dunno […] Yeah I'm not any less sort of like lonely but I'm just sort of ok [.] I don't know (shaking head)

Therapist: you know when things are changing it can be quite hard to put them into words because things are actually on the change, on the move […] and if you are in a situation that is actually changing so at times you feel good and at times you don't and [.] at times you really like yourself and at times you don't so it's just not very fixed but [.] things are going to develop, change. I'm wondering if we are completely out of touch with the reflecting team, I wonder what they have been thinking, listening to us talking. Would you be ok to invite them in?

All: mmm, yeah

Just prior to this extract, Peter has been describing that therapy has helped the family to become more emotionally attuned and states that they are now "closer but less hands on". Peter makes a claim that this change in the family dynamics is the most significant outcome of the therapy and prioritises this over any problem reduction; "the worries haven't really changed". Peter

is proposing that the therapy has been successful because it has helped how they work together as a family unit, which unites the family as both the source of the difficulty as well as the source of the solution. This reflects the principles of family therapy and demonstrates the family's openness and collaboration with the family therapy process. This unity and collaboration can be seen from the first session, where the family describe how they are able to be open with each other and talk about difficulties. Therefore, Peter is reinforcing an idea held by this family that talking helps you to become closer and therefore is beneficial for a 'successful' family. In this extract, Emma takes ownership of this change by stating that "I just deal with it better I guess". Emma constructs herself as in control, which also constructs her in an adult western identity where she is responsible and autonomous for what happens in her life. This reflects her upcoming transition to university where she will be an independent adult and therefore portrays this identity to her family and the therapist in the session when she claims that she is able to deal with problems better now. The therapist takes a reflective position and offers a validation of the viewpoint that the family are holding which is that a positive outcome does not always mean that everything has got better. By reflecting that change can be flexible or that some problems may not have been eradicated, the therapist is building on the other participants use of the interpretative repertoire (IR) that change is about increasing resilience rather than symptom reduction. This IR constructs a certain 'realistic' expectation for the future and what therapy can achieve. It also provides a sense of hope for the future, by constructing that change is about how you relate to a problem and increased resilience for expected future difficulties. This conveys that even if there are times in the future when a problem reappears, they will have the resources and skills to manage it. Change being constructed as something that is not static by the therapist, encourages the family to keep persevering even when things are difficult in the future.

Following on from this extract, the reflecting team enter the room and offer their perspective on the changes they have noticed within the family. They reinforce the change in how well the family emotionally relate to each other and how they have found a balance in their roles and expectations of each other. When the reflecting team finish, the family continue to discuss the

upcoming transition to university for Emma and how they will manage it, but this is only a brief conversation lasting a few minutes before the therapist brings the session to a close.

Extract 3

The following extract comes from the end of the session, where the family and therapist are reflecting on the therapy process overall:

Therapist: So I think it's time to stop talking [Emma: ok] we've said quite a lot of things and it's you'll get on, you'll do stuff

Emma: mmm (nodding)

Therapist: anything else before we finish off?

Emma: (shaking head, looking between parents)

Deborah: no […] thankyou [Emma & Peter: yeah]

Therapist: I have really enjoyed working with you [.] and you know I think you have really stuck in with something and put in, put in the work that gets you the results and builds you

Peter: It's been hard at times [Therapist: yes] we've done some soul searching and we've had things, sessions when we've come to the end and we've got feeling like that went alright and then 2 or 3 days afterwards when you start to think and we've had a couple of rocky weekends haven't we where it's, where it's been difficult but in general I think all the sessions have been they've generally been, the majority have been positive

Emma: If you're willing to try you'll get something out of it

Peter: yeah, yeah

Therapist: If you're willing to try, you'll get something out of it [.] and you have taken some risks in what you've said, spoken your feelings I think, haven't you? (Emma: nodding)

Peter: I think we have all benefitted from it, I think it has been difficult we had some very difficult sessions but overall I think we have all benefitted from it as well and I think, I think in another way that Lily

has benefitted from it even though she has not been part of it I think we may find it easier when it's Lily's turn to move into this stage of education and the next stage in her life and that we may be able to make sure that we don't maybe make the mistakes we did with Emma with Lily. So you know it may benefit someone else as well.

In this extract the participants are all drawing upon two IRs; that change is a result of hard work and effort and that the responsibility of change lies with the family. Both of these IRs are used in this extract to praise the family for their efforts in therapy and to provide hope for the future. The therapist introduces these two IRs, praising the family for the hard work they have put into the therapy and suggesting that it is this hard work by them that has produced the positive outcomes and has made the therapy a success. By locating the change in the hard work of the family, the therapist constructs that they have the resources and power to continue to make changes outside of therapy. This empowers them as a family and unites them together as the source of the solution for any future difficulties, as well as validating everyone's contribution in the therapy process. Emma also draws upon these IRs saying "if you are willing to try, you'll get something out of it". This constructs the family identity as hard working and strong and justifies the positive outcomes with who they are as a family, constructing that they deserve a good outcome because of the effort they have put in. The therapist mirrors this phrase back to the family to reinforce this as a strong narrative for this family. Peter on two occasions states that therapy has been difficult, which also qualifies their hard work and effort. By reinforcing that it has been difficult, he makes a claim that they are a family who do not give up and are willing to work together to help each other. This family identity links with the previous extract where they are reinforcing that they are a close family, who work and talk well together.

The session is then brought to a close by the therapist and the family leave the room. The overall consensus of this final session is that therapy has been successful. The family collaborate together in this session and put forward a shared idea that the outcomes of therapy have been that they are able to work together more as a family and that this has been an adjustment of parents having less control, Emma having more independence but also

there being increased emotional connections between them from understanding each other's points of view.

Family 2

Pen Portrait

This family consists of Tanya (mother) and Brooke (14). There are 3 other younger siblings who live at home, but they did not attend any of the sessions. The lead family therapist was John and there was a reflecting team (only one present in the final session). The family attended for 6 sessions of Family Therapy over 6 months.

Referral and background context

The family were referred to the SHIFT project from their local CAMHS team. Brooke was seen by CAMHS following being admitted to A&E after taking an overdose of tablets. The self-harm had started before this and the school had phoned Tanya on a couple of occasions to say that Brooke had cut herself. There was another incident a few weeks before they started with SHIFT, where Tanya had gone away for the weekend, so Brooke and her siblings were being looked after by their grandmother. During this time, there was a big argument and Brooke was threatening to harm herself with a knife. There had also been two recent deaths in the extended family, which were a source of distress for both Tanya and Brooke.

The first session

In the first session, Brooke said that she had started to self-harm because her friends were doing it and so she did it too. Tanya described that she had recently had keyhole surgery and she thinks that Brooke was trying to push the boundaries. Tanya suggested that the self-harm was a way for Brooke to get back at her for things she didn't like (such as taking her phone away). However, Tanya did also describe that there has been an improvement in Brooke's behaviour since year 7, where she was drinking and getting into trouble and she suggested that Brooke has moved on from rebellious behaviour to hurting herself.

The last session

At the very start of the session, Brooke sits in a chair in the corner of the room, whilst Tanya and the therapist sit in the chairs in the centre of the

room opposite one another. During the session, Brooke is frequently looking at and scrolling through her phone and although Tanya asks her to put away on a number of occasions, Brooke continues to use her phone and ignores her mum's requests. The final session is characterised by Tanya doing most of the talking and Brooke rebelling against the session, either by being on her phone, sitting in a chair away from everyone else, not answering questions or changing the conversation (often by saying something to indicate she wants to leave). The therapist frequently attempts to engage Brooke into the conversation to try and pull together a shared understanding of the therapy, but this is resisted by Brooke who throughout the session pushes against this.

Extract 1

At the start of the session, the therapist initiates a review about what has happened since the last time they met. Tanya reports that she has passed her driving test and so they have been able to go out in the car and they also speak about Brooke's birthday and what they did to celebrate. The therapist then changes the task of the session to ask the family to reflect on the journey they have had through therapy and what they think has changed:

> *Therapist: So I suppose I was just thinking back over the 6 months that we've known you for and [.] it feels like at the beginning there were a huge number of really big upsets and worries and difficult things that you were facing [.] yeah? [Tanya: mmm] and it was [.] seems like you have put so many of them behind you and I don't know [.] moved on in ways which really work for you as a family? [Tanya: yeah, yeah, I do think we've made a lot more progress] what do you think about the last 6 months and the journey you have been over in that time? (directed at Brooke)*

> *Brooke: I don't know [Tanya: you don't know?] I don't know*

> *Tanya: I think Brooke is a lot more chilled in herself, and she has grown up that little bit more as well which I think makes all the difference [Brooke: what you talking about, I'm a kid] [.] no, when you are trying to get through to someone who is still very 'I'm not listening to you' and no matter what you say, even though they know you are*

talking sense, they still won't listen to ya and it's like banging your head on a brick wall init [.] so now she listens a little bit more [.] and she'll have a strop but after that she will sit down and go I do know what you mean mum but it's still not fair, you know [.] so at least she's getting to see my side [T: so you can have a healthy argument about it, rather than have a (big hand gesture) major stress if she can't see where I'm coming from that I'm not doing it just be mean, I'm trying to do it for her benefit

Therapist: And it feels like you have more confidence in saying that this is what's going to be involved and this is what's going to happen [Tanya: yes, yes]

Tanya: Yes and she likes it and lumps it

The therapist introduces the task of reflecting on the therapy process. By offering the family a compliment whilst also introducing the task, the therapist is making a request for the family to explain what has contributed to any positive change over the therapy process; priming them to reflect on the positives rather than the negatives. Although Tanya contributes first showing agreement whilst he is still talking, the therapist tries to engage Brooke by directing the question to her. The therapist is actively trying to pull Brooke into the conversation, yet this is resisted by Brooke by saying "I don't know". There is a disagreement between Brooke and Tanya when Tanya starts to talk about the changes she has noticed. Tanya states that Brooke has grown up over the therapy process, however Brooke rejects this by stating the opposite that she is a kid. Here, both Tanya and Brooke are making different claims about Brooke's identity and where she is at in her development. Tanya is constructing Brooke in an adult identity and by doing this, she is complimenting Brooke for her behaviour now, to encourage her to continue to act in this more 'grown up way'. However, Brooke rejects this identity of being grown up and the associated traits of adulthood, such as responsibility and independence. Brooke's rejection of the therapist's task to reflect on the therapy process encourages and allows Tanya to take control of the conversation and be the 'adult' who is responsible for answering the questions. Therefore, Brooke may be rejecting a grown up or mature identity

because she wants to stay cared for and dependent on someone else, rather than being an adult who has to be responsible for themselves. She is conveying to both her mother and the therapist that she still needs to be looked after and by rejecting the therapist's task, Tanya does come to her rescue and help her by answering the question instead of Brooke. When we look at the family context, Brooke is the eldest of 4 children in a single parent family and therefore is the closest to a second 'adult' in the home. It may be that because of this dynamic Brooke feels she is pushed into being more grown up at home and actually what she wants is to be cared for like her younger siblings. This dynamic of Brooke rejecting an adult or responsible identity can be seen throughout the session and therefore seems to be a characteristic of the family dynamics.

Extract 2

The following extract follows straight on from the last extract. The therapist brings the conversation back to thinking about how things were at the start of therapy to prompt the family to think about what has changed and what has influenced any change:

> *Therapist: But I guess we were facing a lot of [.] there were worries about your health [Tanya: mmm] and there was all the stuff about the deaths that [.] you know was still a real source of [.] of distress for all of you wasn't it? [Tanya: yeah]*

> *Tanya: I think we still will have days like that [.] I don't think it will ever [Therapist: yeah it won't vanish will it?] no so [.] it's just more Brooke learning to deal with it a bit better [Brooke: I'm over it (scrunched up face) (mum laughing) [.] she's got that attitude on her today! Haven't you missus? [Brooke: No I'm just over it] alright, ok*

> *Therapist: So do think at all back to the sort of time when you were cutting yourself Brooke and what you think about that now [Brooke: no (looking at lap) is that something you are ever tempted to do? [Brooke: no] no, why not? (Brooke shrugs) [.] why would I? (Brooke nodding) yeah*

Tanya: So do you see it as something that were a bit silly? [Brooke: yes! (exasperated tone)] (Mum and therapist laughing) she's like that today!

In this extract, there is a difference between how Brooke responds to the therapist compared to how she interacts with her mother. Tanya begins by acknowledging the limits of change suggesting that not all problems will be eradicated, which is validated and normalised by the therapist as to be expected. Tanya draws upon the IR of change being about increased resilience to problems rather than resolution and attributes the responsibility of this resilience to Brooke. When Brooke responds by claiming that she is over it, she dismisses her mother's point and rejects the attribution of responsibility for future problems, i.e. that she does not need to think about how she will manage future difficulties because she is 'over it'. Her scrunched up face and annoyed tone convey her frustration with her mother attributing the responsibility to her. When Tanya then dismisses this by making a joke of it saying that "she's got that attitude on her today", Brooke once again defends herself, rejecting Tanya's opinion. The therapist then intervenes and changes the focus to ask Brooke to reflect on the self-harm. Brooke responds in a more passive way to the therapist, looking down at her lap and using non-verbal communication like shrugging and nodding. This may reflect the perceived authority of the therapist, but also that Brooke does not think that the therapist is attributing blame for the self-harm. Then when Tanya suggests that the self-harm was silly, Brooke reverts to being annoyed which can be understood from her exasperated tone. Once again, Brooke is expressing her frustration at her mother's assertion that she was not only responsible for the self-harm but that it was silly, which undermines the act of self-harm and Brooke seems to take this personally (that *she* is silly) by her frustrated reaction to her mother. This extract is representative of the whole session where Brooke responds differently to her mother and to the therapist. Brooke appears to respond in a more defensive or argumentative manner towards her mother and in a more passive way to the therapist. This appears to be influenced by what Brooke perceives as their different agendas in the session. In this extract, Brooke responds in a defensive manner towards her mother because Tanya is attributing

responsibility to Brooke and constructing Brooke in an identity that Brooke does not want. Whereas, Brooke is more open and passive to the therapist's responses as she may believe that he has a more neutral agenda of being curious rather than making a claim on her identity.

After this extract, the therapist then changes the task to ask Tanya if there was anything in particular she had wanted to talk about today. Tanya says that she wants to talk about whether they will stay open to CAMHS after this. The therapist then asks Brooke if there was anything she specifically wanted to talk about it today's session. Whilst saying no, Brooke is playing with a toy sheep and Tanya gets frustrated with her and asks her to leave the sheep alone. Brooke refuses and then gets another toy from the box. The therapist then changes the focus back to Tanya's concern she has raised and this then leads on to a conversation about what happens next in terms of support once the SHIFT intervention ends.

Extract 3

Tanya puts forward her concerns regarding how hard it is to get support when you need it from their experience prior to the SHIFT project. She wants to be able to stay open to CAMHS, so that if things were to be difficult in the future, they would be able to see someone immediately. The therapist acknowledges her concerns, but also states that often when families are not being seen actively that they are usually closed. The following extract is a discussion regarding whether the family continue to be seen by CAMHS after this session or if they are in a good enough place to be discharged from services altogether. During the conversation, Brooke is scrolling through her phone and sitting away from the therapist and her mum:

> Therapist: Can I just ask you Brooke, what does it mean to you whether our work is sort of closed off and finished and you are discharged or whether it is still open [.] [Brooke: I'm not bothered, do whatever you want (annoyed tone)] does it make any […] cause it obviously makes a difference to your mum if you are feeling really badly again we have access to some help [.]
>
> Brooke: It's up to you, I'm not bothered

Therapist: I suppose it's also about what you think the chances are of it blowing up again?

Brooke: no (shaking head, scrunching face) nah

Tanya: you never know with you, you're right stroppy

Therapist: Cause for me there's, you know [.] there's the mother, daughter, growing up, arguments, battles about [.] which is about (trails off)

Tanya: Oh yeah! That's normal it's just when it gets to that certain point because when she did have that last one, where like my brother and my mum were there and that and so were the other littl'uns and I can't have it where she gets to that point and puts the others at risk [.] and that's where I have got to have somebody [.] do you know what I mean [.] I don't want it to get to that point

Therapist: I suppose what I was thinking of was [.] at that time there were lots of other things that happened recently and were sources of a lot upset and worry

Tanya: There was but I mean it was like we had done it for so long and I had done all of the grief counselling with her and stuff like that we had done that so really so [.] she was like this for a good few months and then we hit that major thingy [Therapist: your life hasn't been easy either, you've had sort of] yeah but it's not where I can just blame it all on that, I know that she can go through a stage where for months and months she is like the ideal daughter but then we can hit a major thingy [.] and all I want to know is that there is someone that I can ring up and I don't have to wait [.] god knows how many months before anyone gets their act together and does something

Therapist: When […] what do you think about that Brooke?

Tanya: Go on say it as it is woman! [Brooke: I dunno] Right get rid of that phone

Brooke: It's hidden

In this extract, all three participants have different agendas; the therapist is holding the position that they are ready to be discharged, whereas Tanya is stating her worry and fear of the future and Brooke is rejecting of the therapy. Prior to this extract, Tanya has been stating her concerns about the future if problems were to arise again and they were not open to CAMHS. The therapist has been trying to validate Tanya's worries, but also reflect on the progress they have made and he suggests that this progress is an indicator that they are ready to be discharged. His agenda is that of both listening and responding to the family as a clinician but also having a responsibility to the service. This agenda can be seen in the therapist's contributions. Firstly, he normalises that there will be arguments and difficulties between them to set their expectation that therapy will not make things perfect in their relationship. This is initially accepted by Tanya but she then continues to state her concerns. The therapist suggests that things are different now to how they were at the beginning of therapy, to construct the idea that they are ready to be discharged and to persuade them that it is an appropriate plan of action. At the beginning of the extract, the therapist switches focus to engage Brooke into the conversation and to directly ask her opinion on whether she wants to remain an open case or be discharged. Brooke dismisses this invitation to participate and claims that she is not bothered and rejects the therapy by stating that she is not bothered about the decision. It is difficult to pinpoint the reason for Brooke rejecting the therapy but it may be that she is conveying her anger or upset at it ending, which could be seen from her repeated claims that she is not bothered and her annoyed tone. Brooke's claim that she is 'kid' may be that she is wanting to be cared for and therefore, she may feel abandoned by the therapist who is saying that he feels they are ready to be discharged completely and consequently, she is rejecting him to counteract this.

This pattern of Brooke refusing to engage is seen throughout the rest of the session. Once the reflecting team member leaves the room, Brooke states that she wants chips now. This signals that she wants the session to end, but Tanya rejects this and tells her she needs to wait. Brooke continues to use her phone and when Tanya gets frustrated with this and tells her to put the phone away, the therapist then brings the session to an end suggesting

it is chips time. This acknowledges Brooke's refusal to engage and her desire for the session to end. In this session, there is no shared consensus about the outcome of therapy. Tanya suggests that things are better than they were at the beginning but conveys her worry that things may go back to how they were at some point in the future. It is left that the SHIFT therapist will talk to the CAMHS worker to see if they can stay an open case. Therefore, although the SHIFT intervention has ended, it is not clear about what will happen after this and there is no agreement between Tanya and Brooke about what the outcome is and what they want for the future.

Family 3

Pen Portrait

This family consists of Lorraine (mother) and Isobel (13) and they are the only ones living in the family home. The lead family therapist was John and there was a reflecting team of 2 other family therapists. The family attended for 9 sessions of Family Therapy over 6 months.

Referral and background context

The family were referred to the SHIFT project from their local CAMHS team. The family were seen in CAMHS after being referred by the GP. Lorraine had taken Isobel to the GP when Isobel had said that she wanted to cut herself and wanted the day off of school. It was only when they were seen at CAMHS that Lorraine found out that Isobel had actually been cutting herself.

The first session

In the first session, Isobel said that she was cutting her arms using a knife, every day or every other day, but that she wanted this to change as she didn't think it was helpful. They discussed their hopes for therapy; Lorraine said that she wanted to find a way to improve their communication with each other, to move forward and to know how to support Isobel, particularly in how to approach the self-harm as she didn't know what to say or do. Isobel said that she wanted her mum to start treating her as her own person, to let her grow up and to not treat her like a child. She said that she wanted to change the way the relationship was working and for her mum to not be as inconsistent. Isobel's father has mental health difficulties and he was not allowed to have contact with her at this time. In the first session, the therapist reinforced that self-harm will be a topic of conversation and would be an outcome to monitor.

The last session

The final session is characterised by the theme of increased resilience to be able to cope with life's difficulties and problems, rather than problems being eradicated. Following a general catch up, there is a discussion about how things are now, with Isobel focusing on the improvement saying things are

better than they were, whilst Lorraine conveys that things are not perfect by saying that there are things to work on still. They discuss therapy as a forum for helping with the transition of Isobel growing up and the change in roles and dynamics in their relationship. There is a focus on how things have changed between them and how their communication with each other has improved.

Extract 1

The following extract comes after the family have been explaining that Isobel still gets angry but that it is not happening every day and has reduced. Isobel has also just stated that she has not had any thoughts of self-harm either.

Therapist: And if there was a very angry bit, what do you think would happen now?

Isobel: Obviously I'd slam the door and mum would probably come and take my door off and I'd get really angry. (to Lorraine) And then I'd probably attempt to take your door off (half-laughs) and then you'd angry and we'd just a fight. But I don't think I'd cut (shakes head) no. (Quietly, to Lorraine) Don't do that [??] [Lorraine: All right Isobel] At least I'm telling you, because you were sat there just kind of chewing your face like [Lorraine: Well, we're just talking about you] Yeah, but I don't like it. I'm sorry, but it was annoying [Lorraine: Okay.]

Therapist: So you might get really wound up if your door ended up, so slamming your door is kind of a way of?

Isobel: Yeah, I'd get really wound up but I don't think I'd cut myself.

Lorraine: I think still for me [.] I'd still like to know, I mean I don't know whether we can know, I don't know as to how we came (turns to Isobel) to you cutting.

Isobel: I don't know. Honestly I don't know […] [Lorraine: Hmm] I guess I was just stressed when it happened.

Lorraine: And what was the stress?

Isobel: Everything.

Lorraine: Everything?

Isobel: Friends; school; family […] So everything. It was like nothing [.] good.

Lorraine: Yeah, which you think, yeah.

Therapist: So that idea that all the bits of your life were falling [Isobel: Yeah] apart?

Isobel: Were bad

Therapist: But you find those things better now?

Isobel: Yeah, definitely, yeah.

Therapist: And is that something you've sorted out (indicates Lorraine and Isobel)?

Isobel: Yeah (nods).That we've all sorted out between us.

In this extract, the participants are discussing change and outcome related to Isobel's anger and self-harm. Both the therapist and Lorraine are trying to gain an understanding of this change that Isobel has stated but do so in different ways. The therapist makes a request for Isobel to give an explanation for the change in her anger and use of self-harm by asking a hypothetical question about future conflicts. Isobel responds to this by giving a description of how her anger might be displayed but within this she asserts that she doesn't think she would self-harm and she repeats this when the therapist inquires further. Lorraine on the other hand, makes a request for a specific reason to justify the self-harm behaviour. Isobel responds differently to her mother than she does the therapist and rather than giving a specific reason, Isobel resists her mother's request and tries to end any further questioning by giving a generic reason of stress. Yet, Lorraine perseveres and asks again for a specific reason for what the stress was. Isobel then responds by using an extreme case formulation (Willig, 2013). By using the extreme case formulation that "everything" in the past was stressful, Isobel is trying to convince both her mother and the therapist that things are completely different now to how they were at the beginning of therapy. This may be to alleviate their worries, but also to stop any further questioning about the specific details of the past. Also, by using an extreme case formulation, it constructs that the past was very difficult and communicates

this to both Lorraine and the therapist. By constructing that things were different and difficult in the past, it justifies the use of self-harm at that time, whilst also providing a justification for why she is unlikely to self-harm now; because the context is different. Unlike Lorraine, the therapist does not make a request for any more information from Isobel but instead acknowledges how difficult the past was and validates Isobel's extreme case formulation by giving a similar reflection that "all of the bits of your life were falling apart". Isobel then responds in agreement and is more open to the therapist's questions. When Lorraine is asking for information Isobel responds by closing down the conversation, yet when responding to the therapist, Isobel is more willing to engage and give her understanding. This may reflect the dynamics in the relationship between Lorraine and Isobel and that Isobel is more defensive of her mother's direct questioning approach, possibly because of the different positions that Lorraine and the therapist hold.

Extract 2

The session continues with a discussion about how there have been improvements in the communication between Isobel and Lorraine, where they are able to talk about difficult things and that Isobel feels able to cope more with stressors. The following extract comes just after they have been discussing how they continue to try and talk about things that each of them is finding difficult:

Lorraine: It's hard you see, it's difficult because at this point you don't want to fully remember what it was like six months ago (referring to herself) [Therapist: That's fine.] I suppose (.) in a way.

Therapist: Well, I suppose they're pretty sort of scary

Isobel: But you have to remember it because if you don't remember it it'll just happen again, won't it? [Lorraine: Hmm] If you forget about bad things then it all starts again, doesn't it? So we can remember, that's why we have history lessons, isn't it? 'Cos we have to look at all the bad things that they did (.) so we don't do it again. Because people didn't talk and that made it worse, so you have to remember to

talk so it doesn't get worse. If it is getting worse you can talk and make it better.

Lorraine: See, I think you Isobel, is better at it than me. Part of me just wants to stick my head in the sand [short laugh] and let it be rosy again (to Isobel) whereas I think you face things a lot more head on that me, so I mean I do when there's (..) I do [Isobel: You do when there's some things it just depends what it is for you.] Yeah I suppose it does.

Therapist: I suppose some people, remembering how bad things have been, that can be helpful in thinking: "We got through that." Whereas I suppose some people actually remembering "What we did to actually get through it," can be important [Lorraine: Yes.] So remembering how- how skilled you've become at working out ways of talking [Lorraine: Yeah] and unlocking something you hold onto, rather than thinking "Oh, there was that bit where we didn't talk." [Lorraine: Yeah] So sometimes it's sort of thinking "Well, okay, what worked?" [Lorraine: Yeah] "What helped us out of that really bad place?"

Lorraine: Definitely.

Isobel: Yeah, I agree.

Lorraine: Yeah, definitely.

In this extract, Lorraine is expressing her fear of remembering the past and is possibly looking for reassurance from the other people in the room. The therapist does give this reassurance by validating Lorraine's fear but this is contested by Isobel when she disagrees with her mother and offers an explanation for why they need to remember how things used to be in the past. Isobel may believe that her mother's agenda is to dismiss the past, but she wants her mother to remember the past so that she takes responsibility for it. Isobel therefore contests Lorraine's opinion to demonstrate the power of her voice in the session and potentially in their relationship. Lorraine responds by taking a 'one down' position, where she praises Isobel for her opinion and how she tackles problems and denigrates herself. By doing this, Lorraine gives Isobel the power in the session, which Isobel may have been striving for in their relationship. Isobel then responds by complimenting

Lorraine; it appears that Lorraine taking a one down position, gave Isobel what she wanted and so she no longer needed to contest what her mother was saying and instead offers her some recognition and praise. Taking this one down position seems to be effective in developing a shared understanding. The therapist then moves to a mediating position, where he acknowledges and privileges both viewpoints. In this extract, the therapist has changed stake by moving from a validating position of reassuring Lorraine, to a mediating position to help develop a shared perspective. This task is then accomplished as both Isobel and Lorraine express definite agreement with the therapist's summary holding both perspectives.

Following this extract, the lead therapist changes the task and invites the reflecting team to enter the room. The reflecting team then have a discussion where they validate the changes that they have made and reflect on the positive communication between Lorraine and Isobel.

Extract 3

After the reflecting team leave the room, there is a final discussion about having realistic expectations for the future, that there will be difficult days but that they have the skills to manage this. The following extract comes from the very end of the session as they are saying goodbye and about to leave the room:

> *Therapist And, yeah, there's really a sense of that journey that you've made through really tough times, yeah?*
>
> *Isobel: Yeah.*
>
> *Therapist: A lot of skills to-*
>
> *Lorraine: To take us through, definitely.*
>
> *Therapist: Okay.*
>
> *Lorraine: I'd just like to say on our behalf, thank you to all three of you [Isobel: Yeah, thank you]*
>
> *Therapist: Thank you.*
>
> *Lorraine: You've really changed us around and, um-*
>
> *Isobel: Helped. (Lorraine nods)*

Therapist: Well, you've changed yourselves around but just-

Lorraine: Yeah, I remember we'd reached a point where we couldn't do anything right, so thank you.

All participants leave the room and the session is ended.

The therapist offers a positive evaluation of the family's hard work during the therapy process, labelling it as a journey. This compliments both Isobel and Lorraine and locates the power to change with them. This is accepted by both and Lorraine agrees that they have skills that will benefit them in the future, constructing that they do not need the support of therapy to keep the changes going. Lorraine offers her appreciation to the whole therapy team, which is echoed by Isobel who agrees with her mum. Lorraine then makes a claim that the therapy team have been responsible for the change. This praises the therapy team for their role in the changes they have been discussing and constructs the therapy team in the expert position, having the power to change them as a family. Isobel agrees with her mum by acknowledging that their input has been helpful. The lead therapists responds to this by reframing it to locate the agency of change within the family, claiming that they have changed themselves, rejecting the idea that the therapy team are responsible for the change. This negotiation demonstrates the different stakes at play here. Lorraine is using the interpretative repertoire that therapists are responsible for change, to give praise to the therapy team and to show her gratitude for their input. This is a common IR within our culture as therapists are positioned as the experts and individuals and families are in the inferior or passive position, receiving the help. However, the therapist is rejecting this expert position and uses the alternative IR that families are responsible for change. This is intended to empower the family and constructs that they do not need therapy to make changes to provide hope for the future. However, Lorraine dismisses this and reinforces her point by constructing that they were helpless prior to therapy and it was therapy and them as therapists who helped when they were stuck. This positions the therapy team as their rescuers, once again giving them special praise. This differentiates the therapists from ordinary people, so that they cannot be compared to.

The overall consensus by all participants is that the therapy intervention has been successful. Both Lorraine and Isobel state that an outcome of the therapy has been improved communication between them and this is demonstrated in the session, when they handle a difference of opinion about remembering the past. This relational change is also echoed by the therapist and there is a sense that they have all worked together to create the positive changes. Self-harm is raised in the session and it is put forward by Isobel that a reduction in stress has meant that she no longer uses self-harm to cope. There is agreement between all participants that therapy has increased resilience to difficulties and that they have the skills to cope in the future.

Family 4

Pen Portrait

This family consists of Sarah (mother), Tom (step-father), Harry (11) and Evie (younger sister). Tom was not present for the first session due to work commitments but attended the other sessions, including the final session. Both children were given activities (toys, drawing) during the sessions. The lead therapist was Linda and there were 2 other family therapists in the reflecting team, although there was no reflecting team present for the final session. The family attended for 8 sessions over 6 months.

Referral and background context

The family were initially seen in CAMHS because of Harry's self-harm, which was head–banging. They were then referred to the SHIFT project by their CAMHS team. In the first session, a basic history was given about some of the difficulties the family have been through. Sarah was in an abusive relationship with the children's biological father and when she left him they went to a refuge and both the police and social services were involved. They then moved to a different city, the children moved schools and Tom moved in with them and was now a step-father to both children. It was only recently after the move that Harry started to have angry outbursts and was head-banging, hurting his sister and destroying objects around the home.

The first session

In the first session, Harry stated that head-banging is addictive and that it gave him self-relief. The family said that they had already started to talk outside of the CAMHS sessions with Harry and that they were focusing on his emotions and the chain of events that led to the self-harm. They also described that they had introduced a star-chart, rewards of activities and some money incentives. Their goal for therapy was that they wanted support to help Harry and to stop the self-harm.

The last session

The final session for this family is characterised by the sense of them all being more relaxed. There is a discussion about how the parents

(particularly mum) has learnt to let go of some control and adjust her parenting to allow Harry to be more independent and start making the transition to being a teenager. This is noted by the therapist as she reinforces that the family seem more relaxed and able to be a bit humorous with each other.

Extract 1

In this session, both children are drawing and playing with toys, whilst the parents are speaking with the therapist. The session begins with a catch up with things that have been happening in their life, including Harry being in a drama production and attending rehearsals. They then move on to speaking about Harry now having a mobile phone and both parents are speaking about how they have adjusted to giving him more independence and they have been discussing how they are managing their expectations of communication when Harry is away from them. The therapist asks the parents to reflect on how they have managed the change and adjustment in terms of Harry having a phone and more independence from them:

> *Sarah: (to Tom) I think after coming here – (to therapist) it sounds a bit weird, well to me it sounds a bit weird- (back to Tom) but it helped me to come here and say this, because I don't think I would have said it to you [Tom: Yeah] otherwise? [Tom: (nodding) Um- hmm] and then you said it to me about how you manage with Harry having a phone and stuff and I thought: "Oh." Had we not come in then we would have probably never had that conversation. And I think that's helped solve it quicker because I've thought: "Oh, Tom sees it this way, that's a very sensible way and also it's a way in which I can kind of stop (.) you know, being kind of [??] to Harry, pestering as Harry says.*

> *Tom: Hmm.*

> *Therapist: So what was it about coming- what was it about sort of coming here then that-? Was it just the sort of- that you had the space just the two of you to review (Tom nods) or was it particular question or something that you said before and afterwards, what was it about-?*

> *Tom: I think it's because we've both got such busy lives that when we come home from work we just tend to kind of come home and [Harry: Relax] uh- no, not straight away (Sarah laughs)- and get them ready for the next day and all of that kind of stuff, and then when the children have gone to bed or settled down it's quite late, so usually we're- you know, any conversation we have is usually quite superficial to start off [Harry: And boring.] with because obviously we're trying to do lots of different stuff at the same time and anything later on tends to be more- I don't know, it's kind of [Sarah: "How was your day? What did you do?"] Yes. "What did you do today, how was your day?"*

Sarah initially addresses Tom to engage him in a discussion about the therapy process, however she changes focus briefly to warn the therapist about what she is about to say "sounds a bit weird" (line 1). This may reflect Sarah's construction that the therapist is in the expert position and therefore may judge what she is saying. By Sarah forewarning that it may sound weird, she pre-empts this judgement. Sarah makes a claim that therapy has allowed them to have a conversation that they wouldn't have had at home, justifying the need for therapy. She also makes a claim that by having this conversation, it helped solve the problem quicker, which constructs that they have the ability to solve the problem but that therapy gave them the resource of time and space to speed this process up; therapy is supportive rather than transformative. The therapist inquires further about this, by making a request for an explanation of what was significant from the therapy process to allow this conversation to happen. Tom rationalises the need for therapy, by explaining how busy they are at home and how there is very little space and time to be able to have reflective conversations. This then constructs that as parents they are hard-working and that the family are not 'abnormal' for needing therapy or that there is something wrong with them but that the struggle is lack of time rather than incompetence. This discussion draws upon the ideological dilemma of change occurs from the family vs change occurs from therapy. It constructs therapy as a valuable resource that helps with transitions and changes in families, but that the family also have control and are not helpless. This is important at the end of therapy because it

justifies the original need for therapy whilst also providing hope for the future that they have the resources to manage without therapy.

The conversation then moves to thinking about what conversations they do have at home and the role of conversations in different relationships. The therapist asks the family to reflect on whether they may try and have more reflective conversations at home, as something that they will take away from therapy. Both parents agree with this and they start talking about how they will need to continue adjusting their parenting style as the children grow up.

Extract 2

In this part of the session, the parents are talking with the therapist about how therapy has helped them to look at how they parent and in particular Sarah has been commenting on how she now thinks about what are appropriate conversations for Harry to be involved in and how she can fulfil the parent role rather than a friend role:

> *Sarah: If I rephrase it then, I feel that my repertoire as a parent [Tom: (nodding) Hmm.] has had to adjust as Harry is getting older and certain skills that I bring to parenting have had to adjust and [Harry: It'll need to improve!"] (Sarah stops and makes a face at Harry, Sarah and Tom laugh)*

> *Therapist: What did he say?*

> *Tom: He said "It'll need to improve!"*

> *Everyone: [laughter, smiling]*

> *Therapist: Yeah. I saw that as really interesting actually, because, um, I don't know whether it's when somebody first comes to us it's sometimes a bit: "I don't know what the rules are." But I wonder whether when you'd first come, you'd been a bit worried about Harry saying something like that, but you actually seem very relaxed. This feels really comfortable actually [Sarah: Yeah] I was just reflecting on how it seems that what you're saying and what you're hoping, aspiring to, actually seems to be happening I think.*

Whilst Sarah is making a claim about the changes she thinks she has made in terms of her parenting skills, Harry interrupts her to make a joke, by

saying that she needs to improve her parenting. This is received with warmth and acceptance, with everyone laughing at the joke. The therapist then compliments the family, particularly the parents about how they have just responded to the joke. The therapist uses her stake as the professional to pass judgement on how the family are interacting when she says "this feels really comfortable" (line 11). By offering her opinion on how it feels in the room, she reinforces how the parents are being with Harry. By making reference to the beginning of therapy, the therapist is recognising this more relaxed interaction as a change and a potential outcome of the therapy. In other parts of the session (see previous extract), the therapist holds a reflective or questioning stance to allow the family to lead the session. However in this extract the therapist is taking a more directive role and using her position for a different agenda. Here, the therapist is using her position to not only validate but to strengthen the changes the family have made to praise them and to encourage them to continue with these changes after therapy. It is interesting to note that although the parents do the majority of the talking in the session, Harry does make contributions to the conversation by chipping in; this can be seen in this extract (the joke) and the previous one (saying the conversations at home are boring). This may be a way for Harry to remind the other participants that he is there and listening and as a way for him to contribute to the session in a more indirect way. This may be indicative of Harry's age/development and will be explored in the discussion.

Extract 3

This extract then follows on straight after the previous extract:

> *Sarah: Yeah, I think it's also recognising that (…) you just have to adjust. Like, being a parent you just have to constantly adjust. Reflecting on that at the moment and I find that really- actually no, I don't find that difficult. Um, I don't often have time to reflect on what I'm doing, but it's good when I do have those moment where I'm able to kind of go: "Yeah, it's okay, when things change I have to change my parenting approach to you, I have to lay off a bit more and just let it a bit and let you kind of, you know, have fun and make mistakes*

and get lost and, you know, do whatever you're going to do. I know I have to relax into that and it's going to be okay.

Therapist: So in what way do you think your repertoire has extended, what would you say about each other's repertoire and how maybe that sort of-?

Tom: (to Sarah) I think like you say you've learned to sort of, you know, ease up on the sort of (makes an unsure hand gesture, Sarah makes a 'nagging' gesture with her hand) yeah (Harry laughs) I don't want to say that, it's not very nice but, uh, you know, you kind of get on and constantly worry about where he is and things like that [Harry: Nagging] but, like you say, you've probably had a more sort of relaxed about where- [Sarah: Hmm] I should perhaps said [?nebbing?] actually

Sarah is claiming the changes she has made in terms of her parenting. She justifies the need for this adjustment by suggesting that it is a normal part of being a parent. She is offering this explanation to the therapist to evidence her work and learning from the therapy process. The therapist has just been condoning the changes they have made and Sarah is building on this by proving that she has changed by explaining her learning. The therapist then changes the focus by asking the parents to reflect on each other's parenting, which opens it up to engage a discussion about Tom's parenting skills as well as Sarah's. However, Tom is first to respond and compliments Sarah on the changes he thinks she has made. Tom shows his concern about upsetting Sarah, by not committing to a description of how she used to be (using an unsure hand gesture). However, Sarah offers the nagging gesture with her hand, indicating that she is in agreement with what she thinks he is concerned about saying. Tom shows guilt for this (saying "it's not very nice), to construct that he is not being critical of Sarah and praises her for the changes she has made. This once again reinforces that Sarah holds the agency for change within the family and empowers her, to provide hope for the future. This may reflect the different positions held within the family. Tom is step-father to the children and has only been in their life for the last two years, whereas Sarah is their biological mother and has always had

responsibility for caring for them, particularly when she left their father and was on her own with them. Therefore, this context may be shaping the parenting relationship and the dynamics within this. In this extract and throughout the session, the focus is on Sarah and the changes she has made to her parenting. This does include Tom, but this seems to be in a supportive way to Sarah. By empowering Sarah, it recognises the specific context of this family and fits with how they construct what type of family they are; that Sarah is responsible for the children and Tom supports both Sarah and the children equally.

In the last part of the session, the therapist directly asks Harry about what changes he has noticed and also asks about his current thoughts on using self-harm. Harry says that his family are more relaxed and they are able to talk more together at home. He says that he does not self-harm anymore and attributes this to less stress, particularly around school and having more friends. He acknowledges that his parents have changed, saying that they listen to him more and they interact with him and that it is more enjoyable being at home. The session is brought to a close by the therapist who offers thanks to the family for their hard work and reinforces the progress they have made over the therapy process. Sarah and Tom reciprocate this gratitude to the therapy team and state that they now have long term strategies to use in the future and that they think they will be ok in the future. There is consensus in the room that therapy has been a success and that the outcome of therapy has been a shift in how they manage the difficulties rather than problems being eradicated.

Family 5

Pen Portrait

This family consists of Leanne (mum) and Lexi (15) and they are the only ones in the family home. The lead therapist was John and there were 2 other family therapists in the reflecting team. The family attended for 7 sessions of Family Therapy over 6 months.

Referral and background context

The family were referred to the SHIFT project from their local CAMHS team, where they were being seen for support for Lexi's low mood and self-harm. CAMHS had offered family sessions prior to this, but the family only attended one session and did not think it was helpful at the time. Leanne has 3 other older children to Lexi's dad. They are all in their 30's and live away from home. Leanne and Lexi's dad ended their relationship 5 years ago when Lexi was in year 6. There was domestic violence from Lexi's father to Leanne and the children. Leanne says she was not aware of Lexi's dad being violent to the children until she saw him be physically aggressive with Lexi and that was when the relationship ended. Lexi has very infrequent contact with her dad now. Since this time, Leanne and Lexi have lived alone and Leanne has had to stop working due to her health.

The first session

In the first session, it was clear that a lot of the difficulties were stemming from the relationship between Leanne and Lexi. They both stated that there were several arguments every day and that they struggled to have any positive interactions. The session illustrated this as they argued during the session and there was a lot of tension and disagreement between them. The therapist tried to enquire about self-harm with Lexi; however she refused to talk about it in the session saying that it was too difficult and awkward. Leanne said that Lexi had told her when she had taken the overdose of tablets, but Lexi said that this was different because she had to tell her because she needed to go to hospital. Leanne said that she hopes therapy will help to resolve things, which she says would be Lexi changing how she speaks to her and not being abusive, for Lexi to have respect and for them

to have a better relationship. Lexi said that she wants her mum to take responsibility for her part in arguments and to not pretend to be innocent. Both Leanne and Lexi agree that they want things to be different, but there are several disagreements in the first session about what needs to change, who is to blame and whether change is possible. Lexi says that she wants things to be better between them, but she doesn't believe her mum will be honest and take responsibility for her part in the difficulties. In this first session, the therapist tries to mediate between the two of them and allow both voices to be heard.

The last session

This final session is characterised by Leanne and Lexi being able to get on more and be playful with each other. This is demonstrated in the session with them recounting a funny experience they had and being able to tease each other about it. They start the session discussing this recent experience and the therapist attempts to pull out the positive changes from this experience, however neither Lexi or Leanne engage with the therapists attempts to do this and continue to recount their experience and teasing each other.

Extract 1

Just before this extract, the family are talking to the therapist about an argument they had just before coming to the session and are explaining how they moved on from the argument by using humour and being silly together. The therapist then reflects on this being different to how they have dealt with arguments in the past:

> Therapist: If I just think about how things have been when we've seen you before, and it's been hard for either one of you to think: "This could be different." Yeah?

> Lexi: It's been a load of conflict until the last few days [Therapist: It's been a-?] (to Leanne) it's only been the past few days that it's changed.

> Leanne: Yeah, I think- [T: So what's happened in the last few days?] I think the change has been (.) um, because she's needed a lot and

she's needed someone to cheer her up, (to Lexi) haven't you, basically?

Lexi: No [Leanne: You have!] you've learned how to smile.

Therapist: How has your mum learned how to smile?

Lexi: (shrugs) I don't know she just (.) oh, I don't know. [T: ???] Let's see: there's been loads of times when we've been shopping when she was saying: "This is one of the worst days we've ever had. And it was like: "Urrgh."

Therapist: So in the middle of the worst days, somehow your mum remembered that she's actually really good at smiling? Because I've not seen you smiling much since you've been here and it's lovely to see you both smiling (Leanne nods) Yeah? So what reminded your mum that she could smile when you two were together?

Lexi: When we were having the meal. (Leanne turns to meet Lexi's eye again)

In this extract, it may appear that Leanne and Lexi are having an argument about what has influenced the change; however their interaction is different to the arguments from the first session. They are being playful with each other and this can be seen from them smiling and laughing together and also staying engaged in the conversation. The difference of opinion is not a negative conflict and rather is them winding each other up in a playful way. This is recognised by the therapist who then responds to this with a positive reflection, focusing on the fact that they are both smiling and enquiring about this rather than the difference of opinion. The therapist is therefore directing the conversation to focus on the positives and the relational aspect of change. This then reinforces these positives as the outcomes of therapy for the family.

Extract 2

The session continues with the therapist continuing to try and think relationally about the change and what they can do in the future to continue with the changes they have seen. However, Lexi and Leanne continue to

engage with each other and often do not answer the therapist's questions. This extract comes from the very end of the session, where the therapist is bringing the session to a close and putting forward his final thoughts on the therapy process:

> *Therapist: Okay, I, I'm really impressed by the steps you've taken, it's not the end, is it? It's the beginning [Lexi: Yeah] and I guess there might well be times when the greeting after school get forgotten, or the "I'd really like to come down and have a chat with my mum over tea." Gets forgotten, or whatever it is, but you've got this as: "This is possible," and this is not something you've done in here, it's something you've done out there before, yeah?*

> *Leanne: Hmm (nods).*

> *Therapist: Shall we think about the time?*

> *Lexi: Um (checks her phone)*

> *Therapist: Do you want to go now?*

> *[??? Can't work out the last little exchange between Leanne and Lexi, too indistinct]*

> *Family leave the room, session ends.*

The therapist offers a reflection of the therapy process to signal the end of the session. He compliments the family for their efforts in the therapy process and frames this as the beginning, rather than the end. He offers a warning that things may not be perfect in the future but reassures them that they have the skills to manage this, which constructs a sense of hope for the future. The therapist is drawing upon the IR that therapy helps to increase resilience and coping rather than eradicating all problems. This hands over control to the family for the future and constructs that they will need to keep working together even once therapy has finished. Unlike with the other families, there is very little input from the family at this point. There is a tentative acknowledgment from Leanne, but there is no other verbal response from either Leanne or Lexi. This lack of response dismisses the therapist's invite to talk about the future or the therapy process. Both Leanne and Lexi have teamed up in the session, by engaging with each other, being

playful together and not answering the therapist's questions. This ending is once again reflective of this, where Leanne and Lexi are together in their silence and the therapist is trying to hold the therapeutic process by inviting any final reflections on the therapy and thoughts about the future before they end the session. The lack of response from the family then brings the session to a close and there are no final responses from either Lexi or Leanne. This is different to the closing of several of the other sessions, where the family offer thanks and closing remarks regarding the therapy.

Family 6

Pen Portrait

This family consists of Jane (mum), Rachel (14), David (step-dad) and Luke (older brother). Jane and Rachel attended all of the sessions, whilst David attended a couple of sessions but not the first or the final session. The lead therapist was Karen and there were 2 other family therapists in the reflecting team. The family attended for 8 sessions over 6 months.

Referral and background context

The family were referred to the SHIFT project by their local CAMHS team. They were referred to CAMHS by the school, in response to Rachel's self-harm. Rachel was using self-harm to manage her anxiety and low mood, which was in relation to difficulties in school (high pressure, friendships). There was also an incident of Rachel's father being involved in a criminal activity, which had affected the whole family and in particular Rachel. There were strained relationships at home, particularly between Rachel and David, which caused tension and arguments.

The first session

In the first session, Jane and Rachel set goals that they wanted to work on during therapy, which were; to communicate more with school, to improve communication and understanding of each other at home and to find other coping strategies rather than self-harm. Rachel spoke about her self-harm as a way to manage the anxiety and pressure at school and described it as a release. They spoke about the difficulties at home, in terms of communicating with each other and said that this was something that they wanted to change. The family were able to communicate well in the session and both Jane and Rachel expressed their opinions and listened to each other. The therapist helped them to set their goals for therapy and to ask about the background context and current difficulties.

The last session

This family use the last session to discuss what the outcome of therapy has been. They begin with a general catch up with how things have been and

then the therapist begins to review the goals they set in the first session one after another. There is a theme around having a realistic expectation of change that things might not be perfect but they are a lot better than they were.

Extract 1

The session begins with the therapist asking the family to review the goals they set in the first session. In the following extract, the family and the therapist are reviewing the first goal they set, which was to help communicate with the school:

> *Therapist: Yeah, yeah (looks to papers on the table) If we were going to rate these then, starting to look at these because this is what we need to do, um 'Helping communicate with the school' we've got: 'Goal not met at all'; 'Half-way to reaching the goal'; 'Don't know'; and 'Goal reached'.*

> *Rachel: I don't know, because we've communicated with them but they haven't understood it.*

> *Jane: And Rachel has made the decision based on her experience that she doesn't want to stay there. So I think –I think we've come to a- this school and ourselves have come to accept that it's not the right place for Rachel [Therapist: Hmm] so actually that's what that's done - that's achieved it really.*

> *Therapist: Hmm, it's really- I suppose in a way what I think is really important about that- which is probably more important actually- is about your thinking Rachel, about, um, evaluating who can meet what needs, and instead of banging your head up against a brick wall if you're not getting somewhere, going: "Hmm, that's not going to work [Rachel: Yeah] so I'm going to do something different. That's a much more important lesson in life in some ways, isn't it? [Jane: (nodding head) Hmm] In terms of- [Jane: Yeah, you're right.]*

> *Rachel: I think that the experience I've had at school has been good because I know now what to do, like, I know now if I were to go*

somewhere and they didn't understand, they'd know how to deal with it [Therapist: Hmm]. So it's set me up for that [Therapist: Hmm] yeah.

Therapist: Do you think we ought to write that down? Because the goal changed, didn't it? So what you've learned is something around accepting the limitations and then accepting your [Rachel: Yeah], changing your strategy.

Rachel: Yeah [nods)

Unlike with the other sessions, this therapist wrote down the family's goals from the first session and brought them to the final session to review by scoring whether they have achieved each goal out of 10. The therapist introduces the task of rating the first goal that was set and offers the different options available on the goal sheet. Rachel expresses her uncertainty of the answer and explains why she is unsure. The therapist responds to Rachel's uncertainty by changing the focus of what the outcome is and constructs that the outcome is how Rachel approaches problems rather than the problem changing itself. The therapist takes a directive role in doing this and is more active in shaping the outcome related to the goal. The therapist is drawing upon the IR that change comes from how someone deals with a problem rather than the problem being eradicated. With Rachel saying that the problem (i.e. the school) has not changed, the therapist reframes the goal to be in line with what the family have achieved; that Rachel has taken a different course of action. This empowers Rachel as the agent of change and offers a positive outcome for therapy as well as providing hope for future difficulties that she will encounter.

Extract 2

The session continues with the family then rating and discussing the second goal which was improving communication between Jane and Rachel. They talk about how this has been achieved and that although it is not perfect, they are able to communicate and have more understanding of each other. In the following extract, the family and therapist are discussing the final goal for therapy which was to not use self-harm as a coping strategy:

Therapist: What have we got here? (Puts on glasses to read paper) 'Different strategies to deal with difficult situations as opposed to resorting to self-harm' (writing down) 'Different strategies' (…) My writing's getting worse and worse, I think it's because we're always on the computer. [Jane: Yeah (nods)] My writing's become pretty appalling- (reading aloud) 'Different strategies to deal with difficult situations.' How do you think you're doing on that?

(Rachel and Jane look at each other)

Rachel: I'd say ten.

Therapist: Would you say ten?

Rachel: Yeah. [Therapist: Hmm] I'd never cut myself again.

Therapist: You'd never do it again? (Rachel shakes her head) You do you think was (..), what do you think you're doing differently now, then, that's helping you not to feel like you need to self-harm?

Rachel: I dealt with problems- the way that I did go to self-harm was because of friends [Therapist: Friends?] and that's not massively overwhelming me, like, I'm moving- I'm leaving the school in like twenty-nine, twenty-eight days [Therapist: Yeah, yeah]. Like, it's nothing [Therapist: Yeah] do you know what I mean? It's like, it's sort of like hit me that, like (.) firstly, why did I let them get to me? [Therapist: Yeah] (..) Um, and yeah, I was self-harming because, like, I would do it and it would get me on a higher level like for a few hours and then I'd feel really, really bad again and so it just didn't really help.

Therapist: Okay. What if, so there's one bit that you're leaving that school and leaving that friendship group so the problems going away and that's nice- what if you had a similar problem in the future with a different group of friends? What would you do differently?

Rachel: I think because of dance, because of the stuff I've been through there I've sort of learned [Therapist: Hmm]- especially when I start doing something every day that I love [Therapist: Hmm] so-

[Therapist: So what's really important is having something in your life that makes you feel good?] Yeah. And, you know, like I used to wait until a Tuesday came, or now a Thursday or a Sunday, to dance, but now I'll sort of have it every day to sort of be doing and it'll sort of be like (.) be there and that will keep me alive, literally like- (making swiping gesture with hand) [Therapist: Alright] Because two of my best friends that, you know, I'm so close to I can't choose between or anything, they're going to my class as well [Therapist: okay] so I'll sort of be with them, and I'm joyful, I'm happy that they're into the same thing as me, but I won't get too attached

When reviewing this goal related to using self-harm as a coping strategy, Rachel makes the claim that she will never cut herself again. This use of the superlative "never" constructs that there has been a complete change in terms of self-harm and creates a distinction between how things are now and how things used to be. It also suggests the permanence of the change and that the problem of self-harm has been resolved. Rachel is using an extreme case formulation to convince the therapist and her mother that she will not self-harm again and to distance the past from the present. The therapist reflects this statement back to her to check with Rachel's intent and then she makes a request for more information and a justification about what has influenced this change. Rachel makes a claim that external stressors have changed or are about to change, but also that she has learnt that self-harm does not help her. She continues to say that she has learnt that having dance in her life is important for her happiness. By Rachel saying she has learnt from the therapy process, she is taking responsibility for the changes and constructing that she has developed and changed and taken on board the 'lessons' of therapy. Rachel is proving to the therapist that therapy has been successful and that she has achieved this from her engagement in the process. Rachel constructing that self-harm was the result of external stressors this then removes any blame or responsibility for the self-harm because it was external to her. Rachel is then claiming her identity as someone separate to the self-harm and using the extreme case formulation is another way to distance herself from the distress that it caused both her and her family.

After this, there is a discussion about how Rachel has changed her expectations of her dad which has meant that she is not as upset about her relationship with him. Once again the therapist reinforces that Rachel is the catalyst of this change and empowers her for future problems. The reflecting team are then invited in and they also reiterate that therapy is a making sense process and draw upon the IR that change comes from generating new meanings rather than problems being resolved. They also reiterate that change occurs relationally and that both Jane and Rachel have worked together to create the changes, which reinforces the systemic principles of family therapy. The session is closed by the therapist who offers praise to the family for their hard work, commenting that it is rewarding to work with people who are able to use this work so well. Jane and Rachel also express their gratitude to the therapy team and suggest that it has put them into a much better place and improved the quality of their lives.

Group Analysis

Having looked at the data within the context of each family, I will now give an overview of the patterns and differences across the sample. For the first part of this analysis, I will look at what is achieved with the talk in the final session and this will be split into 3 tasks that were identified within all of the sessions; evaluating the therapy, attributing agency for change and preparing for the future after therapy. For each task, the positions and actions of the different stakeholders will be considered. The second part of this group analysis will look at whether a shared understanding is negotiated and what patterns of interaction can be identified that either help or hinder this process.

Tasks of the final session

Evaluating the therapy

In all of these final family therapy sessions, there is an evaluation and review of the therapy and its outcome. This is primarily initiated by the therapist, which is to be expected as this is one of the recommended tasks in a final family therapy session (Pote et al., 2001). In all of these final sessions, the therapist contextualises it as the final session and then invites the family to reflect on the process of therapy, setting the focus for the entire session. In all six sessions, it is the therapist who introduces the task of evaluating the therapy, without offering a personal opinion. This encourages the family to make sense of the therapy process themselves and to put forward their own opinions first. This can be seen in family 4 (extract 1) where the therapist is making a request to the parents for them to explain what was helpful about the therapy process. This invites the parents to describe and evaluate what has contributed to the change that they are discussing. The therapist may try and influence who gives their opinion first by directing the task to a particular participant. In family 2 (extract 1), the therapist introduces the task of evaluating the therapy and directs this at Brooke. This appears to be a strategy that the therapist is taking to try and encourage Brooke to speak

and offer her opinion before her mum does. When looking at the session, it is apparent that Tanya does more of the talking compared to Brooke and this was also seen in the first session, so it was likely to be a pattern seen in the whole therapy process. The therapist is therefore using this direct invitation to give Brooke a voice and power within the session, yet this is rejected by Brooke. During the session, there is a pattern of Brooke resisting answering questions directed at her, not engaging in the session or contributing to the task of evaluating the therapy. Although, Tanya does reflect on some of the changes that have occurred, she is primarily concerned with what will happen afterwards in terms of support and therefore is less engaged with evaluating the therapy. Tanya throughout the session suggests that she wants them to remain an open case to CAMHS in case they need support in the future. Tanya's concerns suggest her fear of the future and possibly her worry that they are not ready to end therapy. The task of evaluating the therapy may be resisted in this session because of the family's fear of the therapy ending. For the other families, there is a shared consensus about this being the right time to end the therapy and they are therefore more open to the task of reflecting on the therapy process.

Although the therapist often initiates the task of reflecting on the therapy, they would often put forward a positive reflection or connotation of what the family have said. This can be seen in family 5 (extract 1) where the therapist asks the family to give an explanation for the change they have noticed. There is a difference of opinion being stated between mum and Lexi about what has influenced the change, yet the therapist does not acknowledge this difference and rather attends to what Lexi is saying that her mother has learnt to smile. This validates Lexi's point and encourages her to expand on this and give more detail. In this extract the therapist attends to and affirms the positives that can be drawn out from what they are saying. By doing this, the therapist acknowledges their contribution to the therapy process and its outcome and offers praise for the changes they have made. This can also be seen in family 1 (extract 3), where the therapist herself offers a positive evaluation of the therapy process and its outcome. In this, the therapist is praising the family for their hard work during therapy and acknowledging their contributions. This statement also positions her as the professional,

where she can pass a final judgement on the overall outcome of the therapy and she offers a conclusion that it was a successful intervention. Peter then qualifies this by describing the process and how hard it has been at times, but affirms the positives and reinforces the therapist's judgement that the therapy has been worth it and successful overall. Thus, there is a pattern of the therapist initially taking a more neutral stance to introduce the task of evaluating the therapy, but then giving their own evaluation once that family has done so; often to give a positive re-frame of what the family are saying.

When evaluating the therapy in relation to self-harm, Isobel (Family 3, extract 1) Rachel (Family 6, extract 2) and Harry (Family 4) say that they would not self-harm in the future. They use an extreme case formulation, which separates how things are now to how they used to be, constructing this difference as an explanation for why they will not self-harm. The use of extremes is only used by some of the young people and is not observed for any of the other stakeholders (parents or therapists). The adults in the room often hold a more flexible position where they acknowledge realistic change. For example in family 6, Jane says *"I would still like Rachel to understand things from my point of view sometimes, but I think as a parent, you know, realistically they never can one hundred percent"*. Therefore, the parents can be seen to be holding a more dynamic understanding of change, whereas the young people are constructing a fixed idea of therapeutic change.

Attributing Agency

In all of the sessions, there are different constructions about who is responsible for the change being discussed; where the agency of change is located. Attributing agency has different functions across the families. One function is to empower an individual within the family. In family 6 (extract 1) the therapist reframes the goal in light of what the family are describing and within this positions Rachel as responsible for the change in how she thinks and approaches this particular problem (the school). She makes a claim that this is a more important change, implicitly praising Rachel and empowering her by suggesting that she has the resources to change problems in the future. In family 4 (extract 3), change is being attributed to Sarah (mother). Sarah acknowledges the changes she has made in her parenting skills and

then this is validated and reiterated by both the therapist and Tom (her partner). Throughout the session, Sarah is constructed as the agent of change, which serves to empower Sarah and recognise the effort she has put into the therapy process. The therapist focuses more on empowering the parents (particularly Sarah) rather than the young person in this family, which is different to the other cases. This may be related to Harry's age and will be expanded upon further in the discussion.

In family 1 (extract 1), there is a disagreement when attributing agency of change. The parents and the therapist work together to try and empower Emma as responsible for change and they do this by recognising what she is doing differently. Emma is initially open to this and agreeable when the therapist is complimenting her for the steps she has taken; she then contests it when her parents describe how she is doing jobs around the house. Emma rejects her parent's statements, so to claim a positive identity. It is only when Peter recognises that Emma is contesting a negative identity that he then moves into a mediating position by acknowledging Emma's viewpoint and agreeing with her claim on a positive identity and then justifying what he meant when he said she is doing more around the house. This then reframes the attribution of change in a positive light and then Emma is accepting of this and a shared understanding is reached. In family 5 (extract 1) there is also a disagreement about who is responsible for the change between Lexi and Leanne. They both hold different ideas about the change, so to manage this, the therapist holds a different position by mediating between the two and offering a positive reframe. This illustrates that when there is a difference in how various participants are constructing the change that attributions of agency will also differ. In both of these extracts, there was a need for someone in the room to hold a mediating position to allow them to move forward towards a more shared understanding. This is not always the therapist and illustrates that different stakeholders contribute to the therapeutic tasks of the final session.

In family 2 (extract 1), Tanya also attributes change to her daughter, Brooke by claiming that Brooke has grown up during the therapy process. This statement positions her in an adult identity, to empower her as responsible. However, this is rejected by Brooke, stating her identity as "a kid". Brooke

rejects an adult identity and with that the responsibility for change. This is reflected further on in the session in extract 3 when Brooke also rejects the therapists invite to contribute an opinion to whether the case should be kept open. Brooke gives responsibility for the decision to her mum and the therapist, which again rejects an adult identity and rejects any effort from others in the room to empower her. In family 3 (extract 3), there is a difference of opinion when attributing agency of change. Lorraine attributes the change to the work of the therapy team and offers her gratitude in doing this. However, this is contested by the lead therapist who locates the agency within the family to empower them as responsible for the change. This reflects a difference in agenda and stake in this discussion; Lorraine is expressing her gratitude for the help and support from the therapy team and praising them for the work they have done, whereas the therapist is trying to empower the family by reinforcing the principle in systemic therapy that families have the resources to enable change within them. This is also reflected in family 1 (extract 3) where the family offer their thanks and gratitude to the therapist and the therapist responds by attributing the change to the family.

Preparing for the future

A task within the last session of family therapy is to prepare for life after therapy ends. For several of the families, this is linked with evaluating the therapy and the positive changes providing hope for the future. In family 1 (extract 2), the therapist reinforces that the change has been an increase in coping and resilience rather than problem reduction, which Emma agrees with and expands upon to take ownership of this. In this the therapist is conveying the limitation of therapy that it will not solve all problems and therefore, provides a warning or expectation for the future that they will have more difficulties or that the same problems may reappear. Yet, in addition to this warning, the therapist offers hope for the future by suggesting that Emma and the family have the coping skills to manage these future difficulties. The therapist is balancing giving a realistic expectation for the future, whilst also providing a sense of hope. This hope for the future is located within the family, which also reinforces that they do not need therapy to manage future problems. This is taken on board by Emma, who agrees

with the therapist and she identifies her role in how she will deal with problems in the future. This constructs Emma as taking responsibility for the future and her independence from needing therapy as a way to manage. This can also be seen in family 4 at the end of the session just before they leave the room:

> *Sarah: (to the therapist) I think we're going to be okay (therapist nods) and, you know, it's a settling in process. Yeah (..) but I have been very grateful for the opportunity to work with the team and have this opportunity and hopefully we've now got long-term strategies that we can use.*

Here, Sarah is conveying that they are no longer in need of therapy. She offers her gratitude for the therapy and to the team, but suggests that they now have the resources to cope in the future. This is a positive rejection of the therapy, by saying that they no longer need the external support. This construction of independence from the therapy process can be seen in families 1, 3, 4 and 6 and may be a way for the families to assert their power in the ending process and ultimately the power and control they have in the future.

In these final sessions, the therapists are often holding a balanced position between setting realistic expectations for life after therapy as well as providing and encouraging a sense of hope for the future. In family 3, one of the reflecting team members offers an idea of the future which holds both of these components:

> *RTM: Because there is no perfect relationship is there? And you kind of fumble things along and some things go really well, and then something will happen, and I think what you're trying to do is make sense of it yourself, then you're asking questions to form a new understanding again about the new challenges that lie ahead … Sometimes you will get it wrong, sometimes you will get it right. But I'm quite hopeful for this family.*

The therapist uses his stake as the expert to justify his opinion and hope. This can also be seen in family 4 (extract 2), where the therapist offers a positive judgement on how the family are presenting in the session and

proposes that this reflects what they want for the future. This not only compliments the family, but also fosters a sense for hope for achieving what they want to in the future. Once again, the therapist uses her stake as the professional to communicate this to the family and to strengthen this hope for the future. For family 5, there is less discussion from Leanne and Lexi about the future and it is the therapist who offers an idea of the future, which can be seen in extract 2. Once again the therapist offers realistic hope for the future but in this instance it is not taken on further by Leanne or Lexi. This reluctance to engage in a conversation about the future may be indicative of their reluctance about the ending of therapy. There is a similar pattern in family 2 (extract 3), where Brooke claims her autonomy by refusing to engage in the conversation about the future. Her resistance and refusal closes down a shared perspective of the future, which is her stake in the session.

Patterns of interaction in the final session

There appear to be two different patterns of interaction in these final therapy sessions. For four of the families, the sessions are characterised by the participants collaborating together to try and achieve a shared understanding of the therapy process and its outcome. This does not mean that there is agreement on every point, but that differences are able to be held, accepted or worked through. For the other two families, there is a pattern where there is a pairing up in the session, causing a divide between these two participants and the one other in the room. This seems to be when there are opposing agendas and that this creates a conflict within the session. I will now use examples from the sessions to expand on this further.

Collaboration in the Therapeutic Process

For families 1, 3, 4 and 6 there is an overall sense of collaboration in these final sessions. This is demonstrated in family 3 (extract 2), where Isobel and Lorraine are voicing a difference of opinion about whether it is helpful to remember how things used to be at the beginning of therapy. Isobel contests her mother's opinion and gives a rationale for her belief that they need to remember and think about the past. Lorraine accepts and praises Isobel's

opinion, which then allows Isobel to reciprocate this by reassuring her mother that she *"can do it"*. Initially the therapist validates Lorraine's viewpoint, but then switches to a mediating position at the end of the extract where he holds and condones both opinions and offers an alternative view that captures both. This is then accepted by both Lorraine and Isobel and this shared understanding is agreed upon. In family 1 (extract 2) this collaboration can be seen, where each participant is building upon what the last person has said. Peter makes the claim that the target problem of loneliness has not gone away but that they have changed as a family. The therapist then expands on Peter's point and reframes it into therapeutic terms, proposing that the meaning in relation to the problem has changed. By doing this, the therapist is accepting Peter's statement and then offering her stake in the process by framing it in therapeutic terms and the goals of family therapy. Emma then builds on this further by specifying what she thinks has changed. This then acknowledges both Peter and the therapist's earlier points and provides a rationale, explaining that she is able to deal with the loneliness better than before. The family demonstrate that they are open to the therapeutic process, by accepting this reframing of the change in therapeutic terms. This is then capitalised on by the therapist who then invites the reflecting team in to continue this collaborative thinking. In both of these examples, the family members are able to hold the different opinions in the room, which illustrates that they are open to the therapeutic process as this is one of the key points of family therapy.

Pairing up and Resistance to the Therapeutic Process

For families 2 and 5, there is a split within the session, with two participants appearing to pair up against the other person in the room. In family 2, there is a very apparent split with Brooke separating herself from her mother and the therapist. This can be seen visually with Brooke sitting separately from them, leaving Tanya and the therapist paired together. In extract 1, the therapist introduces the task of reflecting on the therapy process and invites Brooke to comment first by directly engaging her. However, Brooke resists this invitation by saying she *"doesn't know"*. In response to this, Tanya then offers her opinion and states what she thinks has changed. The therapist then goes with this and switches her focus onto Tanya, by acknowledging

what she is saying and inquiring further about it. Brooke's resistance to engage encourages the therapist to align with Tanya as she is participating in the discussion. This reflects Brooke's construction that she is a child, by defying them and this then seems to push the 'adults' in the room together as a pair by Brooke positioning herself in contrast to them. In family 5, it is Leanne and Lexi who appear to pair up together against the therapist and the therapy process as a whole. Throughout the session, the therapist makes several attempts to request that the family reflect on the therapy process, but this is resisted by both Leanne and Lexi and they continue their own discussion about a recent experience.

> *Therapist: So your mum managed to stand back from an argument [Lexi: yeah and cause another one] said something that was funny?*
>
> *Leanne: No I helped her, do you want me to say what it was? (laughs)*
>
> *Lexi: You make me sick! (joking)*
>
> *Therapist: But it sounds like you are both delighted by that change? (Leanne and Lexi look at each other and are laughing)*
>
> *Lexi: You make me sick!*
>
> *Leanne: (Playfully taps Lexi's leg)*
>
> *Lexi: Stop it!*

Here, the therapist is making requests for the family to reflect on this change between them. However, this is not taken up by Leanne or Lexi and they both continue to engage with each other, being silly and playful together. This illustrates the process of them pairing up and resisting the therapeutic interventions being offered by the therapist to reflect on the change he is seeing between them. This rejection of the therapy process is reflected in the ending of the session (extract 2). The therapist offers a final reflection of the therapy process overall to bring the session to a close and to offer a compliment to the family for their efforts in attending therapy. Within this there is an implicit invite for the family to reciprocate a final reflection and to comment on the therapy process as a whole. However, this is not taken up by the family and they show resistance to this by not giving any feedback to

the therapist and Lexi also demonstrates this by looking at her phone. The therapist then acknowledges this resistance and ends the session.

Summary of Results

From the individual analysis of the sessions, I found that the families described outcomes of therapy to be; positive developments in family functioning, reduction in the young person's stress and self-harm behaviour and changes in problem meaning. Some of the families and all of the therapists proposed that it was the family and their hard work that were responsible for the positive changes they were noticing; whereas on some occasions family members would attribute the change to the therapist and the therapy itself. I identified three tasks shared by each of the families in these sessions; evaluating the therapy, attributing agency and preparing for the future. In these final sessions, four of the families appeared to reach a shared understanding of the therapy and its outcome, whereas two families did not seem to develop a shared understanding. The families where they appeared to reach a shared understanding, worked collaboratively and all participants seemed on the whole open to the therapeutic process. However for the two families who did not appear to reach a shared understanding, there seemed to be at least one participant who was not collaborating with the therapeutic process, which created a divide in the session. I will now go on to look at these findings in the context of the wider literature and discuss the different actions taken by the various stakeholders, which either helped or hindered the shared understanding process.

Discussion Chapter

Summary of the Findings

The overall aim of this study was to look at how participants in the final session of family therapy negotiate their understanding of the therapy process and its outcome. This was broken down into three specific research questions which were:

- How do the participants talk about the therapy process and any outcomes i.e. what has changed and how it has changed? What is *done* in the final session?

- How is a shared understanding achieved (or hindered) in the final session?

- What do the stakeholders do in the final session to try and develop a shared understanding?

Research into child stress and trauma has found that developing shared meanings in families has long-term benefits to wellbeing (Gewirtz et al., 2008; Saltzman et al., 2013; Wadsworth & Riggs, 2011). Furthermore, Sundet (2011) found that changes in meaning were reported by families as one of the most helpful aspects of family therapy. It is recognised that meaning making is a beneficial task within family therapy, yet we are still unsure of what shapes this process. This study aimed to develop our knowledge of *how* a shared understanding is negotiated at the end of therapy, as it would be expected that this shared understanding will have positive outcomes for the family in the future.

This analysis found that the outcomes of therapy that were constructed were; increased family resilience and functioning, changes in problem meaning and a reduction in stress for the young people. This reduction in stress was put forward by several young people as being the reason for not engaging in self-harm by the end of therapy. Two interpretative repertoires were predominantly used for constructing agency in the therapy process,

which were that change comes from the family system and that change comes from the therapists and the therapy forum. This analysis found that of the 6 families, 4 worked collaboratively together to develop a shared understanding of the therapy and 2 families resisted the therapeutic process and a shared understanding did not appear to be reached. To understand what was being achieved in the final session, I identified three tasks that were evident for all sessions, which were; evaluating the therapy, attributing agency and preparing for the future. For each task, I identified any differences between the actions of the various stakeholders. For the discussion, I will now explore these actions by the different stakeholders in terms of whether they contributed to or hindered the shared meaning making process in the final session. This chapter provides an understanding of the analysis within the context of the wider literature. This research study is the first to look at how meanings of change, outcome and therapy process are negotiated at the end of family therapy. The findings suggest that there for a shared understanding to be negotiated there needs to be collaboration from all participants. It suggests that if at least one participant is not engaged in the therapeutic process in the end session, that this hinders the shared meaning process. The strengths and limitations of this study are then considered and the chapter closes with the clinical implications from this study and puts forward proposals for future research.

Outcomes of therapy

Family resilience and functioning

Four of the families in this analysis (1, 3, 4 and 6) described that an outcome of their therapy was a positive change within the family dynamics and functioning. This included how the family interacted together, an adjustment in the roles and expectations of individuals and improvements in relationships from understanding and communication. From the literature, this can be understood as a factor supporting an increase in family resilience (Saltzman et al., 2013). One way of making sense of this is the Family Adjustment and Adaptation Response (FAAR) Model, which is based on family stress theory and illustrates the active processes families engage in to

balance family demands with family capabilities as these interact with family meanings to arrive at a level of family adjustment or adaptation (J. Patterson, 2002). Earlier family resilience models focused on identifying the strengths of resilient families (McCubbin & McCubbin, 1988). There was then a move towards conceptual research application approaches, such as the FAAR model, which emphasise a process orientated definition of resilience in family systems. The FAAR model views families as systems with goals, functions and interaction patterns that regulate life at a day to day life at multiple family levels (Henry, Sheffield Morris, & Harrist, 2015). This alongside its orientation to process means that it provides a useful framework to understand the findings in this study.

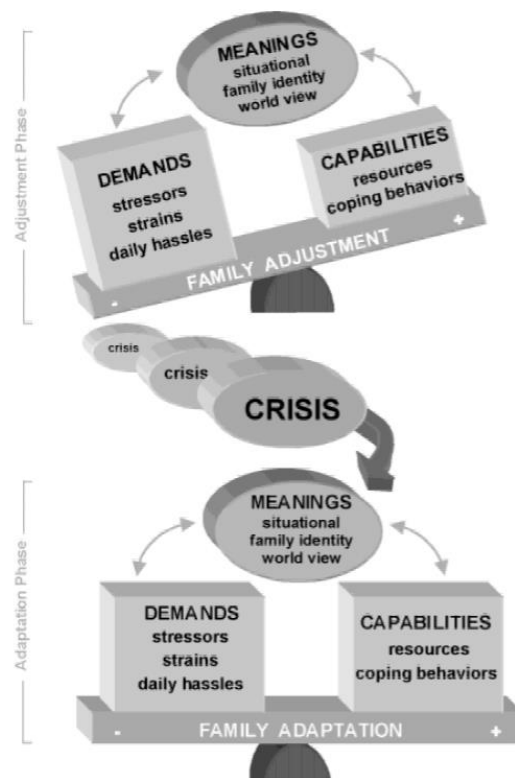**Figure 2: The Family Adjustment and Adaptation Response (FAAR) Model (J. Patterson, 2002)**

Figure 1. Family Adjustment and Adaptation Response (FAAR) Model

On a day to day basis, most families demonstrate fairly stable patterns of interaction when managing the usual demands of family life with their existing capabilities. This allows the family to achieve a sufficient level of family adjustment. However, there are times when demands exceed capabilities and when this imbalance persists there is a crisis, leading to a

major change in the family's functioning or structure. It could be conceptualised that the families in this study all encountered a crisis period prior to beginning therapy, where the demands they were facing outweighed their capabilities (or perceived capabilities) at that time. The outcome of therapy then might relate to the changes in the functioning or structure of the family which have led to the family adapting after the crisis. The FAAR model (J. Patterson, 2002) suggests that families restore balance by reducing demands, increasing capabilities and/or changing meanings. In stress theory this process is called regenerative power and is linked with family resilience. In this analysis, several of the young people (Harry, Isobel and Sarah) describe that the stressors that were present at the beginning of therapy have either reduced or changed (i.e. school, friends). In the FAAR model, this can be understood as a reduction of demands or risks. Several of the families describe outcomes related to increased capabilities; Sarah (family 4) describes how therapy has helped them to adapt their parenting style, Emma and Peter (family 1) suggest that they have learnt how to work together as a family and Lorraine (family 3) suggests that they now have skills to take into the future. Therefore, it can be seen that these four families are constructing that a positive outcome of therapy has been a shift or adaptation in how they are functioning as a family unit and how therapy has helped create this shift to allow them to make positive adaptations. In other words, therapy has increased or developed their family resilience to difficulties. There is a lack of evidence from the final session transcripts that an improvement in family functioning and family resilience is an outcome held by the other two families (2 and 5). It may be that this outcome was explored in the session prior to the final session and therefore it is not discussed in the analysed session, but it may be that for these two families this was not an outcome from their experience of therapy. For these two families, there was no evidence of any talk related to changes in the family's coping strategies, how they work together or any shared meanings. The outcomes that were put forward by these families seemed to only relate to change with an individual such as the young person doing her school work more. This difference many be important when looking at whether a shared understanding is achieved and I will consider this later in this chapter. One of

the key aspects of family resilience in the FAAR model is the meanings the family hold and I will now explore this further in relation to this analysis.

Changes in Problem Meaning

Research into outcome and process within family therapy has primarily used quantitative methods such as outcome measures such as the SOFTA (Escudero et al., 2008; Hogue et al., 2006). This research is based within a positivist epistemological stance, where there is an assumption that change comes from symptom or problem reduction and therefore change can be measured and monitored. However many of the families within this analysis drew upon the Interpretative Repertoire (IR) that change is not about symptom reduction, but rather about relating to the problem differently or developing new meanings. This IR was evident for families 1, 3, 4 and 6 and there are examples of this in family 1 (extract 2) and in family 6 (extract 1). This IR aligns with the aim of family therapy, which is to generate new meanings and that it is this shift in meaning that reduces distress rather than symptom or problem reduction (Dallos & Draper, 2010). In the FAAR model, there are three levels of family meanings that mediate the adaption and adjustment process (J. Patterson, 2002). Firstly there are situational meanings (a family's appraisal of the demands on them and secondary appraisal of their capabilities), secondly their identity as a family (how they see themselves as a unit) and finally their world view (how they see their family in relationship to systems outside of their family) (J. M. Patterson & Garwick, 1994). The situational meanings include the family's primary appraisal of the difficulties and the secondary appraisal of their capabilities to manage the difficulties (J. M. Patterson & Garwick, 1994). It is this subjective judgement in the situational meanings that can then render the family more or less resilient to the risks they perceive. The four families who all described an outcome of therapy to be improvements in how they were functioning as a family, all described how they felt able to tackle any difficulties the future may hold; e.g. both Sarah in family 4 and Lorraine in family 3 stated that they think that as a family they now have strategies to manage difficulties in the future. It may be that they have developed new meanings about their family capabilities or it may be that they have developed new meanings related to their identity as a family (that they can

cope with difficulties and they are a strong unit). The other two families did not comment on any change in meanings. In family 2, there was a lot of uncertainty about the future raised, particularly by Tanya and it may be that there was no change in meaning related to their capabilities to manage difficulties in the future. Family 5 did not engage in the therapist's questions regarding any change in meaning related to how they see themselves as a family or their capabilities for the future. Once again, this difference in outcome may be significant when looking at whether a shared understanding is achieved and therefore how likely the family will be able to manage future difficulties.

Self-Harm

It is interesting to note that although self-harm was the defining problem that linked all of these families and was the reason they were all referred to the SHIFT project, it was not discussed at length in any of these final sessions. From watching the first sessions, self-harm is not a prominent discussion for most of these families at the very start of therapy either and therefore, this may be important to take into account when looking at the role of self-harm as an outcome for these particular families. Family 1 and 5 did not mention self-harm at all in the final session, whereas for the other four families there was reference to the young person not using self-harm anymore. For all of these families, it is the young person who reports that they are not self-harming anymore and three of them (Isobel, Harry and Sarah) directly link this outcome to the reduction of stress from external factors (such as school and friends). Brooke does state that she is not using self-harm anymore, but does not give a reason why, which follows her pattern of not participating in the session. This finding draws upon the psychological discourse of self-harm that it is a way to express and managing suffering (Arcoverde, de Almeida Amazonas, & de Lima, 2016). Self-harm being a way to manage stress is compatible with the growing evidence base. The experiential avoidance model predicts that adolescents who are unable to cope efficiently with emotional distress and regulate behavioural impulses show a stronger link between interpersonal stress and deliberate self-harm (Chapman, Gratz, & Brown, 2006). Jutengren, Kerr, and Stattin (2011) looked at the interaction between deliberate self-harm in adolescents and

interpersonal stress and found that peer victimisation was predictive of self-harm. Therefore, the finding in this analysis that the outcomes of therapy were constructed in terms of reduction in stressors and that this then explained why the young person was no longer using self-harm as a coping strategy matches the current evidence linking interpersonal stress and self-harm.

The Therapy Process

Families and their hard work create the change

A common IR drawn upon by the therapists in these sessions was that change comes from within the family system. This IR is a guiding principle of family therapy and is set out as such in the Leeds Family Therapy Manual (Pote et al., 2001). This IR is used by the therapists to enhance mastery in the family system and to empower the family as a whole. As stated in the introduction chapter, family therapy has moved through different eras and one of the most significant shifts was from seeing the family as problematic or dysfunctional to seeing the family as holding the resources and solutions to their difficulties (Dallos & Draper, 2010). This shift from family deficits to family strengths means that the therapeutic relationship has become more collaborative and empowering of the family (Walsh, 2002). Therefore, in the analysis, therapists drawing on the IR of change being within the family system, empowers the family as a whole and builds resilience for future difficulties. This IR makes the case for family coping and family resilience by locating the skills, resources and strategies within the individuals as well as within the family system as a whole, which can then be collectively drawn upon in the future. By doing so, it constructs that the family do not need support from an external source (therapy/therapist) and therefore also justifies the ending of therapy. It constructs that the skills and resources needed for the future are within the family and therefore cannot be taken away from them and consequently that they are responsible for using these skills and strategies in the future. By drawing on this IR, the families are also constructing that they do not need therapy anymore and positioning themselves as in control of their future

For the therapists it may be that they have stake in the family being responsible for the change, because it then alleviates the pressure of being responsible themselves. This may be the case in family 2, where there appears to be some resistance to end the therapy from the family. Although, Tanya describes how she is not sure they have the skills to cope in the future, the therapist continues to reframe any positive changes as being attributed to the hard work of the family. By locating change within the family, it also constructs that they are responsible for their own future. The therapist may have a vested interest in the family being responsible for the change and trying to amplify any positive changes that have occurred, so that he feels more at ease with the therapy ending and less responsible for their worries or anxieties about the future. The SHIFT trial was limited to 6 months of intervention, therefore the end was determined from the outset rather than negotiated with the family, as would often be the case with family therapy. Therefore, it may be that the therapist's stake was influenced by this 'forced' ending and meant that he was more active in trying to drawn upon this IR even when the family were not co-operating with this.

Therapists and the therapy forum create the change

In some of the sessions, agency is attributed to the therapy team, which often is to show gratitude and to acknowledge the work of the therapists. In family 3 (extract 3) at the end of the session Lorraine offers her gratitude and thanks to the therapy team as a whole. With this she draws upon the IR that professionals are responsible for therapeutic change. By drawing upon this Lorraine is making the case that they could not have changed without therapy. This constructs that the difficulties they were facing were beyond their own skills and capabilities and that they needed something external and 'special' to produce any change. This is contested by the lead therapist who in contrast draws upon the IR that change comes from the family. This clash of IRs illustrates the different agendas and constructions in the room. The IR that Lorraine draws upon is a dominant IR in our society and held within the medical discourse of mental health that professionals have expert knowledge and skills (Walker, 2006). Therefore, it is common to see families drawing upon this IR, because it can absolve them of feeling ashamed that they needed to attend therapy; they did not have the expert or professional

skills to 'fix' the problem. The IR that change comes from within the family is therefore in conflict with this and this may lead to a difference in understanding about the therapy process and change. This once again may illustrate the different stakes at play within the last session. It may be that therapists reject this IR because they do not want to be held as responsible for the change because it means they will continue to be responsible after therapy and are therefore responsible if the problems reappear; that they did not do a 'good enough job' to abolish all difficulties. Whereas a parent may draw upon this IR, because it stops them feeling guilty that they could not 'solve the problem' on their own.

How is a shared understanding achieved in the final session?

Within the analysis, two patterns of interaction were noticed when reviewing the therapy and is outcome. In four of the sessions, all of the participants in the room, worked together to create a collaborative shared understanding of the therapy and its outcome (Families 1, 3, 4 and 6). Yet, in two of the sessions, there was less collaboration between the three participants in the room and there was a pattern of two participants becoming aligned and pairing up (Families 2 and 5). I will now look more closely at what each of the stakeholders did in the final therapy session and how this contributed or shaped the collaboration process to work towards a shared understanding of the therapy and its outcome.

Therapist Actions

Taking a Mediating Position

In order to be collaborative, the therapists often mediated between the different viewpoints in the room. This can be seen in family 3 (extract 2), where the therapist shifts from validating Lorraine to offering a shared view which holds both Lorraine and Isobel's opinions. This shift in position taken by the therapist helps the family come to a shared understanding, demonstrated with the statements of agreement by both Lorraine and Isobel.

This could be understood in terms of the therapist trying to balance and maintain the different alliances in the room. Neutrality is one of the guiding principles of family therapy offered by the Milan school of systemic practice (Brown, 2010). Neutrality is the concept which relates to the therapist trying to build equal alliances with the different participants in the session and ensuring that they do not side with one family member (Brown, 2010). This is recommended as an approach in the Leeds Family Therapy Manual (Pote et al., 2001) for therapists to take to establish their interest in different perspectives that may be held within the system. Therefore, the therapists may be attempting to use the concept of neutrality by holding a mediating position. This mediating position can be seen in other sessions, yet it does not always have the same effect. In family 2 (extract 3), the therapist once again holds a mediating position between Tanya and Brooke, by trying to hear Brooke's view and engage her in the discussion, yet Brooke dismisses this. Therefore, the therapists may use the same techniques, but this has different consequences dependent on the particular family dynamics.

Furthermore, from a social constructionist perspective, neutrality may be something that is aspired to but is unable to be achieved. Neutrality suggests that the therapist can be ethically and emotionally neutral so they do not get pulled into the emotional processes of the family system (Brimhall & Butler, 2010). Yet, social constructionism would argue that these emotional processes are continually being shaped and influenced by the current context and that the therapist will be part of this context and therefore will be part of these processes no matter what they do (Leudar & Antaki, 1996). Therefore, from a social constructionist viewpoint, the therapists in this analysis may try and adopt a neutral position, but they will be influencing and shaping the processes in the room. This can be seen in family 2, where the therapist may be trying to maintain a neutral stance by trying to engage Brooke, however Brooke's dismissal of this then means that the therapist inadvertently aligns with Tanya.

Using the 'Expert' Position

There are a number of occasions when the therapist uses their position as the 'expert' to amplify the change and to propose a shared understanding

using this status. For example, in family 4 (extract 2) the therapist offers her personal opinion on how they family are presenting and she makes a statement that what they hoped to achieve is "actually happening". The therapist is using her position to reinforce the change as a positive outcome with evidence to strengthen her statement. This use of the expert position is in contrast with that of the medical model, where the professional assumes responsibility with their 'expert' position and consequently puts the patient into the powerless and helpless position (Kaye, 1999). In these sessions, the therapist will often draw on the IR that change comes from the family, to empower them as the agent of change, but then use their position as the 'expert' as a strategy to amplify the positive changes being discussed.

Fostering hope for the future

All of these final therapy sessions included discussions which were focused on preparing for the future. In the Leeds Family Therapy Manual (Pote et al., 2001) part of reviewing the therapy process in the final sessions is to think about the future and how the family will tackle any future difficulties. From this analysis, the therapists initiated discussions about the future and one of the key functions of this talk was to provide and foster hope for the future after therapy. Flaskas (2007) reviewed the evidence base for looking at hope with family therapy and found only two books (Flaskas, McCarthy, & Sheehan, 2007) (Monk, Winslade, Crocket, & Epston, 1997), two articles (Perlesz, 1999) (Weingarten, 2000) and one book chapter (Hines, 1998). Flaskas (2007) reflects that even though hope is one of the common factors associated with positive outcome (Sprenkle & Blow, 2004), the evidence base is sparse for helping us to understand the use of hope in family therapy. Yet, hope is commonly talked about in the practice of family therapy and is implicit in many of the techniques and strategies employed by family therapists; reframing, enhancing mastery, amplifying change and developing new stories and assumptions (Pote et al., 2001). For example, in family 1 (extract 3) the therapist enhances beliefs of mastery for the family by reinforcing that it has been their hard work that has created the positive changes. Also, in family 6 (extract 1), the therapist using both reframing and amplifying change. She offers a reframe of the original goal set and suggests that the outcome is increased skills in problem solving, which is

even more beneficial long-term than the outcome they had set at the beginning of therapy. From this analysis, it was not only the therapists who were actively fostering hope for the future but for several of the families this was a collaborative practice. This can be seen in family 1 (extract 3), family 3 (extract 3) family 4 (extract 2) and family 6 (extract 2). Fostering hope is an active and relational process that is occurring throughout these sessions, with the participants collaborating to achieve this. Each participant brings a different perspective on hope and therefore the discussions in each family session are different as they are bound to the context of that family and what hope means to them. Weingarten (2010) writes about a variant of hope, which she calls reasonable hope. She describes that often our construct of hope is idyllic and that it sets up expectations and standards that are without limit. In contrast, she offers the construct of reasonable hope as something which is more realistic to what is within our limits. She also reflects that hope is often viewed as an individualised, intrinsic characteristic, whereas reasonable hope can be the actions of one or many people.

> "Reasonable hope's objective is the process of making sense of what exists now in the belief that this prepares us to meet what lies ahead. With reasonable hope, the present is filled with working not waiting; we scaffold ourselves to prepare for the future." (Weingarten, 2010, p. 7)

When looking at this analysis, the construct of reasonable hope appears to fit with what is being fostered and practiced in these final therapy sessions. The therapists and families are working together to try and make sense of how things are now and how this can helps them for life after therapy. This is illustrated in family 6 (extract 1) where they are reviewing the goals for therapy. Within this discussion, the therapist and Rachel work together to construct reasonable hope that although the problem hasn't changed, Rachel has changed how she relates to the problem and that this skill will be more beneficial for the future, than if the problem had just been solved. Rachel comments that she now knows how to deal with problems like this in the future, which promotes this concept of reasonable change. This is echoed in family 1 (extract 2) where Peter and Emma are suggesting that although the original problem of loneliness is still there, that Emma is more

able to cope with it. In her writings about reasonable hope, Weingarten (2010) suggests that one of the characteristics it accommodates is the ability to hold contradictions. She says that unlike hope which is a black and white category, reasonable hope is not antithetical to despair and doubt and they can run parallel. In the extract, Emma is stating that there has been no change to the loneliness she feels, yet she states that she is more able to deal with it. This is built upon by the therapist who then reinforces this reasonable hope for the future that problems like loneliness will always exist, but that she has the skills and resources to manage these in the future. In family 3 (extract 3), Lorraine states that before therapy they had reached a point where they couldn't do anything right. This constructs that they were hopeless at the beginning of therapy, insinuating that therapy has helped them to foster a sense of hope for the future. For the two families where there was less collaboration (families 2 and 5), fostering hope is still present, but is mainly an action taken by the therapist. In family 5 (extract 1), the therapist reframes what the family are saying to focus on the positive change that Leanne is smiling more. When there is less collaboration in the sessions, the therapist appears to take the position of an 'ambassador of hope' (Beavers & Kaslow, 1981).

Empowering the family

Across the sessions, different attributions of agency in relation to change were constructed. One of the key functions of the therapist attributing agency was to empower either an individual or the family as a whole. The therapists can be seen to shift between empowering the young person or the parent(s) individually, but also then empowering them as a family unit. This then allows them to recognise the solutions and successes for the individuals as well as supporting the development of a shared story of success, which are both recognised as part of the ending tasks for family therapy (Pote et al., 2001). There is a different pattern seen in family 4 to the other families, where there is an emphasis on specifically empowering the parents, particularly Sarah. The difference seen in family 4 may be due to Harry being younger than the adolescents in the other families. Harry is only 11 years old whereas the other young people are between 14 and 16 years old in the final session. Harry is at a different developmental stage as a pre-

teen. This difference can be seen in the session, as Harry is drawing in the session whilst his parents talk with the therapist. The stages of development model by Erikson (1994) states that psychosocial development occurs across the lifespan and identifies eight stages of development. The model proposes that an individual must go through a developmental task of resolving a dilemma at each stage. Erikson proposed that in adolescence between the ages of 12 and 18, there is a dilemma of identity vs identity confusion. In this stage, the young person transitions from childhood to adulthood by gaining a sense of their own identity and the roles they occupy. They begin to form their identity away from the family and develop their autonomy (Graves & Larkin, 2006). In the other families where there is collaboration, the girls are all aged 14-16 and are in this stage of development where they are gaining more autonomy and independence from their parents. In these sessions, the therapist can be seen to be empowering the young person to contribute to helping with their resolution of their identity. This can be seen clearly in family 1 where Emma is progressing towards adulthood as she prepares to go to university and move away from home. In the session, the therapist works together with the parents to empower Emma as the agent of change. They acknowledge the changes she has made, which in turn empowers Emma by constructing that she has the resources and capabilities to manage in the future. However, there is a different pattern in the session for family 4. According to Erikson's stages of development, Harry is still in the childhood stage of industry vs inferiority (5-12 years old). In this stage, it is proposed that in this stage the child needs firmness, support and boundaries to help with building autonomy. At this stage the child is still reliant on their parents to shape and support their progression towards adolescence. Therefore, it could be understood that Harry is at a different development stage than the adolescent girls in the analysis. Harry may still be at a stage where he is more reliant on his parents and therefore they hold more of the power in the family system. It could then be that this is reflected in the session with the therapist empowering them as the agents of change within the system rather than Harry. This issue of development will be continued as I now move to thinking about the actions taken by the parents in the final sessions.

Parent Actions

Acknowledging the young person's development

In all of these final therapy sessions, discourses of adolescence and development were drawn upon to different extents when evaluating the therapy and its outcome. The discourse of 'growing up' was explicit in all of the sessions and the move towards the young person having more independence and taking more responsibility was often portrayed by the parents as a positive outcome of the therapy. This independence was often linked to the young person's developmental stage; this can be seen in family 1 (extract 2) where the family are discussing Emma taking more responsibility and having more autonomy in preparation for going to university and then also in family 4 (extract 1) where the parents are telling the therapist that they have been working on giving Harry more independence from them by allowing him to have a phone as he has now moved up to secondary school. Erica Burman (2016) critiques the dominant discourses of mainstream developmental psychology put forward by models and theories such as Erikson's stages of development (Erikson, 1994). She proposes that our changing images of childhood over the decades can be related to broader social tensions. The introduction of mass schooling allowed for the construction of the child as dependent, imposing a middle-class ideal of childhood as a period of helplessness, presenting the child as ignorant and in need of education and socialisation (Burman, 2016). The discourse of childhood being a state of dependence has remained dominant in society and can be seen in our social and political policies (e.g. safeguarding). Yet, it is important to recognise that discourses of childhood are relational; that they only exist in relation to our constructions of other age and status categories (Burman, 2016). The dominant discourse of adulthood in a western society is that of the autonomous, independent, self-reliant individual. Consequently, this constructs adolescence as the transition from the state of a dependent, helpless child to the autonomous adult. Therefore, in this study the families are drawing upon discourses of growing up and increased independence to illustrate the positive change of the young person becoming more 'adult'. Therapy is constructed as supportive of this

expected development; in family 4 Sarah states that therapy has allowed them to have these conversations about Harry having more independence earlier than they would have without therapy. In all of these sessions, this change of the young person growing up is initially put forward by the parent. This can be seen in the following extract from family 3:

> *Lorraine: I suppose- I think what Isobel is trying to say- for me it's just that full realisation of how grown up Isobel is now, and how much I can talk to her more on a level rather than [Isobel: treating me like a five year old.] before- [Isobel: Well, you do.] I don't think I did Isobel, to be fair, I think that sometimes- [Isobel: Maybe seven or eight year old.] Yeah, but I think [Isobel: (quietly giggles) You did though.]*

Here, as with family 4 (extract 1), it is the parent who is proposing that they have had to realise that their child is growing up and that the change has been in how the parent relates to and 'parents' the young person. This constructs the parents as having the power and as being required to change. This assumes that it is the parent who can privilege the child with the 'rights' of adulthood e.g. independence. This again positions the child as dependent on the adult to gain these rights and to progress with the development into adulthood. The distinction between children and adults is given as a basis for granting certain rights but also for the exercise of certain obligations (Boyden & Hudson, 1985). In these sessions, tensions appear to come from the parent and the child having different ideas about what rights and obligations the young person has. For nearly all of the families, it is the young person who is suggesting that they are further in their development and therefore should be granted their rights of adulthood, whilst the parent in contrast constructs that they are still a child. The only session in which this is not the case is with family 2. Here, Tanya is suggesting that an outcome of therapy has been that Brooke is now more 'grown up' and Tanya also conveys this with how she relates to Brooke, referring to her as 'woman' and 'missus' on different occasions. Tanya is constructing Brooke in an adult identity, yet this is contested by Brooke who makes a claim on her identity as a child. Brooke explicitly does this by saying "I'm a kid" but also by playing with toys during the session and giving all of the decisions and responsibility back to the 'adults' in the room. Brooke may be rejecting the responsibilities

and obligations of being an adult because she wants to stay cared for. Therefore, she may be constructing that she is still a child to encourage Tanya to still support her and take care of her, rather than give her the responsibilities of adulthood.

The study conducted by O'Reilly (2006) found that therapists would interrupt children more during therapy than they would parents and that if they did interrupt the parents they would apologise for this, whereas they wouldn't with the child. This pattern was not seen in this study and it may be influenced by the developmental stage of the young person. The O'Reilly study was with younger children, which would then link to the dominant discourse of the dependent child with little or no power in the session, meaning that they are interrupted by the adults. However, in these sessions all of the young people were teenagers apart from Harry and there was no pattern of interrupting the young person. Therefore, the difference between this study and the O'Reilly study may be indicative of the difference between constructions of children and adolescents and how this plays out in the sessions.

Young Person Actions

Participate or protest

Four of the young people for the most part participate in the final session and collaborate with the other participants in the room. They accept invitations to participate in the tasks of the final sessions and put forward their own opinion of the therapy process and outcome. However, in two of the families, there is a pattern where two participants are aligned together or 'pair up'. In systemic theory, there is the concept of triangulation, which is the idea that what is happening between two people in a system can have a powerful influence on a third person in that system (Dallos & Vetere, 2012). The concept of triangulation does not assume a positive or negative outcome, but recognises that triangles can work to either stabilise or destabilise relationships (Dallos & Vetere, 2012). In both family 2 and family 5, there are three people in the main part of the session. For family 2, it is the therapist and Tanya who are 'paired up'; yet this seems to be in

response to Brooke declining to engage. Brooke demonstrates that she doesn't want to be involved by sitting away in the corner and refusing to answer questions that are directed at her. Even though the therapist continues to try and engage Brooke and to hold a collaborative position to not be aligned with Tanya, Brooke's refusal to engage appears to push the therapist and Tanya into a pair. This then stops the collaborative process that the therapist is trying to achieve in this final session.

From the SHIFT trial itself, one of the conclusions was that the young people who found talking about feelings difficult might do less well in a family intervention, where such expression is encouraged (Cottrell et al., 2018). When watching these sessions, it appeared to me that both Brooke and Lexi found talking about feelings difficult and that this was not something that was commonplace within their family. This may have meant that the family were less open to the process of family therapy and resulted in the lack of collaboration seen in both of these final sessions. This seems particularly relevant to family 5 where it is Leanne and Lexi who pair up, against the therapist. The resistance that they show by not engaging with the therapists questions, may indicate their resistance to the therapy process overall. They do not thank the therapy team at the end and this may demonstrate that they are rejecting the therapy team, to unite themselves as a family.

Strengths and Limitations

One of the overarching strengths of this research was that the epistemological match between the method of discourse analysis with the intervention of family therapy and the focus of outcome. Even though change is conceptualised within interactional terms in family therapy (Diorinou & Tseliou, 2014), there is very little research looking at the discursive practices within family therapy, especially looking at change, outcome and the therapy process. Therefore, this research has begun to address a gap within the evidence base.

The data set was naturally occurring therapy sessions, which is the gold standard when using discursive psychology (Potter & Hepburn, 2005). This allows the researcher to analyse language within the naturally occurring

context and increases the ecological validity of the research (Potter & Hepburn, 2005). Although the sessions were being recorded, which may have impacted the 'natural feel' of the session, I was looking at the final sessions and therefore, it is likely that they families would then be used to being recorded or may have even forgotten that it was happening.

In addition to looking at the final sessions, I also watched the first sessions for each family to gain a sense of the start of therapy and what the family described at the difficulties in the first session. This added to the context of the therapy as a whole and gave me an understanding of the family dynamics across the therapy. This helps to situate the sample (Elliott et al., 1999) and provides the reader with a broader context than just the final sessions that were being looked at.

As the researcher, I took steps to be aware of what I may bring to the research process and how I may influence it. To understand this, I kept a reflective journal and used supervision to discuss how I may be shaping the research. An example of this is my own expectation of self-harm being a prominent discourse in the sessions. As the data set was sessions of family therapy for adolescents who had engaged in self-harm, I initially believed that this would be a dominant feature of the talk in these sessions. Therefore, I started looking at the self-harm literature, prior to the analysis, to gain an understanding of the current literature. I have also worked clinically with young people who self-harm and their families and thus I was aware that I expected these sessions to include descriptions of strategies to manage self-harm or changes in attitudes to the self-harm behaviour. However, when I came to look at the sessions and transcripts there was very little talk relating to self-harm. In fact, for the first stages of the analysis and the preliminary hypotheses, I did not include any talk on self-harm as it was not being spoken about in the sessions as I expected. It was only then using my reflective journal to think about what I had initially expected from the analysis and discussing this in supervision, that I realised that I was neglecting what was being achieved in the session with the talk (or lack of talk more specifically) regarding self-harm. This reflexivity then allowed me to develop my analysis and hypotheses and look beyond what I was expecting and to what was actually happening in these sessions. I was then

able to recognise that the lack of talk about self-harm, illustrated that the families were prioritising other outcomes and this encouraged me to consider whether this was specific to this particular sample of families by thinking about the role of self-harm in the talk of the first sessions.

There were some difficulties in the process of accessing the SHIFT data, which did impact on the research process and the time frame for the analysis. The SHIFT data is held within the Clinical Trials Research Unit (CTRU) and has been used for a number of thesis projects prior to this. However, the CTRU changed their policy on how the data would be managed and accessed to increase the safety of the data. This change was being implemented whist I was waiting to get access to the data, which meant that even though I had been granted ethical approval from the university and the SHIFT panel had given permission for me to use the data, there was a delay in both myself and my transcriber being able to access the videos. There was a delay of 4 months, where I had ethical approval yet could not access the data. Once I was given access this was more restricted than it had been for previous researchers using this data. The data was stored on an encrypted hard drive stored within the CTRU and so I needed to liaise with the data co-ordinator in the CTRU about when I could go and access the videos. This meant that I did not have easy access to go back and watch the sessions, which I would have been able to with the previous protocol where researchers were given access on the secure drive on the university computer system. This limited access impacted the research process because I was not able to regularly check my thoughts against the session recording and this may have inhibited my analysis.

Due to the time constraints on the project, there were some avenues that could have been explored but were unable to be acted upon. One such idea was to watch the entire therapy for each family to get an overview of the therapy process as a whole, to provide further context for the final session. In addition to this, not all of the non-verbal interactions were included in the transcription process. This may have meant that contextual details were missed or over-looked and the inclusion of all non-verbal communication may have provided a different perspective on the spoken language.

The specific SHIFT outcome results for each family were not available to look at when doing the analysis. However, this may have been useful information to have to be able to put the final therapy sessions into context of what was reported on their outcome measures. These outcomes may have given another avenue within the discussion of these findings e.g. whether there were differences in the outcome measures for the families who collaborated compared to those who were less engaged in the final session.

Although the families were selected at random by the data co-ordinator for the SHIFT project, three of the sessions had the same lead therapist. Therefore it is important to acknowledge that some of the findings may be influenced by this therapist's particular way of working; however all of the family therapists were instructed to use the Leeds Family Therapy Manual (Pote et al., 2001) and adherence to the manual was measured as one of the outcome measures for SHIFT. I did not have access to this adherence data either and this may have be beneficial when looking at the differences between therapists actions. Furthermore, there was a lack of diversity in the families selected. The sample consisted of all white British participants, 5 out of the 6 young people were female and 4 out of the 6 families were mother and daughter dyads. Although the sample is fairly homogeneous, this replicates what is found in clinical practice. The gender split is similar to that seen in the wider SHIFT trial where in the family therapy intervention 89% were female and 11% male (Cottrell et al., 2018). The non-attendance of fathers in family work is a commonly cited problem and it is often lone mothers who are seen attending the therapy with their child (Walters, Tasker, & Bichard, 2001). Furthermore, the lack of ethnic diversity in the sample is fairly consistent with wider clinical population where white British adults are more likely to be receiving treatment for a mental or emotional problem than people in other ethnic groups (Saeidi, 2018).

Clinical Implications

The findings from this research indicate that collaboration and an openness to the therapeutic process supports shared meaning making at the end of

therapy. Based on this, therapists would be encouraged to observe how families were behaving towards the end of therapy; whether they were expressing a readiness to end therapy and whether they were co-operative with the ending of the therapeutic process. The two families where the young person appeared less comfortable discussing their feelings, were also the families where there was less engagement with the therapeutic process overall. Therefore, it will be important for clinicians to address and assess engagement and openness to the therapeutic process throughout therapy, particularly in relation to the young person. Clinicians could use alliance measures such at the SOFTA (Friedlander et al., 2006) to consider the alliance and then take this into account when supporting the meaning making process at the end of therapy. The analysis has identified several actions that therapists take which support the shared meaning making process, which include; fostering realistic hope for the future, empowering the family as well as the individuals, using their position as the expert to amplify change and enhance mastery and to take a mediating position to hold the different perspectives in the room. Therefore, there is a positive implication that if clinicians use and develop these strategies within their practice, that they will be able to support and foster the development of shared meanings of change, outcome and the therapy process.

Another finding from this research was the impact of age and developmental stage of the young person on the therapeutic process. The therapists took different actions in the sessions, depending on how the family were constructing the developmental stage of the young person; i.e. either empowering the parent or the young person as responsible after therapy. Thus, therapists may need to reflect on the constructs of child, adolescence and adulthood and how the family are positioning the young person within this context. Therapists may want to be aware of this within the therapy, particularly when thinking about whether non-collaboration from the young person can be understood in terms of a developmental context rather than one of resistance to the process overall. This research found that in the two families who did not collaborate with the process in the end session, there was a pattern of 'pairing up', even when the therapist tried to maintain neutrality. Therefore, this is something for clinicians to continue to try and

notice and be aware of, if they are being 'aligned' with another person in the session and what this may mean for that family. One of the therapist actions that was positive for the collaborative shared meaning making process, was using their position as the 'expert'. Therapists used this at certain times in the sessions to amplify change and to help construct a positive narrative for the family. Therefore, it may be important for therapists to reflect on how they use their own 'expert' position and the impact it has within sessions with families.

Future Research

This study has added to the evidence base that seeks to understand how shared meanings are negotiated within family therapy. More importantly, it is the first study to date which has looked at how meanings of change, outcome and therapy process are constructed at the end of therapy. As it is the first study to look at meanings at the end of therapy, there are several avenues that can be taken to develop our understanding and knowledge further. The evidence base suggests that developing shared meanings is beneficial to longer term wellbeing (Gewirtz et al., 2008; Saltzman et al., 2013). This research has looked at how shared meanings are negotiated at the end of therapy, but it has not linked this to long-term wellbeing or any reported outcomes on measures. Building on this study, further research could look at the relationship between meaning making of change and therapy process with reported outcome and long-term wellbeing. By looking at measures of outcome, in addition to meaning making it will allow us to specifically understand if and how the processes in meaning making of change at the end of therapy do relate to long-term wellbeing after therapy. Another way to understand the processes in meaning making may be to use Interpersonal Process Recall (IPR) to look at what the different participants describe as important for them in the meaning making process. IPR is a video research method, where a therapy session is recorded and then the participants are interviewed separately and asked specific cuing questions about the recorded therapy session whist being able to watch and control the video (Elliot, 1986). The recording acts as a cue to memory and it allows the participant to reflect on their experience. Therefore, using IPR would

allow a researcher to get an understanding of what the different participants would say contributed to the meaning making process and significant moments within this. This study found differences between the different stakeholders actions in the final session, which either helped or hindered the shared meaning process. By asking the different participants to watch the session and to comment on what they were doing in the session, it may give another understanding of the shared meaning making process at the end of therapy. The SHIFT trial suggested in its conclusion that families who found talking about feelings difficult might do less well in a family intervention (Cottrell et al., 2018) and this was supported by the findings of this study. Therefore, it may be helpful to explore this further and what therapists do to help generate shared meanings when the family are less engaged in the therapeutic process and have difficulties in discussing feelings. Furthermore, alliance has been demonstrated to be a key factor in the success of family therapy. Therefore, it would be interesting to look at alliance measures alongside the shared meaning process and whether this has an impact on the family engaging with this at the end of therapy. From this study there was a clear difference between the families who collaborated at the end of therapy and the two families who were less engaged in working together to create a share understanding. However, we do not know if this was always the case or if something shifted in the therapy process. Further research that looks at the whole course of therapy to understand the shared meaning process will help to develop our understanding of how this is negotiated at the end of therapy and may provide some answers to the questions raised by this research.

Conclusion

The aim of this research was to look at how the participants in the final session of family therapy negotiate their understanding of the therapy process and its outcome. The different stakeholders took different courses of action through language which either helped or hindered this collaborative process. There was a difference found between the families who appeared open to the therapeutic process and therefore took actions which supported the collaborative process and there were two families where there was a

lack of engagement from at least one participant in the session and this was detrimental to the collaborative process. We need further research which looks in depth at what impacts this process and how family therapists can adapt their therapeutic style in light of this. This clarification will allow the practice of family therapy to continue to develop to meet the needs of the people who it is trying to support in the best way possible.

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Appendix 1

Approval to use the SHIFT data

David Cottrell
Thu 13/07/2017, 08:04
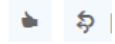
Hi Jessica

I can confirm that your proposal has been approved, please could you let me have a copy of the abstract of your thesis when you have passed your viva. Good Luck, David

Professor David Cottrell
Professor of Child & Adolescent Psychiatry

Please note that I only work two days a week, mostly Mondays and Tuesdays. There may therefore be delays in responding to emails received at the end of the week.

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Appendix 2

Ethical Approval from the university

Faculty of Medicine and Health Research Office
School of Medicine Research Ethics Committee (SoMREC)

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28 September 2017

Jessica Neil
Psychologist in Clinical Training
Clinical Psychology
Leeds Institute of Health Sciences
School of Medicine
Faculty of Medicine and Health
10.91, Level 10, Worsley Building
Clarendon Way
LEEDS LS2 9NL

Dear Jessica

Ref no: MREC16-188

Title: How do the participants in a final family therapy session negotiate their understanding of the therapy and its outcome?

Your research application has been reviewed by the School of Medicine Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the following documentation received from you and listed below.

Document	Version	Date Submitted
Ethical_Review_Form_Thesis_Final_JN	1.0	28/07/2017
Demographic Information for Thesis	1.0	28/07/2017
Transcriber Confidentiality Statement Version 1	1.0	28/07/2017
SHIFT Protocol V10.0_19.02.2016	10.0	28/07/2017
ICD_Young Person 16+_V7.0_2013.08.01	7.0	28/07/2017
PIS ICD_Adults_V7.0_01.08.2013	7.0	28/07/2017
PIS ICD_Young Person_V7.0_01.08.2013	7.0	28/07/2017
ICD Recording FT Sessions_V3.0_2012.02.14	3.0	28/07/2017

Please notify the committee if you intend to make any amendments to the original research ethics application or documentation. All changes must receive ethics approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information (fmhunlethics@leeds.ac.uk)
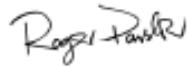
Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, any risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

We wish you every success with the project.

Yours sincerely

Dr Roger Parslow
Co-Chair, SoMREC, University of Leeds

(Approval granted by Dr Roger Parslow on behalf of SoMREC Co-Chairs)

Appendix 3

Example from transcript for Family 3

[Handwritten annotation: TALKING (key of) FT]

175 everything important- it's like, now, really- well, I don't think everything is okay to talk about or, you know, these are the things that are [.] [M: Yeah] All of the things that are trouble to both of you, you

176 feel like they're much more able to sort of say?

177 YP: Yeah (nods)

178 T: Hmm. We need to find a space and a way to talk about that.

179 M and YP: (almost simultaneously) Yeah.

180 M: (To YP) And I think that's [.]- that's better isn't it?

181 Y: Is it?

182 M: I think it's something we still need to work on.

183 YP: Yeah, but it is better though.

[Handwritten annotation: - Checking out with YP - parent saying it's not finished/perfect - YP focusing on improvement]

184 M: It is a lot better- it is. I mean things between us are [YP: Better] so much improved, haven't they?

185 T: And what in particular do you think that's about, what's changed to make that better?

186 M: I think it's just having trust in each other, again and being able to- [YP: (about to speak and then

187 stops herself?) Sorry]. No [laughs] obviously something different, go on, you go first.

188 YP: (to M) No, I just think it's fair that we can say when we want to talk because you used to kind of

189 just put everything on me, and then you take your stress out on me from work and driving and it's

190 like, well, I don't do anything with that [M: Hmm.] and then- I think it's just better that you can talk

191 about it when we're ready, instead of: I'm trying to eat my dinner and you're having a moan at me

192 and I really don't want to listen, so then I get stressed, and then you get more stressed because I'm

193 stressed, and then that's when it- we fight, don't we?

194 M: I suppose- I think what [YP] is trying to say- for me it's just that full realisation of how grown up

195 [YP] is now, and how much I can talk to her more on a level rather than [YP: Treating me like a five

196 year old.] before- [YP: Well, you do.] I don't think I did, [YP], to be fair, I think that sometimes- [YP:

197 Maybe seven or eight year old.] Yeah, but I think [YP: (quietly giggles) You did though.] (To YP) I think

198 the situation before we came here, before everything sort of obviously came out as to what was

199 going on, it was getting very fraught and I would only see- from my point of view I'd only have a

200 chance to talk to you for that five, ten minutes when we're eating and I'd never see you again. So in

201 that ten minutes (turning to T) I threw everything at her I suppose.

202 T: Right, okay (nods), yeah.

[Handwritten annotations: connection trust; how to work together; - Transition & YP growing up]