THERAPISTS' EXPERIENCE OF WORKING WITH NON-REFERRED SIBLINGS' IN FAMILY WORK

Submitted by

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DECLARATION

This work has not been submitted to any other institution or for any other qualification

STRUCTURE AND WORD COUNT

Target Journal

Both the literature review and research report in this thesis have been prepared for and with respect to guidance for The Journal of Family Therapy. This peer reviewed journal was approved by the University of Sheffield (see appendix 1. for author guidelines and journal approval letter)

Word Counts

Literature Review

a) 7, 991	Without references and appendices
b) 9,044	With references and appendices

Research Report

a) 11,989	Without references and appendices
b) 16,112	With references and appendices

Critical Appraisal

a) 3,246	Without references and appendices
b) 3,261	With references and appendices

ABSTRACTS

Section one – Literature Review:

Understanding Clients' Experience of Family Therapy: A Review of the Literature

This section is a critical review of the available literature investigating how clients experience family therapy sessions. All the literature reviewed was qualitative and a number of themes could be seen across clients' experiences. The quality of the research was judged using guidelines to which and indicated that there is a great degree of variability in the extent to which qualitative papers meet these guidelines. The clinical implications and future directions are discussed.

Section two – Research Report

Therapists' Experiences of Working with Non-Referred Siblings In Family Sessions

This study explores therapists' experiences of working with non-referred siblings in family sessions and explores the processes which therapists have to manage when working with non referred siblings. Eight therapists were interviewed and these were analysed using Grounded Theory. The overarching theme that emerged from participants' accounts was 'a complex and demanding balancing act'. Four main themes were related to this, (1) barriers to working with siblings, (2) the benefits of involving siblings, (3) therapeutic tools and techniques and (4) change. These themes influenced the extent to which therapists felt able to involve siblings. The methodological limitations of the study were also discussed as were the implications of the research in clinical work and on future research.

Section three – Critical Appraisal

This is a reflective account on the research process and the learning which resulted from this.

ACKNOWLEDGEMENTS

I'd firstly like to thank the therapists who gave their time willingly and spoke with such honesty and many thanks to Prof Gillian Hardy, for her guidance through the many twists and turns this project has taken me through. A million thanks to Mum, Dad and Sarah, for their constant comfort when things were going wrong and their enthusiasm when they weren't, and to Toby for being a super effective distraction. Finally, a huge thank you to Lee, whose never-ending support and reassurance has kept me going from the very beginning of this research project until the last full stop.

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SECTION ONE: LITERATURE REVIEW

'Understanding Clients' Experience of Family Therapy: A Review of the Literature'

Understanding Clients' Experience of Family Therapy: A Review of the Literature

ABSTRACT

Background: There is a great deal of research which compares the effectiveness of family therapy models from a service or clinician perspective. However, there has been less research which attempts to understand clients' experiences of specific therapies in greater depth outside the realm of effectiveness and outcomes.

Aims: This literature review aims to draw together research which has investigated clients' experiences of attending family therapy to gain comprehensive understanding of the processes which affect their experiences. As all literature found used qualitative methods, the quality of the literature was compared to publishability guidelines to assess the strength of literature.

Method: Relevant studies were identified through literature searches across a number of electronic databases, Google Scholar and by following up cited references.

Results: This review identified 16 papers which explored clients' experiences of family therapy, all of which used qualitative research methods. Commonality in themes reported across studies was found, which added greater validity to the findings of the small scale qualitative studies. Methodological limitations included lack of cohesiveness drawing themes together and a lack of reporting the management of threats to validity and reliability in qualitative research.

Conclusion: There are clear themes across qualitative research which can inform clinicians, who use family therapy models, how families understand their experiences. This learning can be taken forward clinically to help clinicians consider the impact of this on future work with families.

Introduction

Much of professionals' knowledge about clients' experiences of therapy has come from discussions between clinicians and theorists (Kruger, 1986; Fessler, 1983; Napier & Whitaker, 1978). However cultural and political shifts have encouraged the empowerment of clients in service development by helping professionals learn from their experiences through monitoring, assessment and evaluation (Pinsoff, 1988). A lot of feedback from families has come from outcome studies which have used empirical research designs which have compared effectiveness in a 'comparative-competitive' manner in an attempt to assess and evaluate models, cumulating in pronouncing which 'won' (Sells, et al 1996). Within family therapy there have been numerous studies looking at effectiveness and meta-analyses of these studies have shown positive post treatment effects (Shadish, et al 1993). However there have also been studies which have explored clients' experiences to a greater depth. Asking clients about their experiences can help therapists to think about and consider aspects of therapy from a client's perspective, and identify which experiences can be helpful and the factors that can be disruptive or damaging.

The central question within this literature review is 'what has research taught us about family experiences across the field of family therapy?' The review aims to use literature to explore current understanding around clients' perceptions of therapy within the family therapy model and assess the quality of the literature against guidelines for qualitative research (Elliott et al (1999). The review begins by clarifying the definitions used and the search criteria. A summary table of the papers reviewed is presented followed by discussion of the themes across studies and comparison of the studies to guidelines for qualitative research. The implications clinically and for future research are discussed.

Defining Family Therapy

Family therapy has developed over a number of years, beginning with common thinking around systems theory and developing across a number of directions resulting in family therapy becoming an umbrella term for numerous broadly similar approaches. This variety presents a difficulty in defining or providing an overview of what family therapy consists of and it is even difficult to determine particular approaches as used in therapy (Shadish et al, 1993) or to find any impact of different approaches on the outcome of therapy (Stratton, 2005).

The definition of family therapy put forward by the Association for Family Therapy (AFT) reflects the range of therapists that fall under its theoretical umbrella and offers the following definition:

'Family therapists help family members find constructive ways to help each other. They work in ways which acknowledge the contexts of people's families and other relationships, sharing and respecting individuals' different perspectives, beliefs, views and stories and exploring possible ways forward' AFT (2008)

Although the majority of current models pay particular attention to culture, ethnicity, gender and wider physical and societal contexts (Stratton, 2005) in the reality of clinical practice this incorporates a number of ways of working with families. From more traditional and functional models such as structural family therapy that specifically looks at hierarchy, to narrative ways of working which focus on the meanings and beliefs which are held by families.

For the purpose of this literature review family therapy is defined in its broadest sense, in that any model or form of family therapy is considered appropriate for inclusion within this review. It is acknowledged that by its very nature this may mean that families may experience different ways of working and the impact of this on the findings of the studies reviewed is acknowledged.

Defining 'Quality' research: Criteria for judging papers

All studies found for this review came from one of two qualitative traditions. Ethnographical research is rooted in anthropology and involves researchers exploring social and cultural interaction by immersing themselves in the field over time (Erickson, 1986). Phenomenological tradition is rooted in psychology and explores beliefs and meanings (Hoshmand, 1989). With qualitative research there are limitations which include cognitive limits around data analysis, selective bias and first impressions holding a greater weight (Lauer and Asher, 1988). Qualitative research when accounting for these can gain validity in its detail and focus meaning that a great deal can be learnt about a specific group. Although findings cannot be generalized to larger populations they can be taken forward in quantitative investigations.

Steps taken to achieve validity and reliability steps should be clearly reported and the papers in this review were examined in relation to publishability guidelines from Elliott et al (1999). Elliott et al (1999) published seven guidelines (see table one) of which six are used. The guideline around resonance for the reader, which is the extent to which the findings inform the reader, was not included as this is largely subjective and individual and likely to change from reader to reader.

Table One: Guidelines to assess the quality of literature reviewed (Elliott et al. 1999)

1. ***Owning one's perspective*** –Disclosure of values helps readers interpret researchers' data and consider possible alternatives.
2. ***Situating sample*** – Description of participants to help the reader judge the range of persons and situations where findings might be relevant.
3. ***Grounding in examples*** – Examples of the data to illustrate analytic procedures and the resulting understanding.
4. ***Providing credibility checks*** – Includes checking understandings with participants, using multiple analysts, comparing two valid qualitative perspectives and triangulation.
5. **Coherence** – Coherence and integration in that understanding fits together to form a data-based story/narrative map or framework e.g. using diagrams.
6. ***General vs specific research tasks*** – Clear description of the task, applicability of the conclusions and limitations.
7. ***Resonating with readers*** – Readers judge findings to accurately represent the area, or have clarified or expanded their appreciation.

Using guidelines such as those proposed by Elliott et al (1999) can be useful in providing guidance to help readers evaluate qualitative work. However there are also limitations to such checklists which need to be considered. Several papers have proposed that using checklists in a purely prescriptive way can be unhelpful in that they are too narrow and do not allow for the creativity and individuality of qualitative research and that a 'one size fits all' approach is not appropriate (Barbour, 2000; Mays & Pope, 2001). Therefore it is acknowledged that Elliott et al.'s guidelines are used to look generally at aspects which contribute to quality.

Search Criteria and Method

Papers were sought from a number of databases, using a combination of search terms. Databases used included Web of Science (WOK), PSYCHINFO, Psycharticles, Cochrane Library, Cinahl, AMED, and Google Scholar. The following search terms were used:-

- Patient/Client/families understanding of Family Therapy/Family Work
- Patient/Client/Families experience of Family Therapy/Family Work
- Patient/Client/Families perceptions of Family Therapy/Family Work

The results from databases were reduced using advanced searching techniques to combine searches to exclude papers that not meet the criteria outlined in table 2.

<u>Table Two: Inclusion and Exclusion Criteria</u>

Papers considered useful: • Research published in peer reviewed journals or book chapters • Research using participants who had attended therapy as part of a couple or family – research using participants of any age, including children and adolescents, were included. Studies were excluded if: • They focused on experience of individual therapy • They were published before 1980 – the changes in the field of family therapy and the increasing interest in research into client experiences indicates that the most useful research in this area has been published since this date. • Unpublished dissertations

Suitable papers were collected and further papers cited within articles were followed up. A total of 19 studies were found, 16 of which met the criteria. All used qualitative methodologies, seven interviewed couples, three examined children's experiences, four spoke to whole families and two used a mixture of couple and family cases.

Two papers (Burck, 1978 and Lishman, 1978) were not included as they were carried out before 1980 and were based within families' experiences of social work as opposed to family therapy. A study looking at therapists' reflections (Smith et al, 1992) was rejected as this review looked specifically at clients' experiences.

Critical Review of Literature

Table three summarises the sixteen papers reviewed. As can be seen, a variety of different family therapy models were experienced by families across the literature, however there was commonalities within experiences across different approaches.

Table Three: Summary of literature and main themes

Source	Research Aims	Model	Methodology	Participants	Results	Limitations
Bowman and Fine (2000)	- Helpful/ unhelpful activities. - Are opinions of helpful/unhelpful aspects shared	- Social constructionist, narrative, feminist solution focused	- Discovery orientated - Face to face interviews - Analysed using grounded theory	- 5 couples - 4 of whom were still engaged - Sessions ranged from 5-40	Helpful - 1. Trust 2. Structure 3. Equality 4. Refocusing 5. Gender 6. Making links. Unhelpful - 1. Inequality 2. Over talking 3.Session length	- Few unhelpful aspects were identified - Therapy at different points - Large range of attended appointments
Bischoff, R., and McBride, A (1996)	-Client perceptions during treatment - What was helpful /unhelpful and improvements	-Solution orientation, insight orientation.	- Therapists interviewed own clients (videoed) - Key segments transcribed - Constant comparative method.	-28 clients from family and couple cases. -The mean number of sessions 11.26 (range 4-23)	1. Hierarchy within the therapist/client relationship 2. Empathy and ingredients of good therapy 3. Therapy techniques	- Participants interviewed by own therapists
Christensen et al, (1998)	Explanation of change processes in couples therapy	- Trainee therapists curriculum covered various models	- Individual interviews - Constant comparison method	- 13 couples - Between 6-30 sessions - 9 therapists	1. Change in affect, communication and cognition. 2. Conditions for change	Clinicians were student therapists
Helmeke and Sprenkle (2000)	Couples' experiences of pivotal moments	Student using eclectic approach	- Multiple sources of data - Couple interviewed after 10 sessions - Constant comparative method	- 3 couples	1. Pivotal moments at all stages 2. Clients and therapists - different moments 3.Repetition and therapist characteristics.	- Clients knowledge of aim of research
Howe (1989)	Explore the families' problem, route to services and experiences	'brief', 'systemic', 'structural' and 'strategic'	- Interviewed at home – mostly whole families. - Identified concepts and categories	- 32 families - 10 non attenders - 22 attenders	1. To engage 2. To understand 3. To be understood	- Lack of explanation about analysis
Lobatto, (2002)	Childrens' experience of family therapy and investigate parental presence in interviews	- Family sessions with CAMHS workers	-Qualitative study using grounded theory -Interviews took place between 3-6mths post treatment	-2 girls and 4 boys aged 8-12. -Interviewed at home with parents present	1.The position of children in family meetings 2. Strategies for participation, 3. Defining problems in family context 4.The importance of toys and play	- Lack of clarity about approach

Table three - continued

Source	Research Aims	Model	Methodology	Participants	Results	Limitations
Merrington and Corden, (1981)	- Expectations at referral - Therapists and approach to problems - Examine impact of therapy	Passive-reactive.	- Structured interviews. - Caseholder was interviewed. - There was no information analysis.	- 8 families all attended 3 conjoint sessions and treatment terminated for more than 3 but less than 15mths.	1. Little knowledge about services 2. Perception of therapist role changed 3. The child mostly seen as the problem before and after therapy 4. Variation in outcome.	- No detail in analysis - Delay may effect recall
Metcalf et al (1996)	What aspects of solution focused couples therapy helped change to occur	- Solution focused	- No information on analysis	- 6 aged between 25-65. - Eligible if they agreed that therapy was successful	1.Therapists role and what happens 2. Why clients sought therapy and termination 3. Change process and what works	No information on analysis
Newfield et al (1991)	Provide feedback to therapists about families experiences in family therapy	-Structural/ strategic	- Analysis developmental research sequences and domain analysis. - Analysis was subject to validation until experiences represented common experience	- 12 families including 12 mothers, 8 fathers and 17 adolescents - All were attending a program due to adolescent drug abuse.	1.Expectations of counselling 2. Types of psychos and shrinks 3. The setting 4. Individual vs family therapy 5. Counsellor characteristics 6. Adolescent 'bullshitting' 7. Stages of counselling	- No detail on researcher - Unclear whether re-interviews were to check validity
O'Connor et al (1997)	Discovering what clients found helpful/unhelpful	- Narrative	- Interviews at various stages of treatment - Coded using latent and manifest content analysis developed through grounded theory approach..	- 8 families - Whole families in 4 cases, parents only in 4	1. Externalising conversation 2. Unique occurrence 3. Personal agency 4. Audience 5.Unhelpful/helpful aspects 6.Reflecting team	- No acknowledgement of limitations - Interviews at different points of therapy
Sells et al (1994)	Couple and therapist experiences of reflecting team practice	No information	- Developmental research sequence. - Interviewed twice - Therapists participated in group discussions. - Domain analysis to code and categorise data	- 7 couples and 5 therapists - The reflecting team consisted team members, all of whom were doctoral students.	1.Benefits of reflecting team 2. Effects of gender 3. Recommended use 4. Contraindicated use 5. Spatial separateness 6. Sequences of communication that elicit change	-Student therapists

Table three- continued

Source	Research Aims	Model	Methodology	Participants	Results	Limitations
Sells et al (1996)	- Explore client and therapist evaluations - Asked opinion on the research process	- Therapists taught 4 models	Option 1-Therapists interviewed own clients immediately post session Option 2 - Therapists and different clients interviewed by researcher - Analysed using domain analysis	- Option 1 - 3 couples, 1 family and 3 individuals -Option 2 – 3 couples, 2 families and 2 individuals - Therapists attended focus groups	1. Change associated with therapist qualities 2. Effective and ineffective interventions	Clinicians were student therapists
Smith et al(1993)	Couple's opinions of reflecting teams	- Trainee therapists -Various models including structural, strategic	-Constant comparative methods used to code data and define themes	-Reflecting team - 3 students - 11 clients interviewed	3 understanding reflecting teams, helpful aspects, clients understanding of the limitations	- Variation in the number of sessions
Stith et al (1996)	Explore pre-adolescent children's experiences of family therapy	Structural-strategic, problems centred	- Children interviewed twice and parents or siblings interviewed to validate experiences - Used the constant comparative method	-16 children from 12 families aged between 5 and 13	1.Videotaping and live supervision 2. What children understand 3. How children describe what happens 4. What changed	- Children were still in ongoing therapy
Strickland –Clark et al (2000)	To explore the nature of children's experience of being in family therapy	- Children who had attended at two family therapy clinics	-Interviewed post session. - Constant comparison used and significant moments using comprehensive process analysis.	-5 children aged between 11-17 identified as the index patient -Children interviewed alone -Therapists interviewed regarding significant moments	1. Not feeling heard, 2. Coping with challenges 3. Bringing back memories 4. Difficulties contributing 5. Bad reactions 6. Feeling free to speak 7. Needing support in session	-Interviewed post session – impacted on recruitment.
Wark, (1994)	Aspects perceived by therapists and couples as helpful to meaningful change	-Trainee therapists - 2 experiential, 2 solution focused and one structural	-Interviewed clients and therapists after each session - Induction and constant comparative method to result in a focused set of categories.	-5 couples and their therapists were interviewed -Interviewed after each session -Researcher observed the sessions before interviewing couples.	1. Therapists and clients saw different aspects helpful. 2. Therapist views based on model concepts.	- All clients reported impact on quality and effectiveness

Expectations of Family Therapy and The Construction Of The Problem

Expectations emerged as a prominent theme, often with clients who had experienced family therapy for child focused problems. Newfield et al (1991) interviewed twelve families and overwhelmingly clients felt that therapy would be a sombre experience with many adolescents' expectations based on therapy they had seen on television. Families also expected to be 'questioned or grilled' with the focus entirely on the adolescent. Parents reported expectations of professionals offering solutions and 'quick fixes' and on actual experiences of therapy there were mixed feelings around the therapists not providing these. To some this was frustrating and a 'cop out', whilst other parents found this helpful and an indication of a 'good' counsellor.

Merrington and Corden (1981) interviewed families who had attended a child guidance centre and also found expectations of families were different to reality. Eight families were interviewed, and none of the families recalled receiving any guidance or information on what to expect from the clinic, saying that they felt 'uncertain and ignorant'. They also reported that families expected the child to be seen alone and although some had expected one group session, they had expected the focus to return to the young person.

Newfield et al (1991) also reported that clients saw individual therapy as the 'optimal solution' and individual work was viewed as being 'deeper' or as an environment to confess 'secrets'. This was specifically seen by parents who felt that adolescents would speak freely due to the 'generation gap'. Even post therapy parents in Newfield et al's (1991) study believed that individual work was more appropriate and would more likely get 'the root' of the problem. When families felt that the problem was individual they appeared to ignore systemic work and felt misunderstood.

These studies suggest a divergence in problem perception between the theoretical stance of family therapy and the perspective of families attending sessions. This theme is strengthened by

Lobatto (2002) who found that even post-therapy all children took 'possession' of the problem and were reluctant to refer to their parent's participation in the problem. Merrington and Corden (1981) also report that post-therapy five of the eight families they interviewed still viewed the problem as being placed within the child. Stith et al (1996) reported similar problem perception to the other papers suggesting that they saw attendance to be a result of child focused difficulties although one younger child thought that they were attending sessions due to parental conflict. Further support was shown by Howe (1992) who interviewed 10 families who had been offered family therapy and had declined or not attended and 22 families who had attended. All families had been referred for child focused difficulties and parents felt that they wanted 'something done', which reflects similarities to previous studies in client's expectations of therapy as a 'fix'.

O'Connor et al (1997) interviewed eight families who attended family sessions using a narrative approach and showed an alternative perspective in which the construction of the problem was not placed within the referred child. Instead references to the problem were through externalizing conversations, a technique whereby the problem is separated from the person and constructed as being present in the family system. However the flaws in this research make it difficult to assess the impact of its differential findings as it was conducted and analysed by clinicians in narrative therapy. Also there is no reporting of the steps taken to prevent this orientation biasing analysis and all themes closely fitted the model. It would have been helpful for further information on the steps, which were taken by researchers to prevent bias.

Position in Family Therapy Sessions: Power and Hierarchy

The influence of hierarchy and power and the strategies adopted to manage these was also a theme across literature. Papers interviewing only children revealed interesting concepts around children's perceptions of their position and the strategies they use to manage competing demands. It emerged that children juggled perceived expectations with of parents and therapists

(Lobatto, 2002, Strickland-Clark, 2000) with being involved without being the centre of attention (Lobatto, 2002; Stith et al, 1996). A number of strategies that children used to balance these aspects emerged across the literature. Lobatto (2002) found that while children tried to participate, when uncomfortable they used strategies such as being quiet, playing with the toys or with other siblings to deflect attention. Strickland-Clark et al (2000) also reported children going to play with siblings and seeking support when they were uncomfortable. Adolescents in Newfield et al's (1991) study reported more sophisticated strategies with which to maintain their position. A strong theme which emerged was that of 'adolescent bullshitting' which was described as a strategy employed by adolescents to 'trick' their families and therapists in sessions that they were making progress.

Themes around power and position in family therapy were also pertinent when couples were interviewed and divergent themes were reported across studies. Bischoff and McBride (1996) interviewed 28 clients from couple and family cases, clients were interviewed by their therapists and were at different points in their therapy when the interviews took place. One of the predominant themes was the hierarchy of the relationship between clients and therapists and it was reported that clients had a keen sense of power differences. Clients would often defer to their therapists to set the direction sessions, even postponing their own needs. Clients reported that they favoured this approach and, even when frustrated by the direction of the session, they remained faithful to the clinician's position as the expert, although the children within the study reported greater frustration at the therapist led agenda. However, research interviews were held at different points of therapy and were conducted by clinicians working with families which may have impacted on the information shared by families as the perception of the therapists as experts is likely to hold within the research capacity. Families would also be continuing sessions and may have felt unable to criticise the 'expert' therapists.

Alternatively O'Connor et al (1997) found that families were being treated as experts on their own problem, a position they found particularly helpful. This was also pertinent for Bowman and Fine (2000) who interviewed 5 couples with between 5 and 40 sessions of couple's therapy. These couples reported that one of the most helpful aspects was being able to determine their own session focus and find answers whilst not feeling pressured or being expected to arrive at a particular outcome. However, they too hinted at some power of the therapist in that one of the few unhelpful aspects identified was not being able to talk when they wanted because the therapist was talking.

Metcalf et al (1996) looked at couples' experiences of brief solution focused therapy (BSFT), a technique which focuses on strengths and positives in relationships. Although the study does not clearly discuss therapist power and hierarchy there are elements around termination of sessions which suggest that clinicians are seen in a position of power. Metcalf et al (1996) found that clinicians and their clients had very different views of the termination of sessions. Therapists saw this as collaborative, in line with the assumptions of BSFT but clients felt this decision was in the hands of the therapist and some were unhappy with this decision.

Characteristics of the Therapist

Wark (1994) interviewed 5 couples and their therapists immediately after sessions and one of the themes which emerged was the factors and skills the therapist should have personally. Clients overwhelmingly felt that therapists' warm, empathic, casual nature were important in helping them feel relaxed and able to work (Wark, 1994). They also thought therapists should be open and honest and not afraid to ask direct questions. Interestingly, follow up interviews after completion of work found that research had allowed clients to feel empowered which enhanced the quality of their therapy. Whilst useful clinically, this shows that interviews session by session impact on, become part of and therefore change the phenomena being investigated, meaning that these sessions may have been very different to those usually experienced.

Bischoff (1996) reported that therapist empathy and understanding were valued in therapy and lead to the statements therapists made having greater impact. Stith et al (1996), Merrington and Corden (1981), O'Connor (1997) and Bowman and Fine (2000) also showed themes recognising therapists need to be friendly, approachable, warm, respectful and kind. Although some Merrington and Corden (1981) also spoke to families who had hoped the therapist would be more direct and give constructive advice.

Helmeke and Sprenkle (2000) interviewed 3 couples after 10 sessions of marital counselling using clips of therapy which the clients had identified as pivotal in post session questionnaires. One factor which was seen to contribute to pivotal moments without being pivotal itself was characteristics of the counsellor. The couples highlighted positive reinforcement, trusting the therapist, feeling comfortable and the ability of the therapist to offer own perspectives and thoughts. Newfield et al's (1991) study also indicated that therapists reflecting on their own experiences were important as were characteristics such as warmth and empathy. It emerged that adolescents preferred counsellors who had had some experience of drug abuse as they felt this would help them feel understood. Bischoff and McBride (1996) also highlighted the importance of mutual involvement and disclosure. Therapists sharing their perceptions and opinions seemed to be an important marker of their own commitment and investment in family sessions, a further theme which emerged across papers. This was seen within Newfield et al's (1991) study which found that the families who reported success tended to comment on moving more towards a partnership as time evolved and this was facilitated by feeling listened to and that the counsellor cared abut the outcome with the family. Those families that did not feel that they had progressed spoke of more negative therapeutic relationship qualities such as feeling that the therapist was unsympathetic or even unkind.

Therapeutic Techniques

A frequent theme across literature was therapeutic techniques. Some were model specific and only appeared in one paper, for example narrative techniques in O'Connor's (1997) narrative paper whilst other techniques were reported across the literature

Reflecting Teams

Reflecting teams are a group of team members who observe sessions either in the room or from behind a screen. They discuss what they have heard and seen with the therapist or amongst themselves; usually the family watches and hears but do not converse with the team. Smith, Yoshioko and Winton (1993) looked specifically at eleven couples' experience of reflecting teams. The benefits of multiple perspectives emerged as a theme, and it was thought that having lots of feedback could offer a number of perspectives and even disagreement between members of the team could be reassuring in normalizing the importance of different points of view. Stith et al (1996) used videotaping and live supervision in sessions and found that children said they liked working with the team but clearly explaining the reason for the team was important with younger children, including letting them meet and see the technology.

Sells et al (1994) interviewed seven couples on their experience of reflecting teams and similarly echoed the theme that a reflecting team offers more perspectives and opinions and that these were valuable to clients as this helped them to view the problem differently. Sells et al (1994) found that therapists and clients disagreed on what they didn't find helpful as therapists felt that teams were not helpful when there were no issues or crises to work on and that at this point they were surplus; however clients continued to see them as useful at this point as they offered positive reinforcement. The clients interviewed by Sells et al (1994) also commented that they found the process more comfortable when the reflecting team were in the room and not behind the mirror as it helped to see them and feel listened to.

In Newfield et al's (1991) study some families initially referred to the team and recording equipment as 'the jury', feeling they were intrusive. In this study less weight was given to the reflecting team, with families suggesting their opinions were useful when they agreed with the therapist, but not when they diverged as the families deferred to the therapist with whom they felt they had a greater relationship. Further limitations to reflecting teams can be seen in Smith et al's (1993) study in which they echoed the theme of feeling that the team could be intrusive and sometimes felt that they were side tracked by individual biases or prejudices.

In Session and Out of Session Tasks

A second therapeutic technique discussed was the use of therapeutic tasks. Two types of tasks were mentioned, those given in session (e.g. experiential activities such as family sculpts) and those to be completed outside sessions. Bischoff and McBride (1996) differentiated between the tasks and reflected on the importance of in-session tasks as a way of facilitating children's involvement in the session and giving them means to communicate. Similarly Lobatto (2002) spoke about the importance of therapeutic games and toys to help communication. Newfield et al (1991) discussed out of session tasks, which were met with mixed participation, some families finding them useful, others less so. Interestingly it was within this context that 'adolescent bullshitting' was strongest as adolescents spoke about the ways in which they would sabotage the family's participation in the task.

The Progression of Therapy and Therapeutic Change

Change in therapy was a theme through many papers. Sells et al (1996) explored client and therapist evaluations of therapeutic sessions using two design options. The first consisted of three couples, one family and three individuals all of whom were interviewed by their own therapists immediately following a session. The second involved the same therapists and three couples, two families and two individuals but in this design they were interviewed by a researcher and not their therapists. From the analysis clients were able to identify specific areas which had improved as the result of the sessions, these included better communication and insight into presenting problems and these were reflected by the therapists who also identified these areas in which they had seen change. Ineffective moments related to treatment having unclear goals or direction or clients feeling that the therapists did not directly address their difficulties.

Specific therapeutic activities were seen to be related to therapeutic change, as previously noted therapeutic tasks such as homework assignments were a way to build upon progress made in sessions and changes as result of counselling including gaining more perspectives and insights. Clients also noted that therapists noting and making adjustments helped to facilitate change, although it is acknowledged that the therapists who had done the interviews had learnt from the ethnographic interviews and made adjustments accordingly. As with Wark's (1994) study this indicates a useful clinical role for these types of interviews mid therapy, but may have changed the phenomena under investigation so that it is significantly different from the experiences initially being explored.

Christensen et al (1998) interviewed 13 couples, interviewing each person separately. Three clusters were identified and were changes in affect, communication and cognition. Changes in affect related to feeling more able to express emotions and feelings and increase in communication skills was helpful in allowing these feelings to be expressed. Finally increasing cognition through awareness and insight into the multiple perspectives helped clients to appreciate circumstances and connections. All these areas were interlinked in helping clients to make changes. Themes which related to aspects which facilitated these changes were inline with previous themes across research including therapeutic relationship, the safety and trust which a strong therapeutic alliance created and therapist skills in pacing and normalizing in sessions.

The Quality of Research

This review has indicated the themes found across these small scale qualitative research studies which explore client experiences of family therapy. Repeated emergence of these themes helps to strengthen them which is not possible with individual qualitative studies. This section looks at the literature to ascertain the extent to which it meets guidance from Elliott et al (1999). Table four illustrates a summary of this.

Table Four: Comparison of literature against qualitative guidelines (Elliott, 1999)

Paper	Owning own perspective	Situating sample	Grounding in examples	Providing credibility checks	Coherence	General vs specific research tasks
Bowman and Fine (2000)	* Clear description of orientation	* Clear description of sample	* Description of methodology but no example * Quotes used	* Couples received written summaries of codes to comment on * Consultation with others during analysis	* No diagrams or consideration of how categories interact.	* Acknowledges specificity of interpretations and where applicable
Bischoff and McBride (1996)	* Clear description of orientation	* Clear description of sample	* Constant comparative method briefly described but no examples in action * Quotes used	* Two analysts of data	* No diagrams or consideration of how categories interact.	* Clear outline of limitations of study and areas where results may be applicable
Christensen et al (1998)	* Description of qualification but not orientations/values	* Clear description of sample	* Description of methodology – no examples * Some quotes used	* Multiple analysts of data	* Some consideration of how themes fit together – no diagram	* Acknowledgement of limitations of credibility to this setting
Helmeke and Sprenkle (2000)	* Clear description of researchers assumptions and possible biases * Reflexive diary kept	* Clear description of sample	* Description of stages of analysis	* Multiple data sources * Met with couples to check credibility	* Relationship between themes discussed – no diagram	* Acknowledges limitations of findings to specific setting
Howe (1989)	* No description of orientation/values	* Clear description of sample	*Clear description of analysis * Quotes used	* No evidence of multiple analysts or checking with clients	* Description of how themes fit together	* No acknowledgement of limitations of interpretations
Lobatto, (2002)	* Description of sensitizing assumptions	* Clear description of sample	* Description of analysis- no examples * Quotes used	* Multiple interviews to explore codes	* No diagrammatic examples or discussion of how themes interact	* No acknowledgement of limitations of interpretations
Metcalf et al (1996)	* No description of the researchers	* Limited description of sample	* Some basic description of analysis – no examples * Quotes used	* No detail on checking for credibility	* Comparison of all themes to BSFT theory	* Acknowledges limited scope
Merrington and Corden, (1981)	* No description of researcher orientation/values	* Clear description of sample	* No explanation/example of analysis * Quotes used	* Multiple data sources e.g. interviewed therapists	* Describes codes individually - not how they interact	* Acknowledges limitations of interpretations

Table Four: continued.

Paper	Owning own perspective	Situating sample	Grounding in examples	Providing credibility checks	Coherence	General vs specific research tasks
Newfield et al (1991)	* No description of researcher orientation/values	* Clear description of sample	* Clear description of analysis and examples * Quotes used	* Multiple interviews but unclear whether findings checked	* No diagrammatic examples of how domains interact	* Acknowledges limitations of generalizability
O'Connor et al (1997)	* Limited description of researchers * No exploration of the impact of orientation/values	* Clear description of sample	* Brief description of analysis but no example of this in action * Quotes used	* Used outside expert in analysis through principle of triangulation	* Discreet codes -no discussion of how these fit together * No use of diagrams	* No acknowledgement of limitations of findings
Sells et al (1994)	* Clear description of researchers and steps to control bias	* Clear description of sample	* Clear description of analysis and examples * Quotes used	* Findings from initial interviews verified by participants * Multiple sources of data used	* No diagrammatic examples of how domains interact	* Acknowledged results may be idiosyncratic to the clients and therapists
Sells et al (1996)	* Described role of researcher and prior experience	* Clear description of sample	* Clear description of analysis with examples * Used quotes	* Findings checked with participants * Multiple data sources	* Core categories and sub themes discussed separately	* Acknowledges context specificity * Warns against inferring findings to wider populations
Smith et al (1993)	* Described researcher experience and role in context	* Clear description of sample	* Brief description of analysis * Quotes used	* Multiple analysts	* No diagrammatic examples of how categories interact	* Acknowledges care needed in interpretations
Stith et al (1996)	* No description of the researchers	* Clear description of sample	* Clear description of the steps used in analysis * Quotes used	* Multiple analysts * Multiple data sources	* No diagrammatic examples of how domains interact	* Acknowledges specificity of findings
Strickland–Clark et al (2000)	* No description of researchers' experiences or orientations	* Clear description of sample	* Description of analysis – no examples *Quotes used	* Multiple interviews but unclear whether codes checked for validity	* Discussion of interaction of themes but no diagrammatic example	* Acknowledgment of limitations of small small size
Wark, (1994)	* Using research approach supported by feminist researchers – no further description	* Clear description of sample	* Clear description of analysis * Examples used but fewer quotes	* Interviewed about research process – unclear whether findings were checked out * Single analyst	* No diagrammatic examples of how categories interact	* Acknowledges that small *n* studies have limitations

Table four clearly illustrates that there is wide variation in the extent to which qualitative research meets the guidelines set out by Elliott et al (1999). However there are some commonalities:-

Owning own perspective

Seven studies reviewed offered no description of the researcher when presenting their research and further studies offered limited or partial descriptions. It is important that readers can access information about the researcher in order to interpret their findings in respect of the context from which they were written. Reflexivity of the researcher on their orientation and assumptions also increases validity and tells the reader how bias has been addressed. Five papers did not acknowledge reflexivity at all and a number of other papers acknowledged bias without clear indications of how this was dealt with. Only Helmeke and Sprenkle (2000) detailed how this was managed within the study using a reflexive diary. It maybe that other studies used similar methods to ensure reflexivity but did not explicitly report the use of this. In future qualitative studies it may be helpful for researchers to explicitly state their perspective and the ways they attempted to assure reflexivity and include examples.

Situating sample

All papers were strong in their description of the clients who were interviewed which helps to ground the studies into the situation in which the data was collected. Although this does not mean that these themes will necessarily be found across similar situations, it does mean that readers can understand the sample in which the data was collected and where these findings can be seen to be relevant.

Grounding in examples

To add further validity to findings, research is supported by clear descriptions of how themes emerged from the data, the processes used to extract them and evidence from original text to illustrate their presence. Literature in this review showed strength in the use of quotes to 'ground' findings within the original transcripts with all papers using quotes. However there was less reporting of analysis procedures in detail and few presented the process they used, with examples. Although it is acknowledged that space in publications is limited, it would be useful for readers to be able to access examples of the stages of analysis through appendices or diagrams.

Providing credibility checks

Credibility can be strengthened through re-interviewing, checking findings with participants, multiple analysts and using multiple data sources to collect information. Interviewing to check out interpretations and ensure that these represented what the clients had experienced was demonstrated by six studies including Sells et al (1994, 1996), Helmeke and Sprenkle, (2000) and Lobatto, (2002). Bowman and Fine (2000) sent clients a detailed copy of codes on which they could comment and change if necessary. There was a lack of clarity around checking in other studies. In studies when clients were interviewed after each session, which does indicate multiple interviews, it is not stated whether these interviews allowed interpretations to be checked out and although Christensen et al (1988) states that interviews continued until no new data was found it is not stipulated whether this was new interviewees or returning to previous interviewees.

Multiple sources of data were used across literature, and included interviewing other family members (Stith et al, 1996) and using field notes (Helmeke and Sprenkle, 2000) and most frequently, interviewing therapists and clients about the phenomena. Multiple analysts were also frequently used, as much of the research was completed in research teams which facilitated multiple analysts which helps balance bias in analysis.

Coherence

Qualitative papers should be able to clearly state the understanding that they have drawn from their findings in a way that allows readers to understand the categories and how they link together to create the framework of understanding. Elliott et al (1999) recommend the use of diagrams or figures to illustrate this clearly. Within the literature, whilst there were very clear descriptions of themes, the extent to which this was 'drawn' together to look at the interactions between codes was limited. Whilst some papers did do this in discussion of their findings, no paper used a diagrammatic representation to allow the reader to access overall frameworks visually.

General vs specific tasks

Authors of qualitative research should report their findings with respect to the sample in which they were found and should acknowledge to the reader where the findings may be used and guard against generalization of the interpretations, which are made on very specific samples. Generally this was acknowledged by most authors, who reported their findings with caution to the reader to account for the specificity of the task.

DISCUSSION

Overall the literature, whilst a number of themes were explored there were also a number of weaknesses across the literature. A particular difficulty can be seen within Bischoff and McBride (1996) who suggest that clients' prefer clinicians to hold a position of power and that they would choose to defer to their therapists, even postponing their own needs. However this conclusion must be considered alongside the knowledge that these clients were interviewed part way through their therapy by their therapists with whom they had to continue to work which is likely to impact on what they shared during the interviews. Caution also needs to be used when evaluating papers which interview clients mid way through therapy, such as Wark (1994), Sells et al., (1996) and Strickland-Clark (2001). Clients in these studies reflected on the usefulness of the research interviews as they progressed through sessions and therefore the conclusions drawn from studies such as these need to consider whether the interviews changed the phenomena being described and again caution needs to be used when considering the conclusions proposed by these studies. Finally, studies such as those by O'Connor et al (1997) and Metcalf et al (1996) need to be interpreted with caution as both produced themes which replicated the stages or specific aspects of their particular way of working. Neither study reflected upon the researchers' position as therapists who used these models and did not reflect on how they managed preconceptions, which researchers inevitably bring.

Clinical Implications and Future Research

This review has looked at families experiences of family therapy, within which families have experienced a variety of different approaches which fall under the banner of family therapy. The commonality of experiences across approaches indicates that these findings can be clinically useful for all practitioners within the field of family therapy and that a diversity of approach does not reflect in diverse client experiences, other than in reporting of some model specific techniques.

Clinical learning begins at the very beginning of the therapeutic process, perhaps in spending some time with families discussing their expectations and being truly transparent about the way in which therapy progresses. Several papers reported themes of families having clear desires for the 'problem bearer' to be seen alone and expecting this to happen. Perhaps this is an issue which should be made clear very early in therapy, and time given to answer questions or discuss this with families should they disagree as such divergence can clearly impact on the families engagement with therapy and subsequent change.

Power and hierarchy were also seen to be important from the literature and is likely an issue across the different therapeutic approaches. It would be artificial to suggest that clinicians can take learning such as this and eradicate issues of power and hierarchy and enter therapy truly on equal footing with the client; however awareness of these issues may help family therapy teams to take a step back and think about ways to optimise families' feelings of empowerment throughout the process.

Clinically there is also a great deal of learning about the progression of therapy and the meaning of change for different families and couples. In those studies which interviewed therapists alongside clients, it was noted that often everyone in the room had their own individual perspective on what constitutes as change and what was done to achieve this. Clinicians need to be consistently aware of checking out with clients, individually and as families or couples to let them voice what they feel has enabled or indeed prohibited change. This may include opinions on some of the therapeutic tasks which teams choose to use with families and may mean that therapists have to challenge their own view in what they feel may or may not be helpful for families.

In the few papers where children are interviewed there is an overwhelming reoccurrence of the theme that they wish to be included, but that this inclusion means managing a fine balance of not being the main focus but feeling able to contribute. Again clinically it is important to reiterate as each of these papers concluded that family therapists need to be aware of this 'juggling' and think of incorporating more creative and playful tasks into sessions. Further research into the successful use of such creativity, perhaps through detailed case studies would no doubt be welcomed by clinicians who feel less confident in their skills at managing the competing needs of younger family members.

Of the research reviewed, it can be seen that the majority comes from projects based within clinics attached to universities where therapists are trainee family therapists and the families attend university clinics. There are few papers which look at family therapy within the UK, and within experiences as part of usual service delivery. Although useful learning is gained from student research and it is undoubtedly a valuable and rich resource, it maybe that families who attend clinics where family therapy teams are made up of multi disciplinary therapists who have completed training and practised within the 'real world' for longer, may have different experiences. Further research using 'real life' clinical settings, which encompass large and varied areas within which there are a variety of cultural and social backgrounds would undoubtedly be an important addition to this research base.

Further research would also be valuable exploring experiences of family therapy perhaps within different settings and considering different perspectives of family members. There is no research which looks at the experiences of non-referred children, who attend such sessions, for example in families where siblings also attend therapy. It may be useful to have further in depth exploration of what therapy is like for these members of the family to help therapists think about and develop ways of working which engage all family members. It could also be interesting to look at the experiences of family therapy attendees in families where carers or guardians are not parents, in families of looked after children or when children live with grandparents to explore whether these experiences differ from those expressed with the papers in this literature review.

Summary and Conclusions

Current research exploring clients' experience of family therapy shows a number of common themes relating to clients' expectations of coming to family therapy, position and hierarchy in sessions, therapists characteristics, specific therapeutic techniques and the process of change.

Qualitative research has been used to explore this area and there is a large amount of variability within its quality. It can be seen that although the majority of the studies were good at giving information which situated the sample within the context being researched, there was a lack of demonstration of the cohesiveness of themes and how 'fit' together as well as little to tell readers how researchers remained reflexive and managed assumptions and previous knowledge when analysing data. There could be a number of reasons for the lack of reporting in these areas, for example qualitative research offers in depth perspectives it maybe that under the pressure of word limits important in writing research for publication, descriptions of managing these issues or diagrammatic representations simply take up too much space. Perhaps some reporting of challenges faced by researchers feel too personal and therefore threatening to researchers or are processes used to capture these challenges are too informal to be encapsulated. It would be useful to have more transparency about these processes in future research to add further validity and understanding about the way in which qualitative research is used and perhaps one way of doing this may be the inclusion of a worked example or excerpt of a reflexive diary in the appendices of these papers.

As with all qualitative and ethnographic research, the acknowledgement that the researcher becomes part of the process is coupled with concerns that their role may change the process of the phenomenon being explored to the extent that the experience may have been different without their presence. Indeed there were papers within this review that used the therapists as interviewers or interview after each session, which found that these aspects were helpful and significantly supported therapy (Wark, 1994) or they were unhelpful in therapy (Sells, Smith and Moon, 1990). It may be that only when we interview after the therapy is complete that we do not become so much a part of the process that we significantly alter the experience. Obviously interviewing after completion offers its own challenges, in recruitment and in relying on families' recall of their experiences. There is no perfect world in which these difficulties can be eradicated, but perhaps there does need to be further clarity of reporting these aspects and the possible ways that they impact on the conclusions drawn.

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SECTION TWO: RESEARCH REPORT

Therapists' Experiences of Working with Non-Referred Siblings in Family Sessions

Therapists' Experiences of Working with Non-Referred Siblings in Family Sessions

ABSTRACT

Background: Sibling relationships have been extensively researched in relation to the impact they can have on a child's development and studies have also shown these relationships can contribute to both risk and protective factors in problem development. However, within family therapy, there has been little consideration of siblings in family therapy sessions and from the limited research available it appears that siblings' inclusion in family work is limited.

Aim of research: The aim of this research is to investigate therapists' experiences of working with non-referred siblings in family sessions. It is hoped that research will develop understanding of the processes which effect therapists' inclusion of siblings in family work.

Method: Participants were eight therapists from a citywide Child and Adolescent Mental Health Service (CAMHS) who had experience of working with non-referred siblings in family sessions. Semi-structured interviews were used to explore their experiences and Grounded Theory processes were used to analyse data.

Results: The core theme, 'a complex and demanding balancing act' emerged from participants' interviews. There were four main themes which related to the core category; 1) barriers, 2) benefits, 3) tools and techniques and 4) change and development. All of these themes affected the extent to which therapists felt they could meaningfully involve siblings in family sessions.

Conclusions: This study adds to literature on siblings in family therapy and conceptualises the balancing act with which therapists are faced with when working with whole families. Methodological limitations, clinical implications and future research are also discussed.

INTRODUCTION

Sibling relationships have been an area of research which has been neglected within the field of developmental and family research although it is acknowledged that siblings play an important role developmentally in family relationships (Dunn, 2005). Evidence has illustrated that sibling relationships can impact on a child's development and well being with research suggesting that sibling relationships interact with aspects of anti social or deviant behaviour (Criss & Shaw , 2005; Kramer and Kowal, 2005). It is also proposed that sibling relationships can contribute to depressive and internalising behaviour and and to protective factors (Richmond et al, (2005) and Lobato et al, (2005). Further qualitative research of children's perspectives illustrates the complexity and diversity of sibling relationships and shows that they play an important part in the development of identity and group position (Edwards et al, 2005). All this evidence suggests that ignoring the impact of siblings as part of a family group both in problem development and maintenance is somewhat remiss.

Bank and Khan (1975) acknowledged that the focus of family therapy at one time was on correcting parenting processes, although the limited research acknowledged the presence of coalitions between siblings in families (Gerstl, 1956) and differential resentment between discipline given by the parents, which was seen as much less fair than discipline giving by siblings (Bossard and Boll, 1956). However few therapists considered siblings as part of therapy, but one who did used interviews of the 'well' as a way of discovering a more balanced view of the identified child (Greenbaum, 1965).

One important development was the work of Minuchin et al, (1967) who highlighted the importance of the sibling subsystem in their study of families of the slums. They acknowledged the multi-dimensional aspects of sibling interactions which were seen to give reflected self appraisal crucial to the development of identity, as protectors when parents do not offer this, as socialisers and interpreters of the outside world for each other and as 'rescue squads' who have identified roles to protect the group in times of danger. As a result of this family therapy considered sibling subsystems, focusing on strengthening these, making boundaries between these and parental subsystems, limiting the power of siblings in the parental role to return this power to the parent.

Bank and Khan (1975) emphasised the need to include siblings in family therapy, identifying the ways in which siblings could be used, talking about using sibling concepts to re-label family problems, using siblings as consultants and helping clients to 'rehearse' new behaviours and to 'rally' together for support and encouragement. Lewis (1988, 1990) further advocates the use of siblings in family therapy. Lewis describes siblings as useful contributors as participants when a client's current problem is related to an unresolved problem with another sibling, as a consultant to provide new information or a different perspective or as a nurturer to support the development or rekindle supportive relationships.

Although there has been acknowledgement of the importance of sibling relationships and the part they could play in therapy, it appears that even now siblings are largely ignored in family therapy sessions. As models of family therapy have moved on they have developed into a more collaborative approach, which no longer turns families away should not all members attend. Young (2007) entitles her paper 'The forgotten siblings' and argues that sibling dynamics continue to be overlooked in family therapy, suggesting that parent child interactions remain the focus of family therapy with sibling interactions remaining on the periphery. Young (2007) suggests that focus on sibling relationships has come to lie within the issue of sibling rivalry in detriment to the many other emotional interactions which take place in sibling relationships. Young (2007) acknowledges a resurgence in interest in sibling relationships and the consideration of their part in other therapies such as psychoanalysis (Mitchell, 2003) and argues again that sibling relationships 'have a power and dynamism of their own, not to be tidied away as a shadow of parent child relationships' (p.26 Young, 2007).

Despite the common theme that emphasises the importance of siblings in family therapy, there is virtually no literature in this area. A search of the literature uncovered only one paper which looked at the degree to which siblings were actually participating in family therapy sessions. Gustafsson et al (1995) examined the participation of siblings in sessions over 76 consecutive new cases of children who had siblings and were attending a child and adolescent outpatient clinic in Stockholm. Of the 76 cases, 47 siblings attended one or two of the family therapy sessions with just 11 siblings participating in three or more sessions across the process of therapy, leading them to conclude that, although siblings did take part in family therapy, in the main this was limited to one or two sessions.

The authors took a sub sample of nine families and assessed whether siblings in the family were also symptomatic and interviewed the identified patients, siblings and parents about siblings' involvement. Behavioural symptoms suggested that two of the siblings who came with families were above the cut off for moderate psychiatric disturbance and five other children showed a score which suggested distress in day to day life. Post therapy all of the children within the sub sample showed a decrease in symptoms which suggested that attendance at family therapy may not only be useful in support of therapy, but also in helping siblings who are also distressed. The qualitative interview also supported siblings' involvement in family therapy with identified patients suggesting that their involvement may help things to change at home, may help their siblings understand what was happening for them and also reduced embarrassment in attending clinics. Siblings also felt that although some of the problem talk was boring, that their attendance was good as it meant that there were no secrets and allowed them to support their siblings. Parents also felt that it was positive that all family members attended so that the therapist could get to know everyone and that they as well as the siblings learnt about the interdependence of all family members' behaviour.

It is clear from this research that siblings' attendance at therapy is potentially important. There are however many gaps within the research, including the barriers which prevent siblings from attending family sessions and how siblings are involved in therapy across the process of family therapy. Further research into participants experiences in family therapy in which siblings attend could provide some guidance which therapists could use to think about sibling involvement.

Research Aim

The overall aim of this study is to explore therapists' experiences of non referred siblings in family sessions within an NHS setting, to gain understanding about the processes which govern siblings' participation in family work.

METHODOLOGY

Design

As there is little research exploring the meanings and beliefs behind therapists' experiences of siblings in therapy, a qualitative method was chosen as it allows participant generated meanings to be heard and facilitates the emergence of new and unanticipated categories of meaning and experience. The qualitative method most appropriate for this area was grounded theory (Glaser and Strauss, 1967) Grounded theory offers systematic but flexible guidelines for collecting and analyzing data which leads to the construction of theories 'grounded' within the data collected. Grounded theory was chosen over other qualitative methods such as Interpretive Phenomenological Analysis (Smith and Osborn, 2003) as it is the only methodology which aims to provide an explanatory framework which can be used to understand the phenomenon under investigation. Generation of theory around therapists' experiences of siblings in family therapy could be helpful in guiding further larger scale studies within this area, as it will allow hypotheses to be generated to test the theory.

Grounded theory has been adapted for use in many ways as a result of many debates around its use (Willig, 2004). Within this study, the Charmaz (2006) version of grounded theory, which takes a constructionist approach was chosen as this approach understands the interaction between the researcher and the development of the theory and recognises that the theory is a representation of this researcher's understanding of the data and does not claim to represent the absolute truth (Willig, 2004).

Participants - Sampling Rationale

To investigate the processes of involving siblings in family therapy it was important to speak to therapists who have had experiences of siblings in family sessions enabling them to reflect on these. Therefore it was decided that recruitment would be through the teams in the Child and Adolescent Mental Health Service in which therapists regularly work with families.

An important part of Glaser and Strauss's original grounded theory is theoretical sampling, which means using emerging themes to guide sampling. Within this study, theoretical sampling was not possible in its true form due to practical reasons, although the interview schedule did develop to follow up on emerging categories.

Participant Details

Eight participants were interviewed for this research. All participants worked for CAMHS. Participants were deemed suitable for participation if they met the inclusion criteria below:

1. Clinical staff who work regularly with families – Family work is defined within the broad definition of approaches. Such a broad definition of family work reflects the modern stance of family therapy which is often delivered eclectically across services. Therefore all approaches to working with families were included.

2. Clinical staff should have had some experience of working with non-referred siblings as part of family sessions. This will allow therapists to reflect on their actual experiences rather than on what issues they think may arise when working with siblings.

Participants came from a range of professional backgrounds and job titles included Community Psychiatric Nurse, Senior Clinical Psychologist, Consultant Clinical Psychologist, Principal Family

Counsellor, Senior Child Psychiatric Social Worker, Consultant Psychiatrist and Senior Family Therapist.

The approaches used by therapists reflected the eclectic mix of family therapy and included brief solution focused therapy, systemic family therapy and narrative.
The length of time that participants had been working with families ranged between 8yrs and 30yrs. Most therapists felt that siblings attended some sessions during the course of therapeutic work with a family.

Procedure

Participants were recruited from CAMHS teams across a U.K city. The study was advertised within teams and participants approached the researcher if they were willing to participate. Prior to the interview the researcher went through the information sheet (appendix 2) to ensure participants were aware of their right to withdraw and confidentiality. Participants were asked to sign consent forms (appendix 3) and demographic information (appendix 4) was collected to facilitate a clear description of the sample. An original interview schedule (appendix 5) was used with all 8 participants. The interview was developed using guidelines from Charmaz (2006) and used questions formulated within broad topics which aimed to be broad enough to allow for different experiences to be shared whilst being focused enough to gain information on specific experiences. The grounded theory interview remains flexible in order to follow up on themes and experiences which therapists brought to the interview. Following the interviews therapists were given time to de-brief, reflecting on the interview process and ask any questions.

Researcher Characteristics/Experience

The researcher is a white British woman, in her late twenties. The researcher had previously used mainly quantitative research methodology and had not used grounded theory before this study.

The researcher was supported in the development and process of the study by an academic supervisor.

The researcher has prior experience working with children and their families in family therapy. The literature review also had to be completed prior to beginning interviewing, whereas ideally this would have been done after data had been analysed to minimise selective bias and support neutrality.

The researcher recognised that she brought her own preconceptions to this research. She was aware that in her own work with families she felt that involving siblings was particularly demanding and that she struggled with frustrations around the power of blame and problem ownership.

Maintaining a research diary was therefore invaluable in recording ideas and reflections throughout the whole research process, this allowed her to reflect on her part in the research and question coding and hypotheses. Consultation with her research supervisor to check out preliminary ideas and returning to the data to check out emerging codes were also important in managing preconceptions. However, despite these steps were taken to support neutrality, it is recognised that the researcher's ideas and experiences will exert a certain degree of influence on the research.

Ethical consideration

The application was considered by the local ethics research committee (LREC). A favourable opinion to begin the study was given. Research governance was confirmed by the Children's Hospital Trust (Appendix 6)

Confidentiality and Informed Consent

The information sheet outlined issues about confidentiality and right to withdraw and the interviewer went through this with participants before interviews began. Participants were reminded that they would also need to keep the confidentiality of the families they were reflecting on and were asked not to use identifying information. A procedure was outlined to erase the information, should this happen. Participants were also informed that interviews would be recorded and transcribed and that the transcribers would also sign a confidentiality form (appendix 7). This information was contained within the information sheet and the consent form participants were asked to sign also outlined this. Verbal reminders of confidentiality were also used.

Data Protection

Participants were assured that when their contributions were written up as part of the study that they would be identified using pseudonym. This was also emphasised as part of the information sheet and consent form and confirmed verbally by the researcher at the beginning of the interview. Audiotapes and participant details were kept separately and securely to ensure confidentiality.

Data Collection

Data was collected using semi-structured interviews which had been developed using guidelines from Chamaz (2006). The interview developed for this research used a number of topics and there were a number of semi-structured questions or prompts within these sections, as illustrated within the interview schedule. The initial interview was piloted with a clinician to assess its suitability, however this interview was successful and therefore permission was gained to analyse the interview. It was important to remain open and flexible within the interview and encourage participants to elaborate and further explore areas of interest not necessarily part of the interview schedule, to allow full exploration of participant's experiences. This meant that not all the interviews were identical and reflected the responses of the participants. After the interviews, the researcher took time to record initial impressions or ideas in the research diary.

Data Analysis

Six of the interviews were transcribed verbatim by a transcriber, two interviews were transcribed by the researcher. The transcriber signed a confidentiality form and was provided with brief instructions (appendix 8) around the layout and presentation of the scripts based on guidance from MacLean, Meyer and Estable (2004). When transcripts were received from the transcriber, the interviewer listened to the tapes and read the transcripts simultaneously to ensure accuracy.

Before data analysis began, the researcher read the transcripts several times. This allowed familiarisation with the script as well as a chance to record initial impressions and ideas within the research diary. The research diary was an important tool in collecting ideas, thoughts and processes and allowed the researcher to reflect on her position and previous knowledge. This allowed the researcher to question and scrutinise data analysis to minimise any selection bias as well as recording simple, instant ideas which could be built upon.

To record codes the transcripts were entered into a simple table, with large margins within which line by line codes could be recorded clearly and were easy to identify. Focused coding which looked to code larger segments of data were recorded in a second column, this way all the codes were recorded next to the data from which they were extracted, ensuring that they remained grounded in the data and could be traced back to the interview data.

Coding as part of grounded theory results from reading the data collected, rather then emanating codes from a framework previously applied (Charmaz, 2006). Within grounded theory coding takes place in several phases, initial coding and focused coding. Initial coding involves looking at data line by line as this helped to draw out both implicit and explicit information helped to refocus interviews. Initial coding separated the data into categories and allowed the researcher to step back and see actions and significant processes.

The second major phase in coding in grounded theory involved focused coding which moved towards more directed, selective and conceptual codes (Glaser, 1978). At this stage, transcripts were re-read and the most frequent and/or significant codes were recorded. This resulted in new codes being defined and returning to previous coding and the interview transcripts to ensure that the categories could be traced back to their grounding within the data collected.

Axial coding was advocated by Strauss and Corbin (1998) as a way of bringing the separate codes back together, to do this they applied a set of scientific codes which grouped statements to answer questions around 'when, where, why, who, how and with what consequences'. This is thought to provide a framework to support or limit the researcher's vision. Charmaz (2006) does not use formal rules, instead advocating a similar procedure developing the sub categories of a category to illustrate the links between them. It was felt that this illustration of links within a category would be useful and therefore this was done within the major categories.

A further, more sophisticated level of coding was theoretical coding which followed the codes selected during focused coding. The aim of theoretical coding is to 'lend form to the focused codes and tell an analytic story which has coherence' (Charmaz, 2006). It is thought that using theoretical codes can add precision and clarity and help in making analysis comprehensible and coherent (Charmaz, 2006). A useful technique across axial and theoretical coding involved drawing multiple diagrams, these helped to illustrate possible connections and support the development of higher order themes.

Throughout all stages of coding the research diary was essential to record ideas and thoughts and also reflect on these to manage these preconceptions to avoid forcing data into preconceived categories or ideas. Once coding was complete, the codes were developed through memo writing which is the intermediate step between data collection and writing findings. Memo writing prompts the researcher to analyze data and codes and writing successive memos helps to maintain involvement and increase the level of abstraction of ideas (Charmaz, 2006). Memos helped develop analytic notes and fill out the categories coded and helped to develop ideas and link data collection with data analysis and report writing.

Validity and Credibility

Elliott et al's (1999) guidelines for methodological strength or qualitative studies were considered to support this study and steps were taken to promote reliability and validity. Within this research, summarising at the end of interviews and re-visiting participants to check out codes gave the opportunity to check out participant's perspective of validity by asking whether they felt understood, whether accurate descriptions of experiences have been ascertained. Further to this the collection of demographic data allowed a clear description of the sample from which data was collected, which allows readers to situate the sample within the context in which they operate.

From the researcher's perspective, reflexivity contributes to valid data as this ensures that the research process as a whole is scrutinized and the researcher always reviews their own role discouraging impositions on their data. The research diary was a useful space for the researcher to note ideas, expectations and beliefs so that they could be reflected upon in data analysis and used to support neutrality. Coded transcripts were also shared and discussed with the researcher's clinical supervisor to check the adequacy of the coding and to ensure that important themes had not been ignored or minimised. An extract of a coded interview is shown in appendix 9. Clear examples of the data to illustrate the analysis and understanding were included within the results section to illustrate how themes identified related to the data. The tables and codes used meant that there was a clear audit process which allowed conclusions to be tracked backwards to the original data source.

RESULTS

Main finding:

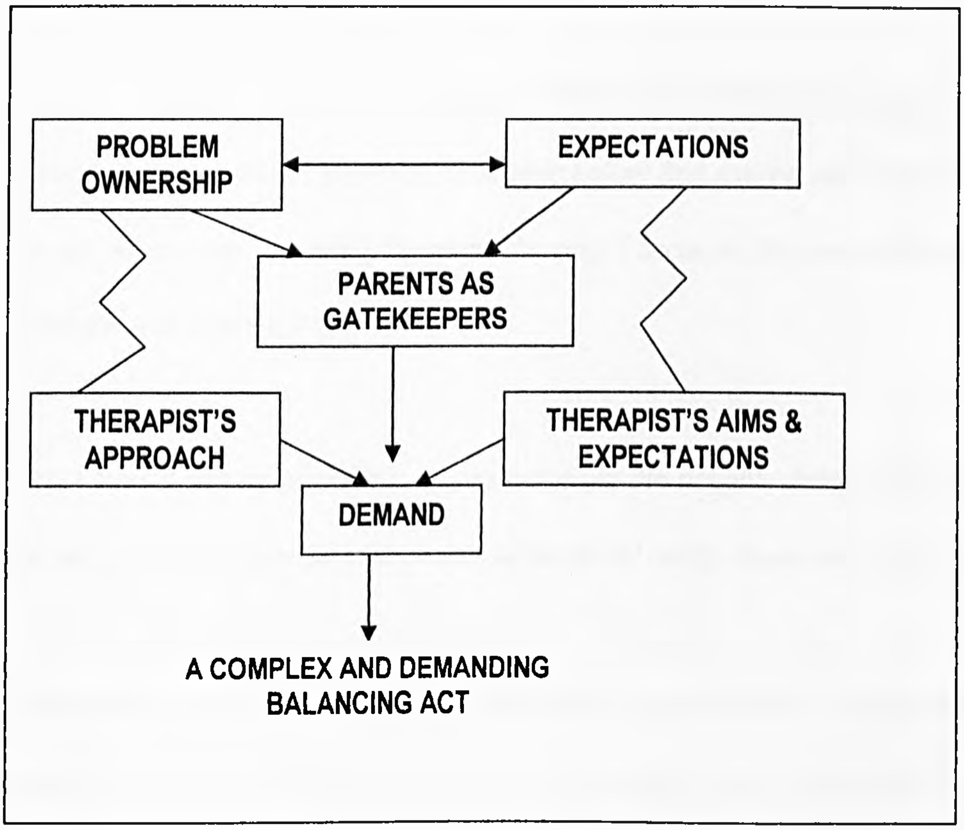
For therapists in this study successful inclusion of siblings in family therapy was a complicated process, which placed a high demand upon them both in and out of the therapy room. The process of inclusion is a fragile balance of managing multiple barriers and benefits, whilst maintaining a pace of change which is acceptable to families. This core category is called 'a complex and demanding balancing act'.

Themes:

There were four main themes which emerged from the focused and theoretical coding which were seen as central to understanding therapists' experience of siblings in family therapy; (1) the **barriers** which need to be managed, (2) the **benefits** which successful inclusion can bring, (3) the **tools** which therapists employ to manage the complexity and (4) the **change and development** in family work and in the therapists themselves. All these themes fed into the core category which represented siblings in family therapy as a process which is 'a complex and demanding balancing act'. Within the four themes there were a number of sub themes which are related to create a major category and these are illustrated within the diagrams which were drawn during axial and theoretical coding. These diagrams illustrate the themes and sub categories visually but do not illustrate causal relationships. The main themes and sub themes are not mutually exclusive and there are connections and therefore some overlap between categories.

Barriers

Figure 1 – The barriers to sibling's inclusion



<u>*Problem perception*</u>

Problem ownership was a common difficulty which therapists felt they had to face in order to manage inclusion of siblings. Families often presented with clear cut ideas that the problem belonged with an individual child and that this idea was maintained by *cultural understanding* and *previous experiences of help seeking behaviour.*

'Well, I guess...I guess the main barrier is the one that they don't expect to have to bring other people. It's not in the public mindset as it were that if one's got a difficulty that another child or other members of the family will be important to being either... being part of the problem or being part of the solution' [Bert]

Polarization between siblings was a particularly difficult dynamic within and outside family sessions. Therapists spoke about the pressure on siblings seen as the 'good' child which sometimes led to them being unhelpful or even sabotaging therapy or feeling uncomfortable in being unable to deviate from this role.

'The older teenage sibling who was there to make sure I understood how bad he was, was a real pain because she wasn't interested in anything other that making sure that I focussed totally on her and when mum was willing to move, she wasn't because she was holding onto the good role for all she was worth' [Lionel]

'Yes, I think it can be a burden ......you are either the naughty child or the good child and.....It can put a lot of pressure on children too, as far as not being allowed to be naughty' [Katie]

This seemed to be an incredibly hard barrier to overcome and therapists talked about the permanence of *problem ownership* and how this would often remain placed within the same individual but that the family could learn to work with to support that person.

'Oh yes, you don't very often ever get rid of it completely but if it works well it becomes a team process, there are things that we want to put right in the family, a lot of things are around little X, but little X and the rest of us are all working to put that right' [Lionel]

In order to engage the whole family in sessions, therapists talked about having to balance the perception of problem ownership with *therapist's approach and expectations* to open out the families' view of the problem, whilst engaging the family and hearing their story, whilst managing their own biases.

'The family can spend an awful lot of time getting stuff that might be desperately interesting to us but isn't necessarily particularly germane to why they have come or not obviously so. They might

think "well, that was interesting but a bloody waste of time" "why did we go?" and "do we want to come back?" and "does that person really know what they are doing?" '[Doug]

Therapists also spoke of the impact of their own organization on problem ownership and the pressures of the service to work in a way which would not be conducive to working towards a systemic model with the whole family.

'We don't actually have a mechanism of registering a family as having a problem, we have to have an index patient, we have to have a person, we can't, you know, our, our database requires that so to some extent my ideas or the way in which I am working is undermined [Bert]

Different View of Problem Perceptions

Therapists commented on the clash between the families and their own way of thinking about problem ownership as therapists working with a systemic model and how this would require a shift in thinking from the parents. Part of a therapist's role in managing this was teaching or helping families to see the systemic and therefore therapist's perception.

'I think that you know if they think that the referred child is the one who, you know is having the problem then I think it can be hard, you know harder work for me to well, you know bring them...I was going to say round to my way of thinking...and I guess it is my perspective....but you know helping them to look at it from a different perspective' [George]

<u>*Parents as gatekeepers*</u>

Parental decisions to bring siblings to sessions were often influenced by expectations and their view of the problem or of the other siblings. One of the tasks for the therapists appeared to be helping parents to see the difficulties from their own systemic view in order to have access to the whole family.

'Well, my immediate thought…is that it's the parents. If they don't buy into having the siblings there or don't see a role for them or if they do come and are sat there saying nothing, then they don't tend to bring them back' [George]

<u>*Demand on the therapist*</u>

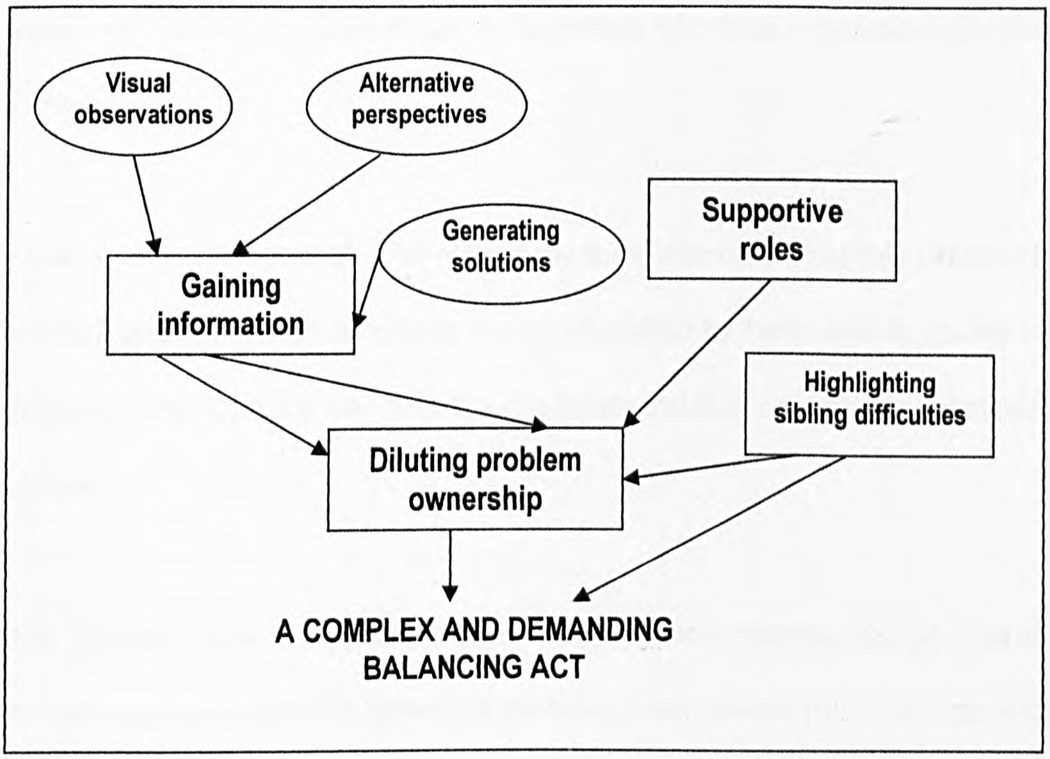
Although therapists felt that siblings could bring the therapist useful information, it *increased the demand* on them in the room and could be quite daunting for a therapist. Whether a therapist feels able to work usefully with a number of people in the room depended on how they feel and this can change with the *pressures and demands on their time and energy.*

'I think they are a bit daunting if I am honest…… there was a bit of me that used to go "oh blimey, okay, oh well, we have got this many". I think there is always a feeling, a bit of danger that you can end up babysitting and whether you are going to be able to actually find out what's going on because there are so many [Jack]

The many barriers which therapists are presented with when working to include siblings in families can make the sessions much more *complex and demanding* and placed a greater burden on them. Overcoming the barriers requires therapists to *carefully balance* the difficulties they face to successfully engage the whole family and therefore the siblings.

Benefits

Figure 2 – Benefits of siblings inclusion in family therapy



<u>*Gaining Information*</u>

The presence of siblings in family therapy could be the key to therapists *gaining information* about the family and this information can be brought through a number of processes. Siblings who become the *information bearer* who offers alternative views and perspectives – as one who overtly shares different point of view and evidence of playing a *helpful and supportive* role which helps therapists to learn more about what is happening at home and use the siblings examples to invite others to look at the difficulty from an alternative perspective.

'My little spy.... as from I think the end of the first session right the way through, we saw them three times, four times maybe and right the way through she was my little spy and she repeatedly brought in really useful information about what mum was doing was helpful, about signs that the boy was getting better, about what difference it made to her that things had improved' [Lionel]

'The sibling will also give you information more readily or of a different quality when you think about the other informants which are the put on the spot, identified patients who are maybe feeling very blamed or unable to talk or the parents who have a particular view on the things' [Doug]

However, even when the sibling did not verbally share information, just their *presence* in the room also facilitated the therapists gaining lots of information by being able to *visually observe* the dynamics in the room and learn from the interactions that they were able to see occurring in front of them.

'Yes, how they interact. That can be quite an eye opener sometimes when you just see parents, perhaps one parent and child haven't got the other parent there or you haven't got rest the rest of the kids there, when you get them all in and just see how they relate to each other, I think that is really important' [Katie]

Whilst gaining information is useful for therapists, it is acknowledged that there is a need to balance this because observing families together in the room brings lots of beneficial information, but the therapist needs to balance this with the level of activity in the room in order for it to be useful to them.

'Sometimes it can actually be unhelpful as well, with lots of children there especially if they are tiny and there is a lot of chaos and it then becomes very, very hard, whilst there is the appreciation it is like to live with the family, it can be very hard to extract information about what's going on. You do definitely get the context of that family, it can be quite.... It stops you from thinking because of the constant interruptions of children climbing up the walls and getting into things' [Amber]

Supportive Roles

There were a number of roles which therapists recognised that siblings could play to support the identified child and these could be both helpful and unhelpful relationships for the therapist. Support could come from the sibling in many forms, both in practical support in reminding people of homework or emotional support in being the confidante or friend to the referred child.

'Yes, I am thinking about a kid who was very depressed and anorexic and the mother was far too anxious and involved in her emotional world and behaviour and sister was very helpful as a comforter and that was very helpful in the way of just diffusing the anxiety and over involvement between the 15 year old and the mother' [Doug].

These roles could be used by therapists to facilitate more open discussion between the family members and also as a way to facilitate positive talk about people in the family.

'Trying to engage them in thinking about reflecting on each others strengths as well as each others weaknesses so I might ask, you know other siblings well, what are Johnny's strengths, what's Johnny's best, you know what makes you really pleased that you've got an older brother whose called Johnny, that kind of stuff, you know engaging them in that way so that they are part of the process.' [Bert]

Whilst close or supportive roles could be helpful to therapists there were also ways in which sibling relationships could be problematic and interrupt the way in which the therapist is working.

'I think you also get the sort of "we are going to mess around and protect you" role, there is quite a lot of rescuing goes on ..... I do tend to put people on the spot and you'll often find then, people

will mess...its about not wanting their siblings to be upset so they will come in and do stuff that means we go off track'. [Jack]

<u>*Highlighting Sibling Difficulties*</u>

A frequent process which therapists described was the realisation that the 'referred' child was not the only one struggling in the family, despite the fact that it was this child who had been referred. Some therapists suggested that the referred child was more of a 'mouth piece' for a families difficulties and that siblings' attendance could highlight other non-referred siblings need for help and support.

'I was thinking "well, you are worried about X, for Christ sake I am worried about Y,Y might kill themselves soon actually if we don't do something". I did ask the mother in that particular case to engage with her GP straight away and get the other kid referred, he was very depressed and I was worried he was at risk of self harm' [Doug]

'Sometimes the referred child can be a help for another child in the family. There might be a child who is perceived as the problem but there might be a child who is quieter who is suffering in a different way' [Katie]

Although this it can be beneficial to the therapists to uncover sibling difficulties it can also be a challenge to manage these alongside those which the family originally presented with and sometimes decisions have to be made to ensure everyone has space within sessions.

'Suppose if the sibling is typically another identified patient or should be, then they maybe so preoccupied with their own concerns that that would get in the way then you would then need to organise appointments so they are then separated' [Doug]

<u>Diluting problem ownership</u>

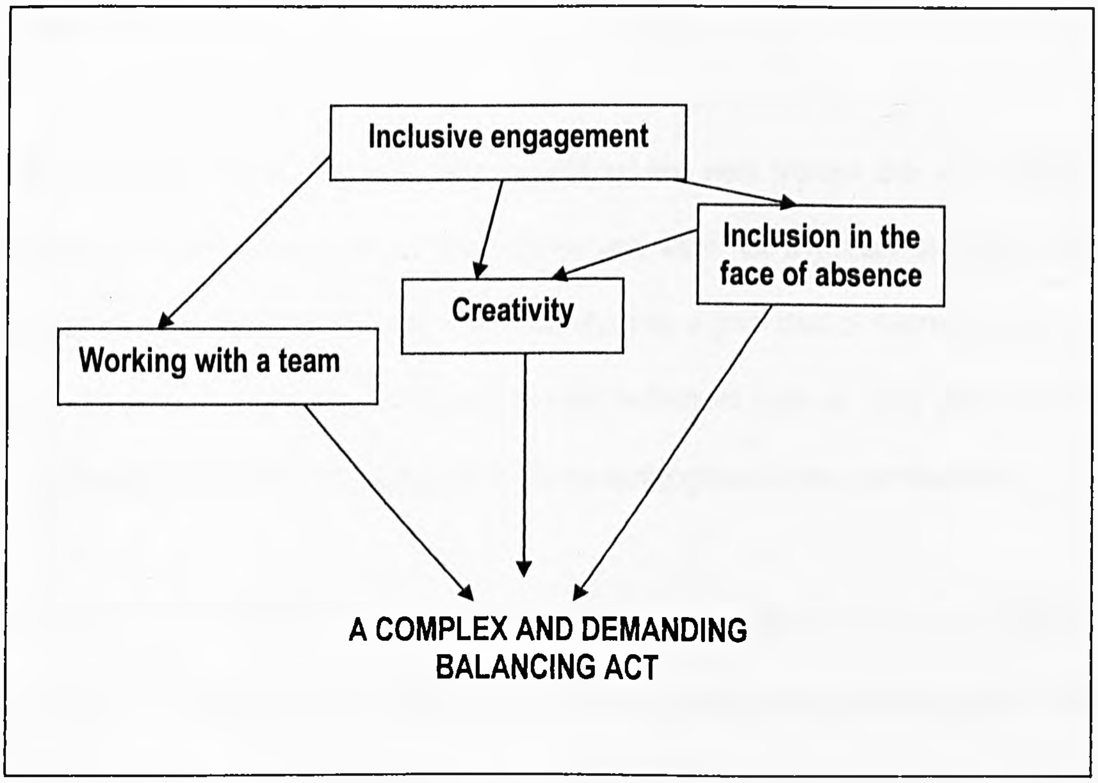
Problem ownership being focused around the referred child was a key barrier to engaging siblings in family sessions. Perceptions of problem ownership impacted on the parents who ultimately hold the power to bring siblings to family sessions and can be a difficult barrier for therapists to overcome. However, just having siblings there can be a beneficial tool in *diluting this problem ownership* and helping the <u>therapists</u> to remain *family focused.*

'I think when siblings are present it does enable you to think much more about the problem within the family rather than the problem within the person because I think we can think we are working with a family but actually we are being quite individual' [Molly]

The process of involving siblings in sessions can bring a number of *benefits* for the therapist which can help to dilute the *barriers* which therapists can face, although these need to be carefully *balanced* in order for them to work well.

Tools and Techniques

Figure 3 – Tools and Techniques Used To Include Siblings



<u>*Inclusive Engagement*</u>

Therapists talked of a number of *tools and techniques* which they used to include siblings in family therapy which helped them to achieve *inclusive engagement* of the whole family. Part of *engaging* the whole family helped to dilute *problem ownership* by talking to and being respectful of each member of the family, this seemed to be a task which had to happen early in the process, meaning that therapists had to *balance expectations* with *engaging* the family.

'Well I have a basic strategy which involves making sure that I get a story from every family member who is willing to talk about things about their life that normal and enjoyable and they are good at so I would take each one in turn and ask them what they did at school and about friends and successes they have had and so on and so forth, and at the same time, acknowledge that sometimes they don't want to talk and that we have to negotiate about how they can contribute and how I can make sure they are not being left out. By and large it is a process that everyone is

part of and by telling everybody in effect that "I am going to be interested in all of you as people and interested in what all of you want to achieve" then that is the first step towards moving away from blame.' [Lionel]

Whilst therapists had strategies for involving siblings who were present, they also spoke of using techniques to think about and include siblings who were not *physically present* in the room. Therapists recognised that although they missed out on a great deal of information if the siblings were not present, they were able to use specific techniques such as '*mind reading*' or '*circular questioning*' to bring absent siblings into the room in recognition of the part they play.

'One of the core techniques of family therapy, what I use is what we call circular question, which is asking about what another persons perspective is, so I would ask the people in the room to say "if so and so was here, what would they say about that?" "When such and such happens, what does an absent member do or what part would they play in that or what's the relationship between the identified patient and the brother? When you are being forced to pay a lot of the attention to the identified patient, what do you think their brother or sister are likely to be doing or who pays attention to them" so you are constantly talking about them, referring to them' [Lionel]

Creativity

Working with children over a wide age range presents a complex challenge to therapists working with families as therapists spoke about having to manage how information is shared to make it useful for everyone. Managing this improperly can lead to siblings feeling *resentful* or information being *over complicated* leaving other children behind.

'What I sometimes observe is a lack of awareness of the difference between developmental issues around the family and actually understanding that the level of understanding and operation

between siblings will vary dramatically between age and the stage of development. The way that I see that being played out in therapists that don't know how to communicate with children of different ages and relate to all children as if they were 8 years old which pisses off a 15 year old but leaves the 5 year old way behind regarding things that are being said' [Doug]

To manage the variability in understanding, therapists often used *creative* techniques to involve all family members and allow them to *show* their perspective if they were not able to *speak* it. Therapists spoke about using informal 'crafty' techniques using art materials and toys to more formal, theoretical techniques. A common theme in the use of creative techniques seemed to be that this allowed family members to visually 'see' or look at difficulties, rather than just verbalizing them.

'I will often use, you know small animals or other things like people or drawings so I might well ask them to draw something or show me....we did erm what is called a family sculpt which originated from the Minuchin structural family therapy school, but it takes you know a snapshot if you like, that looks at the if you like closeness and this distance and the relative power positions and stuff like that within a family and erm in this particular family it was very powerful, what other siblings had done in terms of looking at the position of the mother in the family' [Bert]

'So it is something about how do you involve all the children and I like being creative and I suppose there is something for me about wanting to get them all involved in a more dynamic way instead of just talking.... sometimes I quite like using a lot of pens and paper, I think being quite visual can be quite helpful to how the families look in on themselves, so I think younger children quite like that as well and they can join in' [Molly]

Working with a team

Team working was a common tool which therapists used to help them manage the complexity of working with families with siblings. The team seemed to be a helpful technique in managing the demand of large families and providing support for therapists when there is lots of information. This impacted on therapists' perception of how they then felt in those sessions and how having a team behind them was useful not only to pick up information that the therapist might miss, but also made them feel calmer in these sessions.

'You have got to watch so many different things which is why family therapy so often uses a reflective team because the team can see things that you don't. When mum says this the kids looks at dad like that and you don't see that but the team might. So, it is always more complex but it is complex in a calm way and you don't notice that you are missing very much' [Lionel]

Therapists also spoke of using the team as a therapeutic tool was to contribute to protecting against problem ownership, by using the opportunity of having a *diverse reflecting team* to comment on everyone in the room and to *offer personal opinions and feelings* after sessions which helped therapists think about their own feelings and how to use the information from the team to move forward.

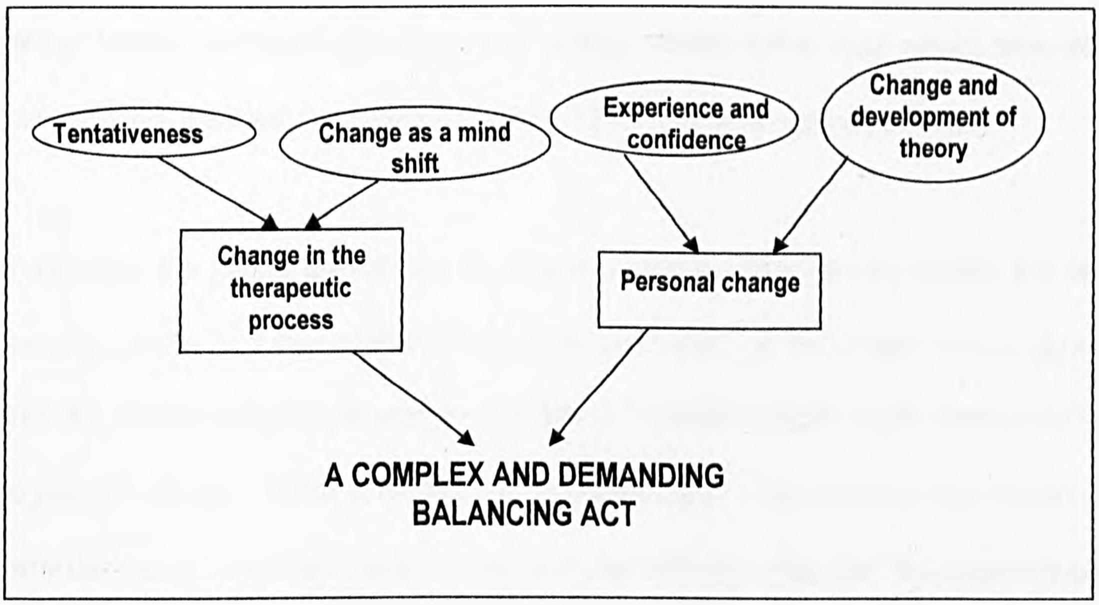
'I think in a team we would often try and make sure that within the reflections try to include something about everyone's perspective so the reflections wouldn't just be focused on the child or the young person so I think that immediately draws everyone in to what's going on..........Yeah, and in the end I think having the benefit of being able to say to folks, "I have really found so-and-so quite difficult, because you work in a team and you know, different people... we are all different aren't we, and we find different things more or less irritating than somebody else, they might say "oh no, it was such-and-such for me". Someone else can give a

completely different take on that child or even just allow you to say it and then for you to think, well what's going to help me next time' [Molly]

Therapists used a variety of tools and techniques which further enabled them to engage siblings in family therapy. These tools often supported in the difficult task of managing problem perception and ownership, a task which therapists felt required *flexible and creative approaches* in order to manage the complex balancing act.

Change and Development

Figure 4: The process of change in siblings' inclusion



<u>*Change within the therapeutic process*</u>

Therapists spoke about change in relation to siblings in the therapeutic process as a *mind shift*, which families would need to make and that this change is often not something the families envisage or expect. This involved changing from the perspective of the problem as belonging to an individual to one of family ownership although. This change did not have to be a complete shift, in order for siblings to be successfully engaged with therapy.

'If you can help them to accept maybe a move slightly away from what their current position is but significantly, sufficiently different then you can help them to change perspective. Which when siblings erm if you like leave behind a position of resentment about being there and all those sort of things erm and are able to or perhaps put that to one side, they don't leave it behind entirely but put it to one side and engage with the process of therapy and come up with ideas and make use of it, I mean, that's, that's the key thing' [Bert]

Therapists described about their approach to such a mind shift as one of *tentativeness* in which they had to judge and manage the *pace of change*. In doing this, therapists have to judge how much families are willing to challenge their views and perceptions and recognise the futility of 'telling' families that their perspectives 'must' change, instead taking small, collaborative steps. By not doing this, the therapist would run the risk of the family disengaging completely.

'I am aware that people will only buy or move so much at a time, so I am judging how far I can creep and move from their position of identifying one person as the problem to a position where they are placing that particular problem in a different context so that's sort of a graduated therapy to process I guess... I think some folk sometimes struggle. I remember a Junior Doctor saying "why don't you just tell them", and actually struggling with the notion that, "because they wouldn't hear it if I did and a lot of them might not even come back" so it is a little or very much about sort of gauging how much' [Doug]

Therapists also spoke of the ways in which they facilitated this process to help the family to manage a sufficient enough mind shift to recognise the value of siblings and indeed the systemic approach.

'There is a bit about certain psycho-education for families, it's about the sort of by-product of therapy is to open up for families and siblings the way in which the whole thing is interwoven and the whole family is a better tool for resolving things than the customer if you like. There is somehow an empowerment of siblings within this process that they suddenly realise "yes, we are a part of this and we will be happier if he is happier" and "yes we can make things happen" and that sort of empowerment with the siblings as part of the family system' [Lionel]

Personal Change

Therapists' thoughts and feelings about involving siblings in family therapy also seemed to have changed and evolved throughout their careers, suggesting that therapists' experiences interact with personal and theoretical changes. Several therapists who had practiced family therapy throughout its evolution and development felt that there was personal change in their own practice as the profession and theory of family therapy was seen to 'relax', allowing them to be more collaborative in their approach, using negotiation with families to think about involvement.

'When I was being trained ......the view then was that in fact that you needed to have everybody in the family present err and family therapists at that stage we're adopting the view that if they don't come then we can't have the session because its not meaningful erm I think that that was consistent with a, with a very expert kind of view which was, was the norm at that stage but was beginning to change. Erm... and I think my position now is that I, I will try and negotiate with people about the presence of siblings and other family members, erm but we're focusing in particular on siblings and I would encourage it but I don't insist on it' [Bert]

Learning and experience, not just as a profession but as an individual therapist also emerged as important to the therapists in this study as they spoke of needing skills and confidence in order to manage including siblings in sessions and that to do this at the beginning of training or learning was incredibly difficult and anxiety provoking.

'I think at the very beginnings when I was a new therapist, I was more nervous and anxious and less certain about things and my confidence has obviously grown....and I have been fortunate to work in teams where the family approach has been seen as important rather than splitting it up into individual work, I would say that I have grown more positive over time' [Amber]

'Once you have got experience I think that is the critical thing and it is the process of mentally of learning to, not only to relate in terms of content, track process with one individual then you have to think about tracking content with more than one individual and tracking progress with more than one individual and then tracking content and progress between the individuals in the sense there's so many layers to it but that in itself, when you are learning to do it, quite literally mind stretching and bloody hard work' [Doug]

Change was an important theme in therapists' experiences of siblings in family sessions. The changes the family would need to make in the eyes of the therapist are part of a *delicate balance* in which the therapist has to work to understand the family's point of view and manage the pace of change to arrive at a place comfortable for both family and therapist to be able to involve siblings in working towards a solution. Therapists personal changes and development supported the involvement of siblings although when training or starting work with families this was an extremely demanding task.

Core Theme: Siblings in family therapy: a complex, demanding balancing act.

Figure 5: Core theme of sibling inclusion as a balancing act

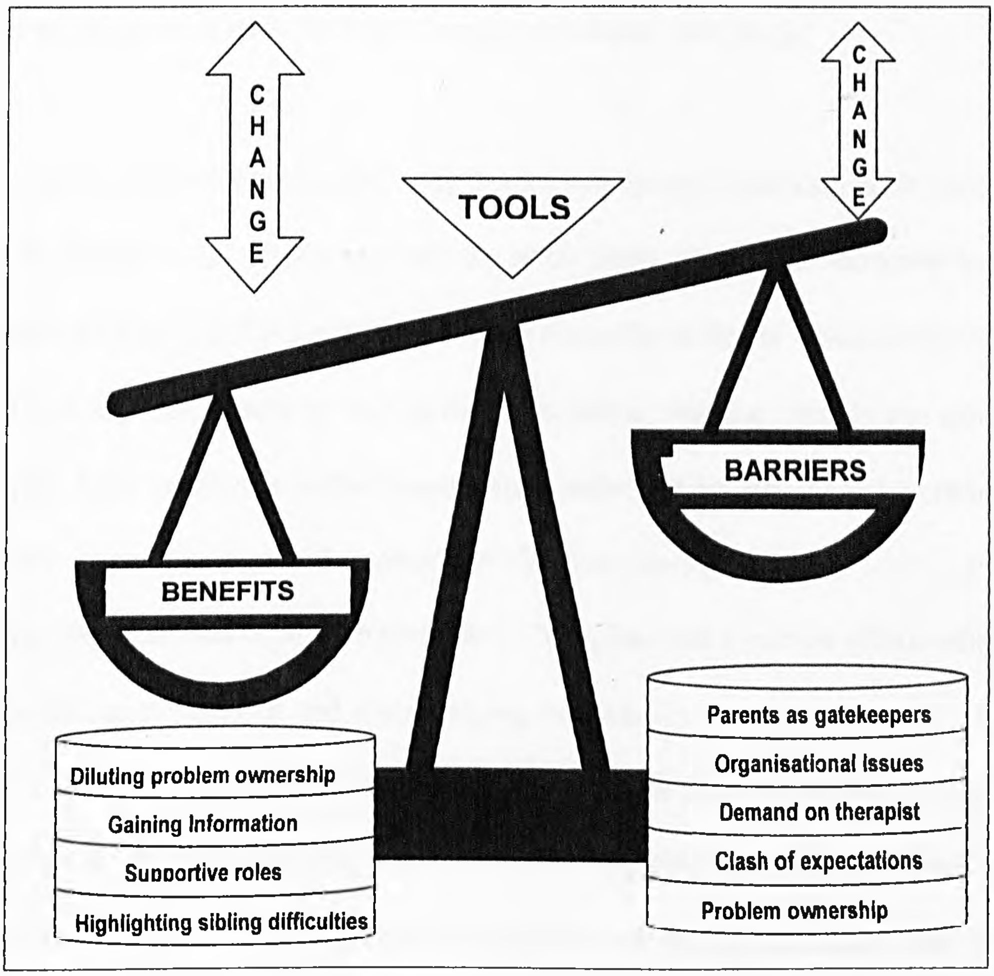


Figure 5 illustrates how the main themes relate to the core category of 'sibling inclusion: a complex and demanding balancing act'. Throughout therapists accounts of their experiences of working with siblings it became obvious that the process of involving siblings in family therapy was a balancing act between the barriers to their involvement and the benefits their involvement brought to therapy.

'It's a delicate balance really and you don't always get it right, it might be how you are feeling that day, you might just not be on the ball' [Amber]

'There is this fragile balance at some points that – are they going to tip this completely the wrong way or are they going to work it out.... You need to be equal ideally, it's hard but [you have to give] equal opportunities to get things wrong and do things right' [Katie]

The process of involving siblings in family therapy is a dynamic balancing act in which therapists have to manage to successfully work with the whole family. This can be extremely demanding on therapists as they try to 'tip' the balance towards supporting a view of '*shared problem ownership*' which is a key task in siblings' involvement in sessions. Working towards this can mean that therapists have to balance families' *expectations* which can be influenced by *cultural views* or *polarised views* of siblings and families previous *help seeking behaviour* which can support a narrower *individual* view of problem perception. Therapists have a number of *tools* which they can use to manage this balance and support sibling inclusion. The use of a *team* was thought to be helpful in supporting the therapists in managing the *demands* of more people in the room and as a way to ensure that the *information gained* from this is captured and helping therapists to protect themselves from being drawn into *individual problem ownership*. Therapists also use *creative* ways of working, other than just dialogue which helps to involve children across *different age ranges* to ensure that all members of the family have a voice. Therapists also have to manage the pace of change, balancing the introduction of the systemic model which facilitates the involvement of siblings in sessions by helping families to see the difficulty as one placed within the context of the systems in which they are in, removing *blame*. Should the therapist move too fast or introduce the change when the family are not ready this can prevent the *mind shift* needed to facilitate sibling involvement. In order to cope with the demands of this balancing act, therapists felt that they personally needed *experience and confidence* when working to include siblings.

DISCUSSION

The study explored the process of involving siblings in family sessions, from the perspectives of the therapists that work with them. The core finding suggested that such involvement was the result of a complex and demanding balancing act by these therapists and there were four themes which were related to this including; 'barriers', 'benefits', 'tools for inclusion' and 'change and development'. All these themes influence the level of inclusion of siblings in family work with the task of the therapist being managing the barriers and promoting the benefits whilst balancing the pace of change and their own position as a therapist. The themes are discussed individually in relation to existing literature. Further to this the strength and limitations of the study are discussed, alongside the implications for future research and clinical practice.

Barriers

There were a number of factors which interacted to form barriers to siblings inclusion, the most prominent of which was the challenge of problem ownership and polarisation of the 'good' or 'bad' sibling. This perception of the identified child as the 'problem' for whom individual therapy is required is supported by research by Newfield et al (1991) who found that families attending family sessions for adolescent drug use expected individual work with the referred child. This belief that the problem is individual and requires individual work can be a static belief as illustrated by some families in Newfield et al's (1991) research and by Merrington and Corden (1981) who interviewed eight families about their experiences of family therapy and found that post therapy five of the eight families still considered the difficulty to be individual to the referred child, which ties into some of the therapist's experiences of the permanence of problem ownership in this study. Kuehl's (1993) paper which looked at working collaboratively in family therapy, suggested that should a parent request it, their wish for individual sessions should be respected, if not for one or two sessions in order to help them feel heard and respected and helps to engage them in therapy. Whilst therapists in this study did feel that siblings were important they also reflected a similar view in that whilst they would try to include siblings, if the family were opposed to this or firm in their perceptions of problem ownership therapists would work in this collaborative way.

The theme of polarisation of children is also supported by the literature with a number of articles looking at favouritism and identified children as 'scapegoats'. Brody et al (1998) indicated in their study that 65% of their sample of 127 college students suggested a level or polarisation or 'favouritism' in their families and Yahav and Sharlin (2002) discovered that children who externalise their behaviour are more likely to be identified as a scapegoat, something which Vogel and Bell, (1960) suggests helps families to maintain a degree of solidarity and cohesiveness in the family, aiding its function. Therefore, it is unsurprising that therapists' find themselves faced with these barriers and that these can be difficult to adapt or change as even if this pattern is uncomfortable for the family, it appears that therapists attempt to widen out the focus and include siblings could threaten their perceived solidarity or functioning. Research by Handel (1994) also supports the challenge therapists' face in diluting this polarisation and that for some siblings it may be a relief and for others a feared outcome, resulting in their loss of power.

A further barrier identified by therapists was the demand of the work upon them and the amount of information in the room, which required much more from them to hold all this information and contain the level of activity in the room. Ruble (1999) reviewed research written about the inclusion of children in family therapy and reported that studies had found that children were regularly excluded if the therapists were not comfortable with them in the room (Johnson and Thomas, 1999 and Korner and Brown, 1990). This supports the finding in this study that therapists will take the decision to split family groups if there is too much commotion and chaos for them to have the time they needed the think or feel like they are working usefully with the family. Sander's (2003), reflections on inviting children to family sessions, further supports the message of the therapists in this study, that whilst she has the skills and ability to interact with the family, young children tend to bring with them chaos which can leave the therapist feeling like the session is useless. Also Smith et al's (1992) study of therapists experiences of working with a reflecting team as part of family therapy also supports the findings from the therapists in this study, that they considered the 'multiple realities' useful as long as they 'increase options for clients and therapists but do not result in 'chaotic' interactions' pp 430 (Smith, 1992).

Benefits

The primary benefit of sibling attendance to the therapists in this study was the wealth of information that siblings brought to the sessions, both in support of their siblings and from their perspective in the system, which could also dilute problem ownership. Stith et al, (1996) study of preadolescent children's views on inclusion indicated, as the therapists in this study did, that not having the children present supported a skewed view of the system, when only given by the parents and Miller and McLeod (2001) also postulate that working with the entire family offers a unique dimension for the therapists' which supports a balanced understanding. Children sharing more information in sessions was also supported by Cicerelli (1976) who suggested that children offer a greater degree of frankness and honesty to the therapists which therapists found to be true of siblings also.

A further benefit of siblings attendance felt by the study was the supportive roles they could play in providing information of change, working together with their 'identified' sibling to support them or just being a supporter or advocate in the room. These positive roles have also been recognised in other literature about siblings role in therapy as Bank and Khan (1982) recognised that siblings could be involved in family sessions to 'rally' around a sibling who is struggling. Therapists in this study also acknowledged positive roles much like those proposed by Lewis (1990) in her work around sibling therapy, in which she suggests that siblings can attend therapy as consultants to provide alternative perspectives and also as nurturers. Finally Gustafsson et al (1995) also recognised similar useful roles for siblings when they spoke with identified children, their siblings and their parents about their perceptions of involvement in sessions. Identified patients felt that siblings role in therapy may be to help things to change at home or offer support in reducing embarrassment in attending clinics. Siblings also felt that although some that their attendance was good as it allowed them to support their siblings.

Therapists in this study also felt that a further benefit of siblings' attendance was that this gave the opportunity for siblings' who expressed their difficulties or feelings in different ways which may mean that parents do not refer them to services, to be noticed and provided with support. This experience is also supported by the literature as Gustaffson et al's (1995) study of siblings in family therapy in which two of the siblings who came with families were above the cut off for moderate psychiatric disturbance and five other children showed a score which suggested distress indicating that siblings frequently attend therapy in need to support themselves.

Tools

Therapists' also spoke of the variety of tools they found useful in managing the barriers to attendance and supporting themselves as therapists and families in including siblings. Therapists regularly spoke of using reflecting teams to support them in both ensuring that they stayed open during sessions and found them useful reminders of neutrality and reflecting a diverseness of opinion that they could use to reflect on. The team also helped manage the chaos and information available to them and were a source of comfort and support which lowered the demand. Smith et al (1992) qualitative study investigating therapists' experiences of reflecting teams supports the findings of this study as they also reported that therapists in their study found the reflecting team useful in reflecting diversity and playing the role of 'reminder' for therapists around 'blind spots' which encouraged them to stay open and flexible. In this study the role of the team was supportive in managing the challenge of problem ownership, in that if a therapist became too 'embroiled' in the story of individual problems, which they felt at times was powerful enough to pull them in, then the team could play a useful role in reminding them of this and helping the therapist to redress the balance.

A further tool which was commonly used to support siblings involvement, was working creatively which linked closely with managing to involve different children across the age ranges, trying to create a balance in which all information is accessible by all family members at their developmental level. Therapists spoke mostly of using unstructured tasks to engage siblings in tasks, using art materials to allow children to participate visually by drawing or by using toys around the room. Studies which have spoken to young people about their involvement in family sessions also talk about the importance of toys and play in family sessions and that young people wished that they would be used (Stith et al (1996), Lobatto (2002). Snow and Paternite (1986), were one of a number of studies reviewed by Ruble (1999) when looking at the therapists inclusion of children in family sessions and was the only quantitative study reviewed that said children were regularly invited to sessions. As with the therapists in this study, they indicated that the tools they used to do this involved more action orientated and interpersonal tools to look at interactional patterns within the family.

Change and development

The final theme which therapists experienced in their management of siblings inclusion was change which included managing the pace of change of the therapy, in that they would need to balance the pace in which they would introduce families to an alternative perspective as well as reflecting the changes in themselves and family therapy over the years. Many therapists felt that change in their own inclusion of siblings in family therapy was supported by a change in themselves, from feeling inexperienced and de-skilled to feeling comfortable and happy working with whole families. This perspective is more than supported by the literature in which majority of research reflects on the perceived lack of experience and training felt by therapists who don't involve children in family sessions (Korner and Brown,1990). As therapists spoken to in this study were all based within child and adolescent services, they did not reflect on the level of training or suggest that they required more to feel greater confidence in including siblings. Instead they did suggest that experience and confidence with skills supports the inclusion of siblings, as it allows them to be more relaxed in their approach and whilst training, extra people and perspectives feel like too much.

Critique and study limitations

In order to promote the reliability and validity of the study, the author tried to meet the guidelines for qualitative research by Elliott et al (1999). With regard to *'owning own perspective'* the author's background and experience have been clearly described and a reflexive diary was kept throughout the research development and analysis to reflect on this to reduce its impact on the data. '*Situating the sample*' is a further guideline which has been acknowledged as a clear description of the therapists involved in the study has been included to help readers understand the context from which these findings have developed. Throughout the results the author has used a number of quotes as a way of '*grounding in examples*', to help readers link the themes being postulated to concrete examples in the data. A clear outline of the stages of analysis are also stated indicating how these conclusions were developed and a worked example is also included as appendix 9. *'Credibility checks'* have also been important to ensure that the findings have validity and summarising throughout interviews was used and a summary of the overarching theoretical codes was shared with the therapists in written and diagrammatic form and their feedback was integrated into the results. Credibility was also supported by having an 'auditor' as an outside influence to check and challenge the researcher's assumptions and findings. In order to demonstrate the *'coherence'* of the findings these have been reported, not only in written discussion but in diagrammatical form so that the links between the categories and how they interact can be clearly seen. *Resonance* with the reader cannot be demonstrated; however use of current literature suggests that the findings resonate with current research around siblings and family therapy. Finally the *specificity of the task* is also acknowledged, in that like all qualitative research whilst these findings appear to be valid to the therapists in this study, it is recognised that they cannot be generalised and may be specific to the therapists within this context.

There are a number of limitations, which need to be taken into account when interpreting the findings of the study. Although steps have been outlined to enhance validity and credibility of findings a number of further steps could be useful in future research to further enhance these. For example it could have been useful to re-interview therapists to explore themes in further detail or to collect data from other sources than the interview perhaps using observation of the therapists in action. Using other data sources other than the interview could have helped to dilute a further limitation present in this study as when therapists referred to case examples, it is unclear how long ago these cases took place and it is therefore important to consider the impact of time and personal change on how a clinician reflects on their experience. Future research using a design in which data was collected from observations of therapists' current casework with families with siblings alongside interviewing therapists could be helpful in minimising the impact of interviewing retrospectively.

It is also essential to reiterate that the sample is unlikely to be representative of other therapists. Whilst the therapists' eclectic ways of working and varying degrees of formal training in family therapy does seem to reflect the modern interpretation of family therapy, it is important to acknowledge the diversity of the individuals in the sample. Therefore the findings must be interpreted with care and should not be generalised to wider populations.

A final limitation is the author's acknowledgement of her position in relation to the research. As the researcher stated, she does have experience in using family therapy within this context and had met some participants previously in very different contexts. Whilst the researcher was very careful to differentiate between clinical and research tasks and took a number of steps to help to prevent bias, it is acknowledged that bias can never be eradicated completely and therefore findings should be interpreted in consideration of this.

Clinical implications

Clinically the findings of this research could be extremely useful for therapists who work using family sessions. Highlighting barriers which are difficult to manage, such as powerful problem ownership and expectations of siblings could help therapists be prepared for aspects which may be challenging and think about the ways in which they can fortify themselves and their service to manage the complexities of managing whole families. For example, looking specifically at the difficulty of problem ownership and expectations, therapists could think about how their services prepares families for family sessions and think about how the model can be shared from the very beginning to facilitate families understanding of the model.

Therapists could also reflect on the findings of this study to think about the tools which they feel they possess to help them to manage barriers and promote the benefits of sibling attendance and to identify areas of further training or practice which they think may be valuable to them. The value of a reflecting team in managing the complex balance is also illustrated by these findings and could help therapists and services to reflect on their use of such tools and think about whether these could be adapted to ensure their usefulness to the clinician, whilst fitting into today's cost effective services.

Clinically, it is also important to consider the impact of power and position on these findings. Clinicians felt that they were struggling against the powerful concept of individual problem ownership and blame and felt they had relatively little power in changing this perception. However literature exploring clients' experiences indicates that clients' feel they defer to clinicians power in family therapy sessions (Bischoff and McBride, 1996). The issue of power and hierarchy is one of great interest and it would be useful to further explore this with further research with both therapists and clients.

A final point of clinical learning could be the recognition of the impact of managing this complex balancing act on therapists in recognition of the challenges this poses to them personally. Recognising such challenges and managing them may support engagement with a family in a useful way. These findings indicate that at times therapists may have to exclude siblings for them to manage and work with a family however there is also useful learning from this research to help those therapists consider how they can work with siblings, even in their absence.

Implications for future research

This study has highlighted a number of areas which could be further explored. Problem ownership was an important theme, which has resonated through several studies in family therapy aside from this one. Further investigation of problem definition and what it means to therapists and families would be useful in further supporting therapists to understand this complicated phenomena which seems to present a difficulty in working from a systemic position in child services.

When exploring siblings' involvement in family sessions, this research feels like it could be the beginning of a series of studies which could explore the phenomena from a number of angles using qualitative research. To truly understand the role of the sibling in family therapy it would be essential to explore this from other positions, including the parents, siblings and referred children of the families that have experience family sessions.

Moon et al (1990) recommend qualitative techniques as a prelude to quantitative research, and therefore the next step in understanding therapists' experiences of siblings could be the development of a questionnaire study which could be sent to many more therapists working with families to establish the generalisability of the findings in this study or the repetition of this design across other contexts, to strengthen the themes found here.

Conclusion

This study adds further understanding to the involvement of siblings in family therapy, specifically from therapists' perspective. The main finding was that for therapists, involving siblings in family sessions is a complicated and demanding balancing act in which therapists had to manage the both positive and negative influences of sibling attendance using tools to manage this balance. Therapists also had to be aware of and manage the pace of change in sessions with families and be aware of the impact of the demand maintaining this balance has on them in working with siblings. Change also occurred in therapists comfort as a result of changes in the field of family therapy theory and as a result of experience or practice. This provides a learning opportunity for therapists who work with siblings to reflect on their own practice and indicates tools which may be beneficial in supporting inclusion an involvement of siblings. Considering the implications of the balancing act is important in developing services to ensure that therapists can identify areas of support or need to help them to manage the demands and work with siblings in family sessions usefully. It is acknowledged that these findings need to be interpreted with respect to the methodological limitations identified and that future research would be beneficial to further explore sibling involvement from other perspectives and in a wider contexts using quantitative methodology.

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CRITICAL APPRAISAL

Introduction

The aim of this appraisal is to reflect in the process of the research, throughout the process there have been many opportunities for personal growth and learning which have been considered throughout this appraisal.

Origins of project

Whilst choosing a project to research, I was always aware that I had a clear idea of what I was interested in and that whilst others who had gone before me recommended choosing a research topic from those available at the research fair, I found myself taking my own path. This was mainly because none of the projects at the fair were focused within child and family services, where I felt my future lay and I decided that I was passionate about doing my project in an area I was interested in as I felt that this may spur me on through the challenging times. I had a clear idea from the beginning that I was interested in family therapy and was planning a 3rd year placement in a family therapy. I began by exploring the available literature, looking at how family therapy had been investigated using qualitative research previously and I found that there had been some research which looked at the family therapy experience from a young person's perspective. This caught my attention and I decided that I would like to speak to young people who had attended family therapy sessions and began to discuss different ways of looking at this subject area with my future clinical supervisor in family therapy. I began to research the possibility of a number of ideas including the experiences of looked after children who come to family sessions and siblings' experiences of family sessions and quickly realised how interested I had become in reading the literature about sibling research. When I realised just how little research there was in this field, I recognised that by exploring siblings' experience of family sessions I had an ideal opportunity for me to complete project I was interested in whilst researching something unique using a qualitative methodology.

I think at this stage, my enthusiasm overpowered thinking logically as with hindsight, I realise that despite therapists across the city saying that they felt there was sufficient participants to recruit from I remember a particular conversation with a head of service who hinted that there may be major changes in the service I was recruiting from. Looking back I believe that had I not been so enamoured of how interesting I found my research I may have been able to think about the implications of this and question whether it would be sensible to continue along this research path. Had I listened to that 'niggle' in the back of my head it may have saved a lot of work and stress as the service did indeed have a major reshuffle and I found myself in January facing a bleak outlook on further participants and the premature end of my study. In my enthusiasm and excitement I had overlooked the fact that by interviewing siblings I had already significantly reduced my potential participant base as siblings do not attend as often as 'referred' children, and this paired with the reshuffle temporarily ending many of the teams' established family therapy clinics meant that this research was not viable at this time. This point was the most difficult point of my research journey as not only did it mean the end of so much hard work, but also I had to face the reality that no matter how interested I was in continuing I had to rethink my research and the time in which I had to do that was much smaller.

Whilst recruitment had shown the signs of failing, although I did not want to admit it I had been thinking about an alternative approach. I was sure that I still wanted to explore this area and I became interested in the thoughts and feelings therapists had about including siblings in family work. From this I decided that turning the project around to investigate from this alternative perspective would allow me to keep hold of the 'essence' of the research and continue to investigate the same phenomena which I had grown so interested in. Although this change allowed me to do this, it placed a great deal of pressure on me and much shorter deadlines, which meant that the relief I felt at holding onto the project, was tinged by panic.

Rationale for lit review

I began my literature review when planning my project around speaking to siblings' about their experiences and had hoped to investigate an area closely related to my study topic. However, I found that whilst there was a great deal of literature around siblings, there was almost nothing which looked at siblings' involvement in family work. Previous consideration of siblings in family therapy was very limited, old and part of a structural/strategic family therapy model which was far from the collaborative models of today, which meant that even a review of this limited research would not be pertinent or useful. I found myself widening my reading to look at all papers which explored client perceptions of family work and recognised that there had been no review of this literature as focus appeared to be on meta analyses of quantitative studies. As the review developed I became aware that all of the papers that I was reviewing used qualitative methodology and I felt that it would be useful to examine the reliability and validity of these studies in relation to guidelines based on Elliott et al's (1999) guidelines, to look at how successfully qualitative research had been used to understand client experiences. When my project changed, I felt that the literature review was still pertinent to the new angle from which I was exploring the phenomena and I was extremely relieved to see that this was still a relevant and useful review.

Implementation of the study

Ethical and research governance

When my research changed focus, I was struck with panic and disappointment when I realised that I would have to go through the ethics and research governance procedure again, having already received approval from them for my first project. The first process through ethics had taken some time as I had been applying alongside all my peers and had not been quick enough to get a slot until late summer. At that point I had been fairly relaxed about this as I was still under the illusion that this would be the only time I would go through this process, however when I was faced with having to repeat this process in a much shorter time period I definitely had a few more sleepless nights worrying whether the project could be fitted into the time limit I was faced with. However I found that the extra pressure meant that I was much more motivated in completing the appropriate paperwork and chasing information from the ethics committee and research governance. I had learnt a great deal about the process of applying from ethics and used that knowledge in my second application, which made the process much faster. I was also far more proactive about doing tasks which I could begin whilst waiting to begin recruiting, such as completing the literature review, piloting the interview and beginning the research report, in order to free up time later for interviewing and analysis.

Recruiting Participants

I was well placed to recruit to this study as the majority of the groundwork had been done whilst speaking to therapists when attempting to recruit siblings to my first project. Therefore I already had informal contact with a number of staff who expressed an interest in the study when I explained that I was planning to change the focus of the study to speaking to therapists about their experiences of siblings. This meant that when approval had been granted I had a ready made pool of participants who were keen and prepared to be involved as soon as my approval was granted in May.

Interviews

Despite the setbacks I had faced and being aware of the ever dwindling amount of time I had, the interviews were one of my favourite parts of the process, although at times they were also quite challenging. I believe that the skills I had developed clinically such as summarising and reflecting back, were extremely helpful during the process as was reflection on my part in the research process. As a researcher using qualitative research I was aware of the importance of neutrality and also of the challenge of remaining neutral. Something that made this harder was that in my own experience of using family therapy, I was just beginning to work with siblings as part of this process and sometimes wanted to 'chip' into the interviews with my own experiences and stories. As I had met some participants briefly outside the research context and in clinical contexts I was very careful to stop myself from 'slipping' from the research role.

At times, during the interviews, I found it hard to keep therapists' focussed on talking about non-referred siblings and could understand the power of problem ownership and how easy it can be to be drawn away from thinking about the whole family. Often therapists' would be drawn into telling stories about families, which would illustrate the power of the story around the referred child and left the siblings marginalised. It felt to me that, at times I had to try hard to keep the focus of the interview from becoming much narrower and reflect to therapists how sometimes it is difficult to fight against problem ownership and the power it has.

A further complexity I was faced with was the sheer anxiety I felt around using the recording equipment. As a person more familiar with the digital age of MP3's, I found I had very little trust in the cassette recorder and would often need to place it somewhere where I could see the reassuring red light which would indicate that it was actually doing its job. Being able to see this helped me to allay my anxiety and helped me to focus on the interview, without being distracted by my worries about the taping. However, towards the end of the interviews I developed some trust in the equipment, only for it to chew and erase 15 mins of conversation from the middle of the tape of my final interview. As time for both the participant and myself was short, I could not reschedule the interview and therefore had to work with the conversation that remained. Next time I do research, I may trust my instincts and try to source a more familiar, and in my eyes trustworthy way of recording.

Data analysis

Initially when I began to code the interviews, I was surprised at how interesting I found it, and how energised I was switching between interviews and my research diary to comment on or note down an idea, thought or something I had noticed. However, this quickly led to panic and feeling incredibly overwhelmed as I looked at all the data and the codes and wondered how I, as just one person, could make sense of all this information. I recognise that I had become so passionate about the subject that I was researching that I became quite 'possessive' of the information and reluctant to discard any of the codes, even if they were relevant for only one clinician or were less important.

I found this stage quite challenging as this was also an unfamiliar way of working for me and I often had flashes of blind panic, wondering whether I was doing it 'right'. During this stage I clung to my copy of Charmaz's (2006) guide to grounded theory and became quite dependent on it, mainly for my own reassurance. I found my supervisor helpful at this stage, and found that I would often plan a meeting feeling panicky and 'lost' in my data and when I arrived, I actually would often have quite clear ideas about where I was going next and perhaps merely needed someone to nod and agree that that may be the right path to take or help me to stand aside from the panic and recognise alternative paths. On reflection, I recognise that perhaps having less time than I had anticipated was actually helpful. I realise that no matter how long I had to analyse I would just have spent longer 'in' my data and perhaps felt even stronger about the less frequent or important themes and struggled even more to let them go or step back and let them blend into the larger theoretical codes. I think perhaps that having such tight constraints, while difficult and opposite to how I usually work, helped me to approach the data with more focus than I naturally would have done.

Writing up

Writing up the research has felt like a process that has been ongoing an impossibly lengthy amount of time, as I have always been working on some part of the literature review or research report, perhaps as a way to manage my anxiety about being held up in analysing and writing the results of my data. Originally I had planned more time for the final stages of my thesis and not having this had me reeling between periods of paralysing panic and productivity. I found writing up the results section of a qualitative research project much more challenging than that of quantitative methodologies I had used previously, in that it felt that there was a lack of 'definiteness' and clarity which I had come to expect in quantitative work, where a statistic gives a definitive 'yes or no' answer around significance. With this project it felt that the results did not have this definiteness and 'black and whiteness' which I was used to and although I knew that what I was reporting was far more valid and 'real' in my eyes and for the therapists I had interviewed and yet part of me wanted more of the structure and clarity. Managing this involved stepping back and recognising the true value of qualitative research and acknowledging the different qualities it brings to data, rather than trying to look for the same clarity as quantitative research.

A final challenge of writing up is one which has been a long term difficulty of mine, which was writing to a word limit. I recognise that my style of prose could be described as 'flowery' and that I am partial to extremely long sentences, which reflect the speed of my speech and reading, both of which make fitting into tight word limits difficult. I found this especially hard in qualitative research as I was so keen to put in quote after quote, because they were all so interesting and I found I had to be, and had to ask others to be, quite hard when reading drafts and help me to cut some of the waffle. I found my supervisor a useful reminder of this and recognised that they had the brutality to suggest chunks of text which could be superfluous that I lacked as someone who often 'fell in love' with what was written. I think that learning this and recognising my style will be incredibly useful in my clinical career in helping me to write clear and concise clinical letters and reports.

Personal Challenges

This research process has been a steep learning curve and there have been many challenges and learning points along the way. The most difficult was the way in which I was forced to manage the time within this piece of work as this contrasted entirely with my usual way of working. When it comes to projects or research, I have always been a 'planner' who starts work early and has self imposed deadlines and ultimate control as I have found in the past that a steady pace of work is much more beneficial personally than rushing close to a deadline. However, the failure in recruitment and collapse of the project, forced me to be the very opposite and I had to manage the increased stress I felt as the research had slipped out of 'my control' and placed me on unfamiliar ground. I recognise that I often felt paralysed by the task and would spend whole days with grand plans and extensive timetables and yet in reality sat on the internet doing nothing to block out the rising tide of panic. I had to learn different ways to manage the stress and found that to do that I did need to let those around me help by creating manageable timetables with me or by letting me work at their house and offering a steady flow of tea and gentle reminders that 'Facebook' wasn't pertinent to my research. Previously I have always tried to hold onto and control everything and this was a firm lesson in accepting support and reassurance, which helped me to be productive, rather than wallowing my own distress.

Dissemination & publication

I fed back the themes and findings of this study to the participants as part of validating the findings prior to write up. I plan to approach the heads of service in Child & Therapy teams to discuss presenting this research to the teams. After I have made the necessary amendments to this piece of work, I also hope to negotiate the time with my employers to write up the findings of my research for publication.

Overall learning points

This research process as whole has been demanding yet, at times, enjoyable and definitely fascinating. I have learnt a great deal about the way in which I approach work which will help me both personally and professionally. I recognise that whilst I am more comfortable with time to plan or think about the work that I do, I am able to work under pressure and manage many competing demands, which I learnt whilst applying for jobs and having interviews at the same time as analysing and writing up data. I have learn to recognise the signs that I am feeling 'overworked' or pressured and feel that this will be useful in future clinical work, where there are undoubtedly many demands.

I have found using qualitative research incredibly useful and feel that this has helped me to develop more varied tools with which to approach research questions. I think that having placed my research within the NHS I have learnt a great deal about the processes required implement research in a 'real world' setting and I feel I can take these forward into my new role in the NHS.

Within the reality of research as one of multiple demands, I have learnt that whilst I find timetabling and planning helpful, I need to be cautious in not setting myself unrealistic targets or deadlines. By being too ambitious, I recognise that I often feel stuck. To become 'unstuck' I recognise that I have learnt to accept support and to give myself a break. With hindsight I have learnt that a short break when feeling anxious or overwhelmed often led to me being more productive than making lists or plans which were unachievable.

References

Charmaz, K (2006) Constructing Grounded Theory: A practical guide though qualitative analysis. Sage. London

APPENDICES

Appendix 1:

Letter for journal approval and guidance for authors

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226550
Fax: 0114 2226610
Email: c.harrison@sheffield.ac.uk

31 March 2008

Kat Baker
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Kat

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature Review: Journal of Family Therapy

Research Report: Journal of Family Therapy

Please ensure that you bind this letter and copies of the relevant Instructions to Authors into an appendix in your thesis.

Yours sincerely

Dr Zaffer Iqbal
Director of Research Training

Journal of Family Therapy

Published on behalf of the Association for Family Therapy and Systemic Practice

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Ivan Eisler

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TopAuthor Guidelines

NOTES FOR AUTHORS

Papers submitted for publication should be original work not previously published in English and not currently submitted elsewhere for consideration. If accepted for publication, a paper cannot be published elsewhere in any language without the consent of Editor and publisher. It is a condition of acceptance that the Association for Family Therapy and Systemic Practice automatically acquires the copyright throughout the world.

Exclusive Licence Form
Authors will be required to sign an Exclusive Licence Form (ELF) for all papers accepted for publication. Signature of the ELF is a condition of publication and papers will not be passed to the publisher for production unless a signed form has been received. Please note that signature of the Exclusive Licence Form does not affect ownership of copyright in the material. (Government employees need to complete the Author Warranty sections, although copyright in such cases does not need to be assigned). After submission authors will retain the right to publish their paper in various media/circumstances (please see the form for further details). To assist authors an appropriate form will be supplied by the editorial office. Alternatively, authors may like to download a copy of the form here.

Manuscript submission

Manuscripts should be submitted to the following website:
http://mc.manuscriptcentral.com/jft

Full submission instructions can be found on this website. If you do not have access to the internet, please contact the Journal of Family Therapy office to discuss alternative means of submission.

Please note that revisions to manuscripts that were not initially submitted to the website should be sent as an e-mail attachment to the Journal of Family Therapy e-mail address.

A cover letter should be submitted with your manuscript and must include a statement that the data have not been published, and is not under consideration for publication elsewhere. It will be presumed that all listed authors of a manuscript have agreed to the listing and have seen and approved the manuscript.

NEW: Online production tracking is now available for your article through Blackwell's Author Services
Author Services enables authors to track their article - once it has been accepted - through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit www.blackwellpublishing.com/bauthor for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

Pre-submission English-language editing
Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at www.blackwellpublishing.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

Format for Manuscripts
1. Manuscripts should allow for 'blind' refereeing and be prepared accordingly. Failure to conform to this requirement will result the manuscript not being reviewed.

2. Manuscripts should be presented on one side of white bond A4 paper with wide margins (3.1cm) and *must* be typed in double spacing throughout, *including quotation, notes and references* in the following order:

i) Title Page: to contain the title of the paper, the full name of each author, their current professional position and work context and an indication of which author will be responsible for correspondence, proofs and reprints. Correspondence address and telephone numbers should be included. A word count *must* be included on the title page together with a suggested running head.

ii) Abstract: On a separate sheet, the title to be repeated followed by not more that 150 words summary of the paper. The suggested running head should also be present.

iii) Organisation of the text: See copy of Journal for the format currently in use.

iv) References: a.) In the text these should be indicated by the name and date e.g. ' Carr (1995).'. If more than two authors are listed, cite the reference as 'McGroary *et al.* (1997).'. Quotations should include page numbers.

b) References used should be listed at the end of the paper in alphabetical order according to the first author and be complete in all details, again following the Journal's existing format.

Articles: -Carr, A. (1995) Family therapy and clinical psychology. *Journal of Family Therapy*, **17:** 435-444.

Chapters: -Carpenter, J. And Treacher, A. (1993) Introduction: the changing contexts of family therapy. In: J. Carpenter and A. Treacher (eds) *Using Family Therapy in the 90s*. Oxford: Blackwell. If there are queries A.P.A. reference style is appropriate.

v) Figures, tables, etc.: All figures and tables should be numbered with consecutive arabic numerals, have descriptive captions and be mentioned in the text. They should be kept separate from the text but an approximate position for them should be indicated.

vi) Style: Whilst the style of the Journals is generally formal, originality in presentation does not necessarily preclude publication if clarity and readability is thereby enhanced. Sexist language forms are unacceptable.

Evaluation of Manuscripts

The Editorial office will acknowledge receipt of manuscripts. The Editor will arrange for evaluation by at least two assessors. Following receipt of the assessors comments the Editor will advise the authors about the decision concerning the manuscript. This will be done as rapidly as possible with the aim being 12 weeks.

On Acceptance

When the article is formally accepted for publication the author(s) will be required to provide two hard copies of the final manuscript and the same version of the article on a computer disc. Advice on preparation of the latter will be provided at that time.

Copy Editing

Following acceptance for publication an article is copy edited for conformity to the style of publication, clarity of presentation, punctuation, standard usage of terms, etc. After an article has been typeset authors will be charged for any changes they wish to make.

Proofs

First-named authors will receive proofs for correction which must be returned within **48 hours** of receipt. The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site:

http://www.adobe.com/products/acrobat/readstep2.html.

This will enable the file to be opened, read on screen and printed out in order for any corrections to be added. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

Reprints

The senior author only will be sent a PDF file of the final version of their article free of charge.

PREPARING THESIS MATERIAL FOR PUBLICATION

Beginning: From the outset, it needs to be appreciated that the audience for a thesis is very different to the readership of a Journal. A thesis is prepared to demonstrate candidates' knowledge of an area, their understranding of how theoretical matters link and their ability to use a wide range of sources to develop arguments. In presenting research material, the thesis will provide explanations about the process of deciding on a methodology, the utilisation of that methodology and a critique of its application. A Journal article by contrast seeks to make one or two points clearly and to link these with the current understandings and conceptions in such a way that there is the development of ideas. The Journal reader assumes that the author has a wide range of knowledge of the area and is looking for the author to make a few points well by building on what is already known. Essentially therefore a thesis and a Journal article are very different pieces of writing and the process of preparing one for the other is more than just re-wording of the title page!

The key to overcoming the difficulties of moving from a thesis to a Journal article is to be aware that one uses the **thesis as a source** rather than using it as an earlier version of the article. In preparing a Journal article you begin with a blank sheet of paper, a lot of knowledge and previous written material. What is available has the potential of being an article but further work will be necessary.

Common Problems: For the reasonably experienced Journal reviewer it is easy to identify thesis based material by the common problems that appear.

- *The introduction is over long and covers too broad an area.* Histories of where family therapy came from and descriptions of core elements of systemic practice are not necessary in Journal articles. Only the theoretical point germane to the article's principle aims need to be outlined.
- *Long explanations as to why particular methodologies are used.* For a Journal article there is no need to enter into discussions of this nature or to compare different methodologies. The decision was made to undertake the research on one particular methodology and this is what should be present.
- *Too many quotes from other authors.* There is a need in thesis to seek validation from a wide range of sources, but in a Journal article the author's own arguments should be enough with a few selected quotes to emphasise points.
- *The attempt to write the journal article by following the same structure of the thesis.* In many cases this is not necessary as the article will demand a different type of structure.
- *Over long self critique of the work.* Although self criticism is a necessary part of any public presentation of one's work, it needs to be pertinent to the material presented. There is no need for a full descriptive account of the self reflective process.
- *De-emphasising the main findings of any research study in an attempt to fit it in with the fuller perspective of the thesis.* In an article the main findings of the research study need to be emphasised and examined and then linked to broader themes relevant to the issues discussed.

In short, writers of the journal articles prepared from thesis often attempt to include as much of their thinking that went into the thesis in the article. There is a need to overcome the reluctance to cut out elements of the thesis in the preparation of an article to keep the writing solely relevant to the ideas being present.

Types of Papers: There are three types of papers that can be prepared from theses (and two of these types could emerge from extended essays):

- 1. *The Literature Review* Unfortunately there are too few of this variety presented for publication even though they are much sought after by the readership. Such a paper would have:

  a. A brief general introduction.
  b. A description of the way in which the themes in the literature are organised by the author for review. This may include conceptual and definition problems.
  c. The review.
  d. An overview of the review process including gaps in existing knowledge.
  e. Future directions.

  Such a review would be in the order of 3,000-6,000 words.

- 2. *A Theoretical Discussion or Argument* Again there are few articles of this nature offered for possible publication. A paper of this type would include:

  a. A brief general introduction.
  b. Review of previous statements of the issues.
  c. Definition of problems and solutions.
  d. Development of an argument (Research based work which was undertaken for a thesis may be referrenced).
  e. Relation of theory to practice.
  f. Issues to be resolved.

  An article of this nature would be in the order of 4,000-6,000 words.

- 3. *Research Presentation* This is the usual type of article that is presented. This article should include:

  a. An introduction to the principal concepts and theoretical issues relevant to the study.
  b. Previous work.
  c. Brief description of methodology including participants. d. Results.
  e. Discussion of results in terms of (a) and (b), including implications for future research and practice.

  Research presentation should typically be of the order of 3,000-4,000 words for M. Sc. thesis and possible 4,000-6,000 for Ph. D. thesis.

Good Marks and Articles

- Because the consumers of theses and articles are different, the potential author needs to be aware that if a thesis is praised it does not necessarily mean it is readily translatable into an article. It simply means a good mark towards the degree. Similarly, even if a thesis or extended essay just scrapes past the pass mark, it may contain some very useful material that can be worked with for future submissions as an article to a Journal.

The Question of Authorship

- In many academic departments there is a tradition that material which is offered for publication which is based on a thesis should be seen as a joint endeavour between the student and the supervisor. The student is seen as being the senior author with the supervisor in a supporting role. Courses and supervisors are quite likely to have different views on this. There are no set rules. However in some situations it may be that by using the thesis material as a source a good quality article could be developed by the student and supervisor working on it jointly. This is a point that should be borne in mind by both students and staff of family therapy courses.

A Final Point

- Writing is a very enjoyable and satisfying way of being involved in the world of family therapy. The exchange of ideas and experience is important for the development of our chosen field and is important for the deveolpment of the individual practitioner. We intellectually sustain ourselves by creating a heathy and vibrant literature. Family therapy needs to develop authors.

The Journal of Family Therapy wants to hear from you. Get writing.

GOOD LUCK!!!!

For further information on publishing in the *Journal of Family Therapy* please contact:

Ivan Eisler
Institute of Psychiatry
Section of Psychotherapy
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Tel: 020 7848 0693
Fax: 020 7848 0205
Email: ift@iop.kcl.ac.uk

Appendix 2:

Participant Information Sheet

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training
& consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: Christie Harrison : 0114 2226650
Email:
Please address any correspondence to Ms. Christie Harrison, Research Support Officer

Project Title: Therapists Experience of Working With Siblings in Family Sessions
Researcher: Kat Baker

Working With Non-Referred Siblings In Family Sessions

You are being invited to take part in a research study about working with non-referred siblings in family sessions. Before you decide whether you want to take part, it is important that you understand why the research is being done and what participation will involve.

If you want to take part, or if you want some more information before deciding, then please return the reply slip on the flier. When I know you're interested I will contact you and you can ask any questions you have.

Why is this research being done?

My name is Kat Baker and I am currently training to be a Clinical Psychologist and as part of my training I am doing some research. I am interested in talking to therapists who have had some experience working with non-referred siblings in family sessions. I hope that by talking to therapists I will be able to find out about how therapists work with non-referred siblings within family sessions.

Why have I been asked to take part?

You have been asked to take in this study because you regularly work with families and may have experience of working with families who bring non referred siblings to family sessions.

Do I have to take part?

No, taking part is completely up to you. If you do decide to take part I will ask you to sign a consent form and you will be given a copy of this information form and your consent form to keep. You can change your mind about joining in at any time, even after you have signed the consent form.

What will happen if I take part?

If you decide to join in the study (or if you just want to know more about it!), you would need to return the slip on the flier with your contact details or telephone me on the above number.

When I have received your contact details I will phone to speak to you answer any questions you have and if you want to go ahead we will arrange a time to meet up. You can choose whether I come to meet you at your base, where we can talking your office or I will book a room, alternatively we can meet at the Clinical Psychology Unit which is part of the University, whichever is easier for you.

When we meet up and I will ask you some questions about your experiences of working with non-referred siblings. I will ask you to think about your experiences and reflect on these, I may ask you to think about specific cases and reflect on these, but I am interested in your experiences and will not need any identifying details about the clients you have worked with. The interviews will take between 1 and 1 ¼ hours.

When we speak I will use a tape recorder to tape our chat, this means that I can listen to what we talked about again. I will keep the tape recordings safe by keeping them in a locked filing cabinet at the university, and only I will have the key for this to make sure that they are safe and when I have finished them, I will make sure that they are destroyed so no-one else can listen to them.

It is really helpful to arrange a second meeting so that I can check that I have understood everything, we can think about a good time to do this at our first interview. If it is really difficult to arrange this, we could find a good time for me to speak with you on the telephone as it is really important that you tell me whether I have understood what you are saying. We can talk about making this decision if you want to join in the research.

What are the risks of the research?

The questions in the interview will ask you to reflect on your experiences, should you find any of the questions distressing you can stop the interview immediately. You can choose to continue when you feel better or to withdraw from the study. If you decide to withdraw any tapes will be destroyed. Should you continue to feel distressed after the session the researcher will be able to signpost you to local support networks, such as Workplace Wellbeing.

What are the benefits of the research?

This aim of this research is to begin to try and understand what it is like for siblings who attend family sessions when they are not the 'referred' child. Hopefully it will help other clinicians to think about what this when working with other families. If you want to hear about the results of the project, I would be happy to share the research findings with you and can present them at team meetings if that would be helpful.

Confidentiality

You will be interviewed by yourself and what you say will be kept private. I will keep the tapes of our conversations locked up in a safe place. I will be writing up my findings for the university and when I write up my report I will use pseudonyms and when I have finished I will destroy the tapes of our talks.

If you refer to specific experiences within our interviews, it is essential that you use a pseudonym to refer to the client and do not share any identifying information. In the unlikely event that identifying information is shared, the interview will be stopped and I will erase this from the tape.

Did someone make sure the research was Ok to do?

I am training to be a Clinical Psychologist with the University of Sheffield and they are supporting me with my research. To make sure that my research is fair it has been check by the University of Sheffield and the Research Ethics Committee.

What would I do if I was unhappy about the research?

If at any time during the research you are unhappy with anything, there are several things you could do.

1. You could talk to the interviewer about what you are unhappy about.
2. You could also contact my research supervisor:

   Professor Gillian Hardy
   Clinical Psychology Unit
   Department of Psychology
   The University of Sheffield
   Western Bank
   Sheffield, S10 2TP, UK

Tel: 0114 2226571
Email: g.hardy@sheffield.ac.uk

4. If you have *any* cause to complain about *any* aspect of the way in which you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms are available to you and are not compromised in any way because you have taken part in a research study. You can use the normal trust complaints procedure and contact the following:-

Chris Sharratt
Chief Executive
Sheffield Children's NHS Trust
Western Bank
Sheffield
S10 2TH
Tel: 0114 271 7317

Thank you for the time you have taken in reading this, I hope that this information sheet has helped.

Appendix 3:

Participant Consent Form

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: Christie Harrison : 0114 2226650
Fax:
Email: dclinpsy@sheffield.ac.uk
Please address any correspondence to Ms. Christie Harrison, Research Support Officer

Project Title: Therapists Experience of Working With Siblings in Family Sessions
Researcher: Kat Baker

Please Initial Box

1. I have read and understood the information sheet dated 30/03/08 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had them answered satisfactorily. ☐

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

3. I understand that a tape recorder will record our conversation and that Kat will keep the tapes locked up until she has finished with them and then they will be destroyed. ☐

4. I understand that this research is being written up for the university to contribute to a doctoral training course. I understand that when it is written up, my name will be changed, so no one will recognise me ☐

5. I am happy to take part in the research ☐

____________________	____________________	____________________
Name of participant	Signature	Date
____________________	____________________	____________________
Name of person taking consent	Signature	Date

Appendix 4:

Participant demographics form

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical sup---earch training
& consultar Christie Harrison : 0114 2226650

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk
Please address any correspondence to Ms. Christie Harrison, Research Support Officer

Project Title: Therapists Experience of Working With Siblings in Family Sessions
Researcher: Kat Baker

In qualitative research it is most helpful when there is a clear description of the background of people who participated. I would be grateful if you could answer the questions below. If you have any questions about these, please do not hesitate to ask me about them.

Thank you

1. Job Title

____

2. How long have you been working with families (approximately)?

____

3. How often do non-referred siblings come to your sessions? (please circle)

Every Session   Most Sessions   Some sessions   One or two sessions   Hardly ever

4. What model or approach would you say you use most frequently with families?

Thank You

Appendix 5:

Interview Schedule

Preamble – (After consent is gained from clinician).

'Okay, we're ready to begin now. Feel free to take time to think about your experiences and its ok to ask me to explain further. Please remember that when thinking of your experiences, it is important that you don't use any client details which may identify them. If you accidentally use their use their names etc, please tell me and we will erase it from the tape. Is that ok?'

(START TAPE RECORDER)

Topic 1:- Perceptions about the family before coming to therapy

Question: - When you send out an appointment to a family who have children other than the non-referred child, what are your hopes for the sessions?

Possible prompts

- Do you feel it's important for the siblings to come with the family?
- If the family don't bring the siblings how do you feel?
- Have you ever asked the family why other siblings don't attend?

Topic 2: - The initial session

Question: How do you think the siblings feel in the first session?

Possible prompts

- Do you think their experience differs from the referred child? If so how?
- Do you do anything differently to engage the siblings?
- What role do siblings usually play in the early stages of therapy?

Topic 3: Further family sessions

Question: How have siblings contributed over the progression of the work?

Possible prompts

- In your experience do siblings often attend follow up family sessions?
- If not why do you think siblings don't attend follow up sessions?

- How do you use siblings over the course of therapy – how are the roles they play negotiated in sessions?
- Do the roles siblings play in therapy change over the course of therapy?

Topic 4:- Positive experiences of siblings in family sessions

Question: Can you tell me about the times that siblings have played a useful role in family sessions?

Possible prompts

- How did siblings participate?
- How did their participation help the work?
- How do you think the sibling felt during this work?
- What, if anything did you take from this experience?
- Have you used this learning in work with other families with non-referred siblings?

Topic 5:- Difficult experiences with siblings in family sessions

Question: Can you talk about any times when siblings' attendance was difficult to manage?

Possible prompts

- What was difficult about the sibling's behaviour in the session?
- How do you feel that impacted on the therapeutic work?
- What did you do to try and manage this?
- How do you think the sibling felt in these sessions?

Topic 6 – Siblings and change

Question: Have there been any families you have worked with where you felt that the sibling played a pivotal role in the outcome of the work – good or bad?

Possible prompts:

- In what ways do you think that the sibling supported change
- Did you recognise the impact of the sibling on the work, or was it something you reflected on after the end of therapy?
- How do you thing the sibling felt in these cases?

Topic 7:- Summary and ending

Question:-Tell me about your views and opinions on involving siblings in family sessions?

Possible prompts

- Have they changed over time?
- In an ideal world, would you prefer siblings played an active role in sessions?
- How would you summarise your learning from your experiences of siblings and how have you taken this forward in your work?
- Is there anything that you have realised or anything that has surprised you during this interview?
- Is there anything which you think I should know, that perhaps I haven't asked yet?
- Is there anything you would like to ask me?

Interview ends – Clinician is thanked for their time and debriefed.

Appendix 6

Documentation for ethical approval and research governance

Page numbering as original

NHS

National Research Ethics Service

South Yorkshire Research Ethics Committee
1st Floor Vickers Corridor
Northern General Hospital
Herries Road
Sheffield
S5 7AU

Telephone: 0114 226 9153
Facsimile: 0114 256 2469
Email: joan.brown@sth.nhs.uk

02 May 2008

Miss Kathryn Baker
Trainee Clinical Psychologist
Sheffield Care Trust
Clinical Psychology Unit
University of Sheffield
Western Bank
S10 2TP

Dear Miss Baker

Full title of study:	**Therapists' Experience of Working With Siblings In Family Sessions**
REC reference number:	**08/H1310/15**

Thank you for your letter of 09 April 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

Ethical review of research sites

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

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

<u>Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.</u>

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

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

Document	*Version*	*Date*
Application		20 February 2008
Investigator CV		
Protocol	3	09 April 2008
Covering Letter		09 April 2008
Covering Letter		
Letter from Sponsor		18 February 2008
Peer Review		15 February 2008
Participant Information Sheet	3	09 April 2008
Participant Consent Form	3	09 April 2008
Response to Request for Further Information		09 April 2008
Research Timetable	3	09 April 2008
Supervisor's CV - Gillian Hardy		
Costing Form	3	09 April 2008
Confidentiality Form for Transcribers	3	09 April 2008
Demographic Information Form	3	09 April 2008
Interview Schedule	3	09 April 2008
Recruitment Flyer	3	09 April 2008

Statement of compliance

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

After ethical review

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

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

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

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

08/H1310/15	**Please quote this number on all correspondence**

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

Yours sincerely

pp **Jo Abbott**
Chair

Enclosures: "After ethical review – guidance for researchers" SL AR2

Copy to: Mr Richard Hudson, Research Office, Research Services, New Spring House, 231 Glossop Road, Sheffield, S10 2GW

Sheffield Children's Hospital, R & D Department

Sheffield Children's NHS Foundation Trust NHS

Please reply to: Clinical Research Facility
D Floor Stephenson Wing
Western Bank
Sheffield

Telephone: 0114 271 7404
Fax: 0114 226 7844
E-mail: jim.bonham@sch.nhs.uk

Miss Kathryn Baker
Clinical Psychology Unit, Department of Psychology
University of Sheffield
Western Bank
Sheffield
S10 2TP

19 May 2008

Dear Miss Baker

ID: SCH/08/013 Therapists Experience of Working With Siblings In Family Sessions

I am pleased to confirm Trust Management Approval for you to proceed with your 'SSA-exempt' study at our Trust in accordance with the Research Governance Framework for Health and Social Care.

I would like to take this opportunity to wish you every success with this study.

Yours sincerely

Dr Jim Bonham
R&D Director

Version 1.0
August 2006

Copy to: Mr Richard Hudson, University of Sheffield

Appendix 7:

Transcriber confidentiality form

Doctorate in Clinical Psychology

University of Sheffield

Confidentiality Form

Type of project: Clinical Skills Assessment Research thesis

Project title ______________________________

Researcher's name ________________________

The tape you are transcribing has been collected as part of a research project. Tapes may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining this confidentiality is of utmost importance to the University.

We would like you to agree not to disclose any information you may hear on the tape to others, to keep the tape in a secure place where it can not be heard by other people, and to show your transcription only to the relevant individual who is involved in the research project. If you find that anyone speaking on a tape is known to you, we would like you to stop transcription work on that tape immediately.

Declaration

I understand that:

1. I will discuss the content of the tape only with the individual involved in the research project
2. I will keep the tape in a secure place where it cannot be heard by others
3. I will treat the transcription of the tape as confidential information
4. If the person being interviewed on the tapes is known to me I will undertake no further transcription work on the tape

I agree to act according to the above constraints

Your name ______________________________

Signature ______________________________

Date ______________________________

Occasionally, the conversations on tapes can be distressing to hear. If you should find it upsetting, please speak to the researcher.

Appendix 8:

Transcribing Instructions

Instructions for transcribers

Page Set Up:

1. Please leave 2.5cm margins all around the text
2. Use double spaced lines
3. Font:- Times New Roman – 12pt
4. Alignment – please use justified
5. Please put PARTICIPANT and the participant number (this is written on the tape) in the header box.
6. Please put the page number in the footer box, aligned to the right.
7. Please number all lines (even if there is no text on them)
8. When someone starts talking, please label the beginning of the speech with I for interviewer or P to indicate the participant is speaking.
9. Please can you provide a front sheet detailing the participant number and any necessary notes or decisions regarding the interpretation of the transcript.

Anonymity

1. Please label any references to names of people with an X
2. Names of services, such as CAMHS can be identified, names of any specific services such as the team name should be labelled A

Flow of the text:

- Please show any pauses or hesitation as ..... These can be used to show gaps in sentences or at the end of a sentence to indicate fade out or pause.
- Emotional content: Please use brackets [ ] and capital letters to show non verbal responses. Some examples are below, use these as and when needed, they are not necessary for every interviewee response.

[LAUGHS]
[SIGHS]
[SOUNDS SARCASTIC]
[LONG PAUSE]
[SPEAKING QUICKLY]

Inaudible/unclear/interferences

- If a word is inaudible or missing you can add additional words to help the flow of the dialogue. If you do this please place them in brackets i.e. (helping)
- Inaudible sentences/phrases can be replaced with [*inaudible*] or [*unclear*]. Please put this in italics. If large portions of the interview are unclear please add an approximate time i.e. [inaudible approx 5 mins]
- Any interviews, like someone coming in, a phone ringing or an emergency should be explained in brackets in italics [*the interview paused as someone entered the room]*. Do not type the content of any chit/chat at these points and resume typing as the interview begins again.

Appendix 9:

Example of analysis

Grounded Theory – Process of Analysis

This section details the analytic process discussed in the method section of this report. To illustrate the analysis process an excerpt from Bert's transcript has been used as an example and is illustrated in table 1.

Analysis began with examination of each individual transcript, which was done in order to the interviews taking place. After each interview and the researcher took time to record thoughts and reflections in a research diary and these were read to refresh the researcher's memory and further notes were recorded.

The first part of coding involved line by line coding which required the researcher to name each line of the interview with a code which denoted the actions and significant processes which were being spoken about (see table 1). In order to guide this analysis the guidance from Charmaz, 2006 was used:

- What processes are the issues here? How can I define it?
- How does this process develop?
- How does the research participant act whilst involved in this process?
- What does the research participant(s) profess to think and feel while involved in this process? What might his or her observed behaviour indicate.
- When, why and how does the process change?
- What are the consequences of the process?

(Charmaz, 2006 p. 51)

Following line by line coding, the next stage was focussed coding, which required the researcher to go through the transcripts looking at the line by line coding, looking for the most significant/frequent codes which were then noted in the right hand margin.

The focused codes were then summarised in the research diary, accompanied by brief memos to explore emerging themes and categories as these were developed. In order to stay active within the data, the researcher moved back and forth between transcripts to look for similarities or differences between them and to follow up the development of existing or new codes.

To develop the categories and codes further axial and theoretical coding was done together to begin to examine the connections between codes and develop sub themes and main themes. The beginning of this process is shown by the arrows on the right hand side of the transcripts. To support the development of these diagrams and pictures were used which developed the overarching themes and the key theoretical finding from the study. To facilitate the write up of the study and development of themes, memos were written in the research diary which helped to develop thinking around the codes before writing up the findings of the study

Extract from Bert's transcript – analysis example

	I: At the very beginning, before the family has come, thinking about when you	
	send out the appointment letter to a family with children other than the	
	referred child, what are your hopes for the sessions?	
Personal feelings/team rules/status quo	P: Umm, well I am hoping, anyway we have a general principle that we invite	Organisational Aspects
Labels & jargon/ team rules	families even when the identified patient comes for first assessment, we, we	
Tentatively	say that we would quite like to meet as many other members of the family as	
Tentatively/Get information	possible, because if nothing else they give you a flavour of what its like being	Tentativeness
Get information/Insight	in that family, they can often give you information and participate in ways that	
Therapists expectations – surprise	are quite surprising, so...erm and quite unique and interesting and informative	
Team rules in harmony with self?	and helpful, so as a general principle that's where I will be coming from but	Information – personal gain
Personal feelings – hope but exceptions – uncertain	what I am hoping for by enlarge by having as many members of the family	
	involved, including sibling, non referred siblings is that they will be part of the	
Labels & jargon Thinking about the future – part of process	solution.	
	I: Right, so you think it's important that the come to the sessions.	
Tentatively	P: I think it is...yes.	

REFLECTING PACE OF CHANGE?

BENEFIT

Extract from Bert's transcript - continued

	I: So if the family don't bring the siblings and you know there are siblings in the family, at the first or even at subsequent sessions, how do you feel when the siblings then don't come?		
Personal preference/conflict	P: Well, obviously there's a dilemma there because I would operate on		
People's choice/ therapist justification	the basis that people need to consent to that erm and I do understand that for	Understanding individual family position	
Different circumstances/unpredictable	different families there are different imperatives like, if you, you might have		
Barriers – specific examples	older siblings who have got exams to do, or you know it's a particularly		
Frequency of barriers – frustration? Competing with other demands	crucial time...it's nearly always a crucial time or there are particular lessons		BARRIERS
Decision making/conflict/choice	they don't want their families to come to that is a dilemma they've got to	Information – personal loss	
Therapist's loss	resolve. But you know it often means that you have an absence of information,		
Generalization to therapists in general/risk	you are dealing with, you are much more likely, I think to get		BARRIERS
Uncomfortable position? Uncomfortable labels/labels	into a position, I, I don't – I am using this advisedly- a scapegoating of the	Problem ownership – blame –power of terminology	
Labelling/problem ownership/negative	identified patient as being the sole problem bearer erm and that's the sense in		
Labels/emotional content of labels/meanings	which I am using scapegoat and not as an aggressive or mean kind of thing,		