HOW DO THERAPISTS AND FAMILIES NEGOTIATE MEANING AND FAMILY

RELATING DURING FAMILY THERAPY FOR SELF-HARM?

Benjamin James Green

Submitted in accordance with the requirements for the degree of

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

The University of Leeds

School of Medicine

Academic Unit of Psychiatry and Behavioural Sciences

May 2015

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

ACKNOWLEDGEMENTS

ABSTRACT

Introduction:

Although the negotiation of new meaning is a common goal in almost all family therapy, and various approaches offer theoretical accounts of how this takes place, the way in which it occurs in practice through the interaction between therapists and families is not well understood. Adolescent self-harm is one of the most difficult to treat presentations facing mental health professionals today, although family interventions offer a potentially effective way of responding. The present research investigated the processes through which family therapists negotiate the meaning of self-harm during therapeutic conversations taking place over the course of therapy.

Method:

A grounded theory analysis of video-tapes of family therapy was conducted. Two full cases of family therapy were selected from a pool of tapes recorded as part of an ongoing randomised controlled trial: Self Harm Intervention Family Therapy ('SHIFT'). A conceptual model of the process through which changes in meaning and relating take place was developed from the analysis of the first case. A second case was selected by means of theoretical sampling and its analysis was used to refine this model.

Results:

The mutual engagement of family members in therapy was found to be of fundamental importance for the joint exploration of meaning and family relating. Without mutual engagement, other elements of the therapy process are constrained and beneficial change is curtailed. Affect regulation was a prominent theme across the two cases.

Discussion:

The findings are discussed in the context of the existing literature on functions of self-harm and alliances in family therapy. Implications of the findings for clinical practice are considered and avenues for further research are proposed.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

CA: Conversation Analysis

CBT: Cognitive Behavioural Therapy

CCCS: Cognitive Constructions Coding Scheme

DA: Discourse Analysis

DBT: Dialectical Behaviour Therapy

DGP: Developmental Group Psychotherapy

GT: Grounded Theory

NICE: National Institute for Clinical Excellence

RCT: Randomised Controlled Trial

SE: Sustained engagement

SHIFT: Self-Harm Intervention Family Therapy

SI: Symbolic Interactionism

SOFTA: System for Observing Family Therapy Alliances

TA: Task Analysis

WHO: World Health Organisation

ZPD: Zone of Proximal Development

CHAPTER 1: INTRODUCTION

Following a review of relevant literature, I will introduce the present research, stating the rationale for the study and the questions it aims to address.

Literature Review

I will begin by reviewing literature on the prevalence of self-harm in young people and research which has investigated the functions that it serves for individuals. I will go on to briefly consider research on the prevention and treatment of self-harm. Finally, I will turn to the family therapy process literature, discussing studies which have investigated within-session changes evident in the talk of families and therapists. This will include a brief look at the literature on the therapeutic alliance in family therapy.

Definitions of Self-harm

There has been considerable debate concerning the appropriateness of various terms used to describe the phenomena we are concerned with. I will use the term 'self-harm', although 'self-injury', 'self-mutilation', 'self-inflicted violence', 'deliberate injury' and 'parasuicide' are all used to a greater or lesser extent in the literature. There is also disagreement concerning the behaviours such terms encompass. For our purposes, "self-harm describes the various things that some people do in order to harm themselves in a deliberate and usually hidden way. The most common methods involve repeatedly cutting the skin, but burning, scalding, banging or scratching one's own body, breaking bones, hair pulling and ingesting toxic substances or objects are all done as well" (Brophy, 2006; p.18).

Prevalence

It has been estimated that around 25,000 young people annually are admitted to hospital in the UK following an act of deliberate self-harm (Hawton, Fagg, Simkin, Bale, & Bond, 2000). However, estimates of prevalence are unreliable due to the secretive nature of such acts and the fact that many young people who harm themselves do not come into contact with services. Parents of children reporting self-harming behaviour are commonly unaware that it is taking place (Meltzer, Harrington, Goodman & Jenkins, 2001; Green, McGinnity, Meltzer, Ford & Goodman, 2005).The National Inquiry into Self-Harm among Young People (Brophy, 2006) concluded that the prevalence rate of self-harm is between 1 in 12

8

and 1 in 15. Worryingly, rates of self-harm appear to be increasing rapidly. In a recent survey of 6000 UK school children conducted by the World Health Organisation, 20% of 15 year olds reported self-harming in the last year (Bacino, 2014). This can be compared with 6.9% in the last survey of comparable size (Hawton, Rodham, Evans, & Weatherall, 2002). Whilst it is thought that four times as many girls than boys self-harm (Fox & Hawton, 2004), this must be accepted with caution, as young males often engage in different methods of self-harm which may be easier to conceal or attribute to other causes (Brophy, 2006). People who self-harm are high users of health and social care services (Comtois et al., 2003), and as the prevalence continues to rise there will be an even greater demand for services. Self-harm is also associated with an increased risk of death, by suicide or other means (e.g. Carter, Reith, Whyte, & McPherson, 2005).

Antecedents and Functions

Rather than resulting from a single event or experience, self-harm often results from a complex combination of experiences (Fox & Hawton, 2004). The National Inquiry report presents a wide range of contributory factors reported by young people, including experience of bullying; not getting on with parents; academic stress; parental divorce; bereavement; unwanted pregnancy; experience of abuse; difficulties associated with sexuality, race, culture or religion; low self-esteem; and perceived rejection by others (Brophy, 2006). In response to these myriad stressors and difficulties, self-harm can serve a range of functions.

Klonsky (2007) reviews 18 studies which directly address the functions of self-harm. The review categorises functions into seven conceptual groups, finding most evidence for an 'affect-regulation' function, through which individuals alleviate acute negative affect or arousal. In reference to this proposed function, the reviewed studies suggest that "(a) acute negative affect precedes self-injury; (b) decreased negative affect and relief are present after self injury; (c) most self-injurers identify the desire to alleviate negative affect as a reason for self-injuring; and (d) the performance of proxies for self-injury in the laboratory leads to reductions in negative affect and arousal" (Klonsky, 2007; p235). A 'self-punishment' function, in which self-harm is used to express anger or denigration towards the self, was also strongly supported by the literature. More modest evidence was found for other functions, including 'anti-dissociation' (ending the experience of depersonalisation or derealisation), 'interpersonal-influence' (seeking help from or manipulating others), 'anti-

suicide' (avoiding suicidal impulses), 'sensation-seeking' (producing excitement or exhilaration) and 'interpersonal boundaries' (asserting one's autonomy or the distinction between self and other).

Nock (2009) offers a theoretical model of the development and maintenance of self-harming behaviour. It proposes that self-harm serves the functions of regulating thoughts and feelings and communicating with or influencing others. It links the difficulties in the management of emotion and interpersonal communication found in many self-harmers to distal risk factors such as childhood abuse and identifies other factors (e.g. social learning) which explain why self-harm is used by certain people to serve the functions stated.

Prevention and Interventions

Compared to the epidemiological study of self-harm in adolescents, its prevention and treatment is under-researched. Studies addressing short- and long-term outcomes of treatment interventions tend to focus on adult populations (McDougall, Armstrong & Trainor, 2010). A review of RCTs investigating the efficacy of treatment interventions concluded that there was not sufficient evidence to make strong recommendations regarding prevention or treatment of self-harm (Hawton et al., 1998). The review included both young people and adults, but numerous RCTs have investigated only adolescents (Cotgrove, Zirinsky, Black, & Weston 1995; Harrington et al. 1998; Wood Trainor, Rothwell, Moore, & Harrington, 2001; Bennewith et al., 2002; Kapur, Cooper & Hiroeh 2004; Carter et al., 2005; Green et al. 2011; Rossouw & Fonagy, 2012). Of these, several provide some evidence for beneficial treatment interventions, including: provision of a 'green card' enabling re-admission to hospital on demand to temporarily escape stressful situations (Cotgrove et al., 1995); on-going contact following discharge via the use of supportive postcards (Carter et al., 2005); referral for 'specialist follow-up' (Kapur et al., 2004); and the group treatment 'developmental group psychotherapy' (DGP; Wood et al., 2001). Further evidence for the efficacy of DGP was sought in two subsequent trials (Hazell et al., 2009; Green et al., 2011), but the promising findings of Wood et al. (2001) were unfortunately not replicated. The Rossouw & Fonagy (2012) trial suggests that a 12-month program of Mentalisation Based Therapy (MBT), which aims to increase understanding of actions in terms of thoughts and feelings, is more effective than treatment as usual in reducing adolescent self-harm.

A number of systematic reviews of evidence for self-harm interventions have been published (Ploeg, Ciliska, & Dobbins, 1996; Hawton et al., 1998; Gould, Greenberg & Velting, 2003; Hepp, Wittman, & Schnyder, 2004; MacGowan, 2004; Merry, McDowell & Hetrick, 2004; Crawford, Thomas, Khan, & Kulinskaya, 2007). Reviewed studies investigated the efficacy of a range of psychological, psychosocial, pharmacological, and educational approaches. A synthesis of these reviews undertaken by the Scottish Executive concludes that, although there is some evidence for the usefulness of on-going contact and the efficacy of particular psychotherapeutic interventions (such as CBT and DBT), the overall picture is one of uncertainty (Leitner, Barr, & Hobby, 2008). Whereas some treatments show promise, further research is needed to provide adequate evidence of efficacy. This view is shared by NICE who state, following their own review of the intervention literature, "the overriding conclusion from this review is that the evidence base for the treatments of self-harm is extremely limited" (NICE, 2004; p.177).

Family Interventions and the SHIFT Project

Problems in parent-child relationships including family discord, attachment difficulties and perceived poor parental caring and communication are related to an increased risk of suicide and self-harm among young people (Fergusson, Woodward, & Horwood, 2000; Bridge, Goldstein & Brent, 2006). Because of this, interventions aiming to improve communication and coping within families are likely to impact beneficially on self-harm. Family therapy, which addresses family relationships, roles and communication styles, is one such intervention. It is therefore surprising that there is only a very small literature on the use of family therapy in self-harm. There is some evidence that family therapy is equally effective as CBT in treating depression in adolescents who self-harm (Barbe, Bridge, Birmaher, Kolko & Brent, 2004). However, as depression was the explicit focus here, it is difficult to make statements about the impact of family therapy on self-harm. This was more clearly addressed in an RCT comparing routine care of self-poisoning adolescents with a brief, home-based family intervention (Harrington et al., 1998). The family intervention was more effective for non-depressed adolescents, but was not demonstrably more effective for those who were depressed. Parents in the family intervention group, however, were more satisfied with the treatment they received. Roussouw and Fonagy's (2012) MBT intervention included monthly family therapy sessions which aimed to improve adolescents' ability to understand their own and others' feelings in emotionally charged situations. The researchers propose that observed reductions in self-harm were related to enhanced interpersonal

functioning and increased capacity for mentalisation, suggesting that family interventions can offer significant benefits for adolescents who self-harm.

Further research is needed to investigate the efficacy of potentially useful family therapy interventions in self-harm. A large RCT is currently taking place across three UK sites, comparing the efficacy of treatment as usual with family therapy delivered according to a modified version of the Leeds Family Therapy & Research Centre Manual (Pote et al., 2000). The Self-Harm Intervention Family Therapy or 'SHIFT' project, has recruited 832 adolescents (aged 11-17) who have engaged in at least one episode of self-harm. The outcome of principal interest is the rate of repetition of self-harm leading to hospital attendance during the 18 months following allocation to treatment or control group. Other outcomes include rate of repetition at 12 months, cost-effectiveness, quality of life measures and process measures.

The research literature addressing adolescent self-harm has provided insight into the prevalence and functions of self-harm, as well the effectiveness of existing treatment interventions. However, there is a need for greater integration of academic-theoretical and clinical research towards the development of more effective therapeutic approaches. Also, the existing literature is strongly biased towards young peoples' own perspectives. Despite a clear suggestion that experiences and relationships within the family are prominent contributors to self-harm (Fergusson, Woodward, & Horwood, 2000; Bridge, Goldstein & Brent, 2006), there is a paucity of research investigating family understandings of self-harming behaviour. For example, a literature search regarding sibling perspectives on self-harm found no studies. The only qualitative investigation which has sought parents' perspectives indicates that they "struggle to make sense of or accept self-harm, leaving them feeling 'at sea' with the situation, no longer knowing how to respond to their child and resulting in poor communication, altered parenting, increased parental burden, and a limited personal and social life" (Oldershaw, 2008, p.142). There is a need for further qualitative research in this area.

Process Research in Family Therapy

Psychotherapy research has traditionally fallen into one of two categories: outcome research or process research. Elliot (2010) proposes that, whereas randomised controlled trials and

single-case designs are concerned with identifying the *existence* of a relationship between psychotherapy and client outcome, other types of research are necessary for investigating the *nature* of change that contributes to therapy outcomes. Indeed, almost 30 years ago, Greenberg (1986) identified the need for more refined psychotherapy change process research for "identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change" (p.4). This remains a pressing concern amongst contemporary researchers. According to Lynn Hoffman (2007), "not all meetings make the kind of difference psychotherapists are looking for, and it behooves us to examine what is the special nature of those that do" (p.69).

Some family therapy researchers are critical of the traditional distinction between 'process' and 'outcome'. Strong, Busch & Couture (2008) propose that conversation, as a fundamental part of the therapy process, represents a form of evidence available to therapists during the moment-to-moment development of therapeutic dialogue. Strong et al. (2008) contrast this type of evidence to the routinely-used outcome measures which evaluate effectiveness through scores on standardised tests administered outside of therapy. They argue that "conversational evidence *is* a tangible, empirical, and justifiable form of evidence useful for examining therapeutic change" and that, as such, it should be incorporated more often into change process research (Strong et al., 2008; p.388).

Various theoretical traditions in family therapy share the view that transforming family members' understandings of their problems is a primary objective of therapy. Both structural family therapy (e.g. Minuchin, 1974) and that of the Milan school (e.g. Boscolo, Cecchin, Hoffman & Penn, 1987) attempt to move from individual to systemic conceptualisations of problems. Viewed from a social constructionist perspective (e.g. McNamee & Gergen, 1992), the aim of therapeutic conversation is to modify constructions of problems and persons, which, in turn, initiates meaningful change in a direction preferable for clients (e.g. White & Epston, 1990). Indeed, for Anderson & Goolishian (1988) "change is the evolution of new meaning through dialogue" (p.48). Although the negotiation of new meanings is a common goal in almost all family therapy, and there are theoretical accounts of how this takes place offered by the various approaches, the ways in which this takes place within the interaction of therapists and families are not well understood. There is a small body of research, however, that has investigated processes of change through in-depth examinations of within-session talk between therapists and

families. In general, these studies propose that, because therapists and clients use language to co-construct meanings and make sense of their interactions, it is appropriate to treat changes in meaning as evidence of "small outcomes" in the therapy process (Strong et al., 2008). It is this literature to which we now turn.

First I will review six studies which share a common focus on the achievement and maintenance of therapeutic engagement. I will then go on to look at three further studies which address other elements of family therapy, such as how therapists manage blame and how new understandings of problems emerge. I will also consider research pertaining to the therapeutic alliance in family therapy.

Sustaining engagement

The engagement of all family members in a therapeutic conversation is seen by many family therapists as an important requirement for meaningful change. Consequently, the establishment and maintenance of engagement, and the overcoming of impasse, has received the attention of change process researchers. Couture & Strong (2004) borrow Lyotard's (1998) concept of 'differend' to refer to a conversational impasse. They propose that such differends "where each family member is invested in her or his own way of understanding a topic, often lead to breaches in relationships, given how relationships are usually sustained by conversations" (p.93). Therapy can assist families stuck in a differend through initiating a change in perspective or understanding so that conversations, and relationships, can continue. The authors call dialogues through which such new understandings emerge "forward-moving conversations".

Couture & Strong (2004) use a combination of discourse analysis and conversation analysis to better understand, respectively, the 'what' and the 'how' of forward moving conversations. Adolescents and parents viewed videotapes of their recent therapy sessions and selected episodes which they felt were examples of forward-moving conversations with a beneficial impact on family relationships. The clinical example they present is pertinent to the current research as it concerns a family struggling to cope with the aftermath of an episode of self-harm. Having recently been discharged from hospital, 14-year-old 'Joe' is attending therapy with his parents. The family are stuck in a differend regarding a 'contract' drawn-up by Joe listing actions he could have taken to avoid cutting. The parents occupy a position of certainty, adamant that Joe will stick to this contract in order to avoid further

self-harm. Joe, however, is unsure he can do this. At this point, the responsibility for avoiding self-harm is placed firmly at Joe's feet. From the incompatible discourses which mark this differend, a 'forward-moving conversation' helps generate a new, shared perspective for the family. The shift begins when the therapist negotiates an opening to discuss Joe's concerns about keeping to the contract, which serves to introduce new possibilities for responsibility within the family. The importance of 'two-way small steps' is accepted by Joe's father, who takes responsibility for supporting Joe to develop a new contract which the whole family can follow. This shared responsibility is reflected in the speech used by Joe's father, who begins to use 'we' when talking about possible action, whereas before he spoke of Joe making 'small steps' on his own. The speech exemplars given illuminate the micro-level of change which occurs in the form of a shift from an impasse of incompatible discourses to a commonly held discursive position typified by shared responsibility. Couture and Strong (2004) argue that the discourse- and conversation-analytic approach they use is consonant with the philosophy of social constructionist family therapy. They propose that such an approach is valuable to further clarify the ways in which understandings and relationships are constructed through therapeutic dialogue.

Avdi (2005) reports a discourse analysis of a family therapy in which an impasse is transcended. They focus on an early phase of therapy, in which presenting problems and the identity of the son 'Tom' is explored. Tom had various psychiatric labels and the family initially sought help to clarify his 'real nature'. Avdi (2005) focuses on the "multiplicity and flexibility of discourses employed by the parents in talking about themselves and their child, and in the way Tom's identity is constructed, particularly with regard to agency" (p.498). At the outset of therapy, Tom's parents draw heavily on a medical discourse, which constructs Tom's identity as pathological. He is portrayed as an 'incomprehensible Other' – incoherent, irrational and possibly dangerous. Avdi's (2005) analysis details how the therapist responds by questioning the dominant medical account, contextualising Tom's behaviour and offering alternative understandings. As the therapy proceeds, the ways of talking used by Tom's parents change. They become more able to flexibly adopt different discourses concerning Tom's behaviour. There is a shift from an intrapersonal to an interpersonal understanding and Tom's parents come to see him as having agency where initially they did not.

Two other studies have used a Task Analysis (TA) methodology (Greenberg, 1984; Greenberg & Foerster, 1996) to investigate the process by which engagement in therapy is

achieved and sustained. TA involves a detailed analysis of what occurs during a 'change event'. A successful change event is composed of three parts: the client marker (statements or interactions which signal that a particular issue needs to be addressed), the task environment (therapist interventions and client performances) and the resolution (an indication in the dialogue that the specific issue has been resolved). The TA approach to investigating change in therapy typically involves the construction of an initial 'rational model' of the change process, based on relevant literature and the clinical experience of researchers. The adequacy of this model in describing change is then tested using therapy material. The details of successful and unsuccessful change events are compared with the rational model, using an approach similar to the constant comparative method of grounded theory (Strauss & Corbin, 1990). A new, refined model is thus developed, which more closely fits the clinical data. The applicability of the refined model to other clinical situations can then be tested.

Friedlander, Heatherington, Steveson & Skowron (1994) used TA to investigate the process through which conversational impasses are overcome, leading to what they call 'sustained engagement' (SE): "a sequence of speaking turns in which family members are observably willing to disclose thoughts or feelings on the designated topic, to share or cooperate, to show interest and involvement in the discussion, or to be responsive and attentive" (p.442). They compared four successful and four unsuccessful 'SE events' selected from the therapies of eight different families seeking help for a range of 'significant behavioural problems'. This produced a five step model of change representing how families move from an interpersonal impasse to sustained engagement. In the first step, family members recognise their own contribution to the impasse. In Step 2, thoughts and emotions associated with disengagement are disclosed by relevant individuals and then, at Step 3, these are acknowledged and validated by other family members. In Step 4, family members introduced new constructions related to the impasse, revealing novel perspectives on one another's attitudes, behaviours or motivations. In Step 5, it is important that family members' motivations for engagement are recognised in terms of the benefits to be gained or difficulties to be avoided from sustaining engagement.

Freidlander et al. (1994) propose that Steps 1 to 4 of their model take place sequentially, whereas Step 5 can take place at any point during the resolution of an impasse. Furthermore, they note that it is more powerful when family members, as opposed to therapists, remind

one another of the importance of engagement. The researchers note that "therapists who focused family members on their own thoughts and feelings about the impasse, on the potential benefits of engagement, and on their attributions of one another's behaviours seemed most able to facilitate the family's movement from disengagement to sustained engagement" (p.446). Friendlander et al. (1994) caution that the actual practice of sustaining engagement was more complex than the model suggests. Progress toward resolution was often irregular, marked by departures from the topic, challenges to therapists' efforts and interventions that failed to have the desired effect.

The conceptual model developed by Friedlander et al. (1994) was later used by another research team as an initial rational model in a development of this research. Higham Friedlander, Escudero & Diamond (2012) explored the factors associated with adolescent engagement in family therapy, again using a TA paradigm. They selected two 'positive engagement events', where a shift from disengagement to engagement was evident in adolescents' contributions, and two 'negative engagement events', where no such shift was apparent. Factors which seemed to account for a positive shift were identified using the grounded theory technique of analytic induction (Strauss & Corbin, 1990). The analysis identified one parental strategy ('support') and five therapist strategies ('structuring the therapeutic conversation', 'fostering autonomy', 'building systemic awareness', 'rolling with resistance', and 'focusing on the adolescent's subjective experience') that contributed to positive engagement.

The refined conceptual model constructed by Higham et al. (2012) showed similarities to that of Friedlander et al. (1994). For instance, authentically expressing thoughts and feelings about the problem under discussion was present in both models. However, whereas this was a step in the journey towards resolution in the Friedlander et al. (1994) analysis, for Higham et al. (2012) it was a signal of the engagement shift and the 'resolution' of the change event. Higham et al. (2012) point to the clinical utility of their findings which suggest that "a therapist's non-judgemental acceptance, respect and focus on the adolescent's experience can positively contribute to a successful engagement shift" (p.48). The strong clinical relevance of this study and the robust analytical methods are to be praised. However, there are limitations related to sampling and design which should be acknowledged. Firstly, all participating families are white, low socio-economic status, single-parent families. The process of sustaining engagement in families of different structure or from different cultures

or economic groups may be quite different. A more serious problem concerns the nature of the presenting problems across the successful and unsuccessful cases. In both successful cases, the problem was related to father abandonment, whereas in both unsuccessful cases the difficulties were identified as emerging from conflict between the adolescent and their parent. It is perhaps not surprising that the parental strategy of support would be identified in the successful cases but not in the unsuccessful ones (where child-parent conflict was the problem being addressed). When trying to develop an explanatory account of a social process it is important to have some degree of parity between conditions being compared. This is not achieved in the present study and the findings are less meaningful as a result.

O'Reilley & Parker (2013) studied the ways in which children engaged in and disengaged from therapeutic activities, and how therapists managed actual or potential ruptures in the alliance. In a conversation analysis of four families' therapies they identify a number of passive and active strategies through which children disengage from therapy, ranging from passive disengagement (e.g. inattention) and passive resistance (e.g. not attending to a direct question) to active resistance (e.g. directly refusing to answer). Children also expressed their autonomy by expressing desires to disengage from therapy, either in terms of wanting to cease participation in the current conversation or wanting to stop attending altogether. Acknowledgement and validation of the child's feelings was shown to be an important technique for establishing or reinstating engagement. It was suggested that this facilitated engagement through helping the child to feel accepted and understood. The authors suggest that children's disengagement from therapy may be a means of avoiding or managing criticism and draw a similarity between this and the way that adults often disengage from therapy when they anticipate threat or criticism (Frankel and Levitt 2009). O'Reilley & Parker (2013) propose that therapists should attend to the passive and active disengagement strategies of children in order that they can respond with acknowledgement and validation when this is recognised. They accept, however, that "this can be a complex task when the parents are especially active and it is easy to overlook the passive disengagement of quieter children" (p. 504).

Related to the notion of engagement in family therapy is that of collaboration, the extent to which clients and therapists work together during therapy. Sutherland and Strong (2011) use conversation analysis to investigate the ways in which collaboration is achieved during one session of constructionist family therapy. The well-know therapist Karl Tomm was invited

to attend an appointment as a consultant. The analysis identified several rhetorical practices used by Tomm to encourage collaboration in the therapeutic conversation. These included attending to disagreements and 'weak agreements', eliciting client's preferences using 'candidate answers', and avoiding an 'expert' status by using tentative and uncertain language. Through these and other conversational techniques the therapist noticeably modified his talk, assisting the process of finding mutually agreeable descriptions and accounts of the family's situation.

Other family therapy studies of in-session processes

Whereas some researchers set out to examine a particular element of family therapy process, others use qualitative research methods to identify significant events or themes for further analysis. In this vein, Frosh, Burck, Strickland-Clark & Morgan (1996) began by using grounded theory (Glaser & Strauss, 1967) to identify significant themes in the therapy of a family struggling in the aftermath of marital separation. Having selected 'management of change' as a key theme, they go on to use discourse analysis to explore the emergence and evolution of this theme in the therapeutic dialogue. Two opposing discourses regarding change were identified; one in which change evolves 'naturally' and another in which change needs to be managed. During therapy, a subtle transition takes place within the family from relatively polarised adherence to one or the other of these discourses to a more flexible adoption of discursive attitudes to change. Frosh et al. (1996) explain that "as family members move in and out of different discourses on change over the course of therapy, they seem to become more comfortable with each others' perspective and more able to acknowledge the complexity of their relationships and of their emotional state" (p.160).

In a further discourse analysis of therapeutic change, Burck, Frosh, Strickland-Clark, & Morgan (1998) used the same grounded theory approach to identify central themes in the therapy of another family. The researchers focused on 'control' as they felt this to be related strongly to the family's relationship to therapy and also to be significant for therapeutic change. Burck et al. (1998) turn their attention more fully to the therapist's contributions to changes in discourse used by the family. They note how the therapist responds to the parents' discourse of being 'out of control'. First, she substitutes a discourse in which the children are seen as being out of their control with a discourse of 'worrying about their parenting'. She then introduces alternative discourses of 'choice' in their parenting and 'being in charge'. Burck et al. (1998) note how, in addition to the *content* of her

contributions, the therapist uses the *process* of the therapy to reinforce being in control, for instance talking about the emotive subject of childhood abuse in a way which makes it manageable. Ultimately, the parents accept and engage with the new position of 'being in charge'.

Coulehan, Friedlander, & Heatherington (1998) investigate the process by which changes in narrative occur during family therapy carried out in line with Sluzki's (1992) narrative approach. Specifically, they aim to "elucidate specific change processes in the *transformation event*, an episode in which the therapist successfully facilitates a shift in family members' constructions of their presenting problems from an intrapersonal or linear perspective, to an interpersonal or systemic one" (p.17). The researchers first used judgements by the therapist, independent observers and an additional panel of clinicians to determine sessions in which a shift in constructions had occurred. These were named 'successful' in contrast to 'unsuccessful' sessions, in which such a transformation was not identified. Parents' dialogue referring to presenting problems was then coded on the intrapersonal-interpersonal dimension of the Cognitive Constructions Coding Scheme (CCCS; Friedlander, 1995). Coulehan et al. (1998) hypothesised that the majority of parents' constructions of the problem would initially be coded as 'intrapersonal' and that they would implicate a child in the family. They predicted that, following successful sessions, parents' statements about problems would be assigned one of the interpersonal codes (e.g. 'dyadic'). Following unsuccessful sessions, on the other hand, the majority of problem constructions would still be coded as intrapersonal. In three out of four successful sessions, it was found that problem constructions had shifted in the direction predicted, from intra- to inter-personal codes. In the fourth successful session, the construction remained intrapersonal, but a different child in the family was construed as problematic. In three of the four unsuccessful sessions, parental constructions were coded as intrapersonal throughout the session, again supporting Coulehan et al.'s (1998) predictions.

In addition to investigating hypotheses about the intra- or inter-personal nature of problem constructions, Coulehan et al. (1998) also used a TA approach to develop a model of the process by which problem constructions change. An initial rational model, derived from Sluzki's (1992) approach to therapy, proposed that such a transformation takes place in two stages. Firstly, the 'old stories' of family members are elicited through circular questioning. Second, 'new stories' are generated by focusing on interpersonal dynamics, values,

'exceptions' to the problem, and possible solutions. The utility of this two-stage model was investigated through a qualitative investigation of successful and unsuccessful transformations. The analysis resulted in a refined model of the transformation event consisting of three stages. In stage 1, the various family members put forward their accounts of the problem. In this stage, different constructions of the problem and potential solutions were expressed, interpersonal aspects of the problem and possible solutions were highlighted, and family members acknowledged differences in accounts and exceptions to the problem. In stage 2 of the model an affective shift is noticeable in the responses of family members. Three sub-stages make up this stage: acknowledgement of positive attributes of the child; recognition of the contribution of the family's history or structure to present difficulties; and identification of family strengths and values related to change. In the third and final stage of the model, there was an acknowledgement of hope or the potential for change. Coulehan et al. (1998) note that the modified conceptual model differs from Sluzki's (1992) model in four ways; it includes family members' behaviours in addition to those of the therapist; it acknowledges the role played by family history or structure; it highlights the importance of affective changes; and it proposes that the existence of hope is important in solidifying transformations in problem constructions.

Coulehan et al. (1998) discuss some limitations of their conceptual model. They acknowledge the possibility of a confirmatory bias within the research team, given that the researchers were working in a department headed by Sluzki, who developed the approach under investigation, in which the therapists were all trained. Also, differences between the successful and unsuccessful groups may have affected how transformations proceeded. There was a greater representation of single-parent families in the unsuccessful group, and a reflecting team approach was used in three quarters of the successful group sessions but in none of the unsuccessful ones. Despite these limitations, the researchers propose "the present model is clinically meaningful: it provides a basis on which to better understand and facilitate in-session transformation events" (p.32). They suggest that further study is needed to relate successful transformation events in early sessions to overall therapeutic outcomes.

Friedlander, Heatherington, & Marrs (2000) were keen to understand how constructionist family therapists respond to instances of blame. They collected tapes of seven therapy sessions conducted by seven prominent constructionist and narrative clinicians and used the CCCS (Friedlander, 1995) to identify blaming statements within them. Therapist responses

to these 'blaming events' were analysed using a combination of conversation analysis and the grounded theory method of constant comparison (Glaser & Strauss, 1967). The analysis resulted in three categories of response to blaming events. Most frequently used by therapists were 'ignoring/diverting' responses, which included 'focusing on the positive', 'interrupting' and 'asking a question to focus on feelings'. Friedlander et al. (2000) point out that the 'ignoring' response used by therapists was not passive, but involved them actively diverting the conversation in one way or another from the blaming that was taking place. The second category was 'acknowledging/challenging', which included 'identifying blame as a topic for discussion', 'challenging all-or-none thinking about the blame' and 'speaking for the client in response to the blamer'. The final category of responses was 'reframing', which contained 'focusing on competence', 'redefining or reinterpreting' and 'expanding the theme to bring in a new perspective'. The authors discuss how the first theme of ignoring/diverting can be seen as fitting within a constructionist or narrative approach to therapy, whereas the other two categories are more in line with cognitive or structural approaches to family therapy. They conclude that "the philosophical/theoretical (how therapists account for change) and technical (what therapists actually do) aspects of treatment do not always map perfectly onto one another" (p.142).

The therapeutic alliance in family therapy

A considerable body of research suggests that the alliance in one-to-one therapy is the foundation for, and a significant contributor towards, therapeutic change (e.g. Horvath & Symonds, 1991; Hatcher & Barends, 1996; Wampold, 2001). Various factors have been shown to influence the strength of the alliance, such as the timing of therapist interventions (e.g. Bordin, 1979), the client's 'stage of change' (Prochaska & Norcross, 2002), and the client's attachment style (Diener & Monroe, 2011). Although recognised as complex in individual therapy, there are additional dimensions to the alliance in family therapy. These derive primarily from the fact that numerous, simultaneous alliances exist between the therapist and family members. Pinsof & Catherall (1986) proposed that these operate on three levels, namely the alliances between a) the therapist and each family member, b) the therapist and each 'subsystem' (e.g. parents or children), and c) the therapist and the family as a whole. A further dimension, the 'within-family alliance', or degree to which family members share a sense of purpose regarding therapy, has been added to this scheme.

Myrna Friedlander and her colleagues have developed observational and self-report measures known as the System for Observing Family Therapy Alliances (SOFTA; Friedlander et al., 2006). In the SOFTA, the within-family alliance or 'shared sense of purpose' is described as a 'felt unity' within the family in relation to therapy. A strong sense of common purpose is indicated by behaviours such as family members validating one another's point of view and asking each other for their perspective. A weak sense of purpose is evidenced by within-family blame or individuals 'siding with the therapist' against other family members. The SOFTA also includes 'safety within the therapeutic context' as an element of the alliance. A strong sense of safety is seen when family members are able to show vulnerability in sessions (e.g. by crying or discussing painful feelings) or reveal secrets to one another or the therapist. Beck, Friedlander & Escudero (2006) found that concerns about safety were more apparent when within-family alliances were weaker. They tentatively point to an association between strong within-family alliance and more positive outcomes, and call for studies of a diverse sample of families with strong and weak intrafamiliar alliances to further examine this association.

As multiple alliances exist within family therapy, there is the potential for 'split' or 'unbalanced' alliances, where family members hold markedly different attitudes towards the therapy or therapist (Pinsof & Catherall; 1986). Robbins et al. (2003) found that families with larger differences between alliance scores of parents and adolescents (i.e. a split alliance) were more likely to drop out of therapy. Split alliances predicted dropout whereas individual alliances did not, suggesting that clinicians and researchers must pay attention to the systemic context in which alliances occur in addition to the quality of alliance reported by individuals. This is far from straight forward, however, especially given that family members' self-reported bonds with the therapist have been shown to be more extreme than their within-session behaviour indicates (Muniz De la Pena, Friedlander & Escudero. 2008).

The complexity of managing multiple alliances is clearly demanding for the therapist. They are required to maintain a systemic perspective from which they can appreciate how the strength of numerous, reciprocally-influencing alliances might impact upon the overall therapy process. Kindsvatter & Lara (2012) discuss several strategies which may facilitate the management of family therapy alliances. One involves forming 'flexible alliances' within which the therapist can affirm or distance themselves from alliances with individual family members according to the current requirements of the therapy. This can help to avoid

or manage split alliances. Another strategy is working to form 'universal consensus' amongst family members concerning the goals of therapy. Establishing universal consensus can enhance trust between family members and the therapist, as well as amongst family members, therefore facilitating an improved within-family alliance (Friedlander, Lambert, & Muniz de la Pena, 2008). Kindsvatter & Lara (2012) propose that universal consensus is a useful starting point to which the therapist may return if the alliance becomes threatened.

Summary of family therapy process literature

It can be seen from the process studies reviewed above that an increasing ability to employ a range of discourses and occupy more diverse subject positions is associated with positive change. When family members move from a rigid adherence to one perspective to using several discourses or constructions in a flexible manner, such a shift is associated with therapeutic benefits (Frosh et al., 1996; Avdi, 2005). Burck et al. (1998) relate this type of shift to theories of change within family therapy, specifically the notion that as family members come to adopt a wider range of discourses and understand one another's perspectives, they become more able to deal flexibly with difficulties they encounter (Boscolo et al. 1987). These findings are in keeping with the assertion of Avdi (2005) that a key task in family therapy involves working towards 'multipositionality' – the acceptance that there are multiple perspectives on, and potentially valid versions of, a situation.

In addition to the flexible adoption of different perspectives and subject positions, there is a suggestion that certain types of problem construction are more conducive to therapeutic improvement. Perhaps most significant in this regard is that interpersonal conceptualisations of problems seem to be more closely associated with sustained engagement and positive shifts in meaning than intrapersonal ones (Coulehan et al., 1998; Avdi, 2005). This is perhaps not surprising, given that, in systemic therapy, one of the primary objectives is to affect a shift in understandings of problems from intrapersonal and dispositional in nature to interpersonal and contextual (e.g. Sluzki, 1992). Other types of discourses and therapist interventions associated with positive change in the reviewed studies are those emphasising shared responsibility for problems (Couture & Strong, 2004), those which endow clients with agency or control (Avdi, 2005; Burck et al., 1996), and those which foreground the client's experience (Higham et al., 2012).

A variety of methods for investigating changes in meaning during family therapy have been employed in the research reviewed above. Grounded theory (Glaser & Strauss, 1967) and conceptually similar approaches have been helpful, both in identifying important themes in family therapy dialogue (e.g. Frosh et al., 1996; Burck et al., 1998) and in developing models of change processes as part of the task analysis method (e.g. Coulehan et al., 1998; Higham et al., 2012). Discourse analysis has been used effectively to examine how new understandings develop over the course of therapy (e.g. Avdi, 2005). Conversation analysis has also been useful in revealing the rhetorical practices used by therapists in particular therapeutic situations (e.g. Sutherland & Strong, 2011; Friedlander et al., 2000).

The literature on therapeutic alliances indicates that managing the multiple, mutually-influencing alliances occurring within family therapy is a complex but important undertaking. The therapist must attend to several sensitive tasks, including negotiating split alliances and fostering a sense of safety and felt unity within the family system. Failing to pay attention to therapeutic alliances can seriously compromise therapy because, as Robbins et al. (2003) state, "the link between treatment process and successful outcome moves through the relationship between family members and the therapist" (p. 542).

<div align="center">Rationale, Aims and Research Questions</div>

Self-harm in adolescents is one of the most challenging clinical problems facing mental health professionals today. Family therapy offers a potentially effective intervention and, in addition to studies investigating therapy outcomes, research looking at the process of family therapy for self-harm is important. Aside from the study by Couture & Strong (2004), there exist no explorations of in-session processes of change taking place during family therapy for self-harm. Even there, the resolution of conversational impasse was the focus, rather than meanings of self-harm. Further research is needed, therefore, to investigate how changes in meaning take place during therapy with the families of adolescents who self-harm. A qualitative analysis of videotapes of family therapy is proposed, considering that "any audio-tape or videotape of family therapy offers rich opportunities to see how outcomes are accomplished and relationships shaped by the 'hows' and 'whats' of therapeutic dialogue" (Strong et al., 2008; p.400). The present research aims to investigate how family therapists negotiate the meaning of self-harm over the course of family therapy. Specific questions of interest include:

1. What are the evident meanings of self-harm for family members and therapists, and do these change over the course of therapy? If so, how do they change?
2. What is the nature of the work which therapists do to bring about changes in the meaning of self-harm and associated changes in actions and family relating? What are the implications of these changes for the individuals involved?
3. Is there an identifiable process through which these changes take place and, if so, what are the contexts and conditions which influence its operation? Can an explanatory account be developed which captures this process?

CHAPTER 2: METHOD

Overview

Qualitative analysis of video-recordings of family therapy sessions with families in which a young person has self-harmed was deemed to be the most appropriate means of addressing the present research questions. Secondary data collected as part of the SHIFT trial was analysed using a constructivist grounded theory methodology. Below I will consider my rationale for selecting grounded theory and discuss my own ontological and epistemological positions and my approach to analysis. I will then describe the design and procedures through which the research was carried out and also consider ethical issues.

Rationale for the use of grounded theory

As the focus of much process research in family therapy has been on the structure of therapeutic dialogue, conversation analysis (CA) has often been the favoured analytic approach (e.g. Sutherland & Strong, 2011). However, in the present case, the focus on language structure and the micro level analysis offered by CA is inappropriate. Other approaches to qualitative inquiry were also considered to be unsuitable to the research aims. The idiographic focus of interpretive phenomenological analysis and the socio-political bent of discourse analysis made these approaches appealing. However, because of the overriding goal of explicating elements of the process of therapeutic change, it was felt that these methodologies were ill-suited. Thematic analysis was overlooked for the same reason. If we take the research question 'How does the therapist negotiate the meaning of self-harm over the course of family therapy?', it can be seen that we are interested in the work of the therapists in facilitating changes in meaning and action over time, the process whereby this occurs and the conditions that enable or constrain change in meaning and action for those family members involved in the therapeutic encounter. There is an interest in meaning, (inter)action and process, and specifically in developing an explanatory account of the process whereby changes in meaning and action occur and the impact of these changes for the individuals involved. Because of these specific interests the methodology and methods of grounded theory (GT) are most appropriate.

Rafuls & Moon (1996) propose that a GT approach fits well with, and is "theoretically consonant" with the practice of family therapy. They believe it is "a methodology that requires skills that parallel those required of therapists… the inductive and deductive process that occurs in GT is similar to the process that therapists experience as they arrive inductively at hypotheses about clients and then deductively check out those hypotheses as therapy takes place" (Rafuls & Moon, 1996; p.76). Burck (2005) agrees, proposing that "the recursive sequences between the tasks of analysis and of enquiry, and the attention paid to contradictions and variability, fit well with systemic practices" (p.245-246).

GT is a close fit with the practice of family therapy, and is an appropriate approach for the present research, partly because of its basis in symbolic interactionism (SI; Blumer, 1969). SI is a prominent sociological paradigm that sees humans as relational beings that create meaning through social interaction. It is a dynamic perspective which emphasises our use of language and symbols and proposes that (inter)action and interpretation are key reciprocal processes through which we construct our selves, our situations and our societies. SI has its roots in the pragmatist tradition which evolved at the University of Chicago in the early twentieth century (E.g. Mead, 1934). From pragmatism, SI takes a view of the social world as fluid and somewhat unpredictable and it therefore puts an emphasis on the study of process and change. "It assumes a view of social life as open-ended and emergent, fosters studying action and process, and takes temporality into account" (Charmaz, 2014; p.263).

The particular type of GT approach adopted will determine how clearly pragmatist and symbolic interactionist ideas shine through in the practice and write-up of the research. I will consider the interpretation of GT currently adopted and its associated epistemology below. However, it can be seen that, broadly speaking, GT is concerned with how meaning is constructed between individuals in a recursive process of action, interaction and interpretation. Furthermore, where other qualitative methodologies can result in analyses which depict the social world as static, a key strength of GT is in allowing researchers to represent the dynamic and processual character of social life. The focus on the construction of meaning through interaction and the ability to explicate processes make GT the obvious choice for the present research.

Philosophical underpinnings

GT was formulated by Barney Glaser and Anselm Strauss in the late 1960's (Glaser & Strauss, 1967) when they articulated a set of methods and strategies to engage in the systematic analysis of qualitative data. However, in keeping with developments in qualitative research and the social sciences in the intervening 50 years, it has diversified and evolved into a group of methodological approaches which share a family resemblance, but also differ in certain ways. Glaser and Strauss each developed the original formulation of GT along divergent paths (e.g. Glaser, 1978; Strauss &Corbin, 1990), in which, for instance, they differ in the significance attached to the verification of theory. A more recent development, represented by the work of notable grounded theorists Adele Clarke (e.g. Clarke, 2003) and Kathy Charmaz (e.g. Charmaz, 2014), concerns a more explicit consideration of the person of the researcher in the collection and interpretation of data.

I will now consider the particular approach to thinking about and doing grounded theory adopted in the present study. I believe that the notion of an unbiased observer is deeply problematic, that there is no one external reality waiting to be 'discovered' and that (in studying the social world at least) 'facts' cannot be separated from values. I have an interpretivist orientation to social psychological theory, and my approach to the present research fits closely with the description of interpretive theory given by Charmaz (2014): "Interpretive theories aim to understand meanings and actions and how people construct them. Thus these theories bring in the subjectivity of the actor and may recognise the subjectivity of the researcher. Interpretive theory calls for the imaginative understanding of the studied phenomena. This type of theory assumes emergent, multiple realities; indeterminacy; facts and values as inextricably linked; truth as provisional; and social life as processual" (p.231).

I believe that 'facts' and knowledge, rather than being enduring and universal, are continually constructed and reconstructed through the use of language in social interaction. I agree with social constructionists (e.g. Berger & Luckmann, 1967; Gergen, 1985) that the language that people use to represent their worlds is constitutive of reality, rather than merely being descriptive of it. Knowledge is consequently subjective, tied to time and place, and constantly open to revision. However, it is important to note that an extreme constructivist position is inappropriate, even untenable, with regard to the present research focus. We are concerned with acts of self-harm and what they mean. These are real acts

which have real consequences (such as pain, bleeding and scars) and can carry real risks (such as serious injury or suicide). Thinking of self-harm purely as a social construct which is 'talked into being' is clearly inappropriate. We cannot get away from what Blumer (1986) calls the "obdurate character of the empirical world" (p.22).

My approach, therefore, is to acknowledge that there are 'real' acts, such as self-harm, taking place in the world but that the understanding we have of them – the meanings we attach to them – are constructed and re-constructed through our use of language. These meanings, of course, are not constructed in a social vacuum but are shaped by the understandings and discourses currently available to us. This position represents a 'critical realist' perspective (Bhaskar, 1978), which "marries the positivist's search for evidence of a reality external to human consciousness with the insistence that all meaning to be made of that reality is socially constructed" (Oliver, 2011; p.2). In the critical realist view, we are bound by perspectivism and therefore cannot 'close the gap' between the objective world and what we know of it. This is not to say, however, that we are left with an extreme relativism in which "all beliefs are equally valid in the sense that there are no rational grounds for preferring one to another" (Bhaskar, 1986, p.72). Although 'true reality' cannot be known for certain, it is possible to discern accounts that are better or worse, more or less true. In GT-informed research the 'rational grounds' used to assess the value of an account are the extent to which the analyst demonstrates it is 'grounded in the data', the coherence of the conceptual account offered and the explanatory reach of the analytic concepts generated.

The "dilemma of qualitative method" is a name given by Martyn Hammersley (1989) to an epistemological tension present in Glaser and Strauss' (1967) original presentation of GT. This refers to a conflicting commitment to both the 'scientific method' and realism on one hand and a type of constructivism, which involves a creative and interpretative analytic process, on the other. Theory in GT cannot truly be said to 'emerge from' or 'reflect' the data as analysis involves interpretations made using the existing theoretical frameworks and assumptions of the researcher. In this way, as Dey (1993) argues, the researcher is hoping to approach analysis with an 'open mind', which is not the same as an 'empty head'. Henwood & Pigeon (1992), like Charmaz (2014), argue that a constructivist rendering of GT resolves this 'dilemma of qualitative method'. They propose constructivist GT captures most fully the combination of a rigorous systematic analysis on the one hand, and, on the other, the fundamentally creative and dynamic nature of the research process.

What is the nature of theory in my 'grounded theory'? I am not seeking (and do not believe it is possible) to develop a universal theory which aims to provide explanations of social phenomena abstracted from time, place and context. Rather, I am interested in developing abstract concepts along the lines of interpretivist theory as described by Charmaz (2014) above. The description offered by Charmaz fits closely with my own ontological and epistemological position and with the symbolic interactionist underpinnings of GT. Henwood & Pigeon (1992) adopt the term "*generation* of theory, rather than *discovery*, as more accurately describing both the epistemological and practical realities of the approach" of GT (Henwood &Pigeon, 1992; p.135; italics added). Along similar lines, Blumer (1979) has commented that instead of theory development in GT being solely an inductive process, there is a back-and-forth dialogue between the data and the analyst's conceptual thinking.

My interpretivist and constructivist outlook determines the nature of the accounts that I provide in the following pages. My conceptual analysis has been developed through a dialogue with the data and is one way of representing the realities of the participants. It is a product of an interaction between my situated and subjective self and the data. Other researchers conducting an analysis of the same data may construct subtly or substantially different explanatory accounts depending on their prior assumptions and theoretical predilections. As Corbin and Strauss (2008) note, "Qualitative data are inherently rich and full of possibilities […] Different analysts focus on different aspects of data, interpret things differently and identify different meanings […] It all depends upon the angle or perspective that the analyst brings to the data" (p.50), My aim is to proceed through a systematic analytic process and provide sufficient excerpts of data to back-up my ideas. The value of the analysis is therefore ultimately for you, the reader, to judge.

Reflexivity

As Charmaz (2014) points out, "conducting and writing research are not neutral acts" (p.240). Here I will describe my professional background as a researcher and my orientation to key phenomena relevant to the study. As a trainee clinical psychologist I have received training in several psychotherapeutic modalities, but it was my interest in postmodern approaches such as narrative therapy (White and Epston, 1990) which led me to embark on the present study. This interest, along with my constructivist leanings, led me to frame the research question as I have, with a focus on how meanings are co-constructed and

negotiated between the participants of family therapy. Advocates of narrative therapy would propose that the central aim of therapy is to co-author narratives of clients' identity and experience which may assist them in engaging in preferred ways of living. Such narratives offer alternatives to the 'problem saturated' stories with which clients often enter therapy. In this model, changes in meaning are fundamental for changes in action. I arrived at the project with a keen interest in exactly how changes in the meaning of key phenomena take place and with what consequences.

My interest in narrative therapy is reflected in the therapy approach employed by the family therapists in the SHIFT trial. The therapy manual developed for the trial was modified from the Leeds Systemic Family Therapy Manual (Pote et al., 2000) and contains elements of narrative practice such as therapeutic letters written to the family after the initial sessions. The three therapist participants also cited narrative therapy as influential in their integrative practice. Due to my own interests in narrative therapy and the fact that this approach is influential in the practice of the SHIFT therapists, it might be expected that the change process identified in the data reflects that proposed by narrative therapy theory. For instance, one likely finding might be that there is concerted effort towards narrative restructuring on the part of the therapists.

As I embarked on the study, my understanding of self-harm was as a way of responding to overwhelming feelings which changes them and/or makes them more manageable. I was also aware of societal and professional discourses about self-harm which characterised self-harm as a way of avoiding suicide, as a 'cry for help' and as a form of behaviour associated with particular youth subcultures (e.g. 'Emo' and 'Goth'). Following my review of literature pertaining to the function of self-harm, which supported an 'affect regulation' understanding of self-harm, my allegiance to this idea was perhaps strengthened.

<div align="center">Research questions:</div>

As previously stated, the present research aims to investigate how family therapists negotiate the meaning of self-harm over the course of family therapy. Questions of interest are:

1. What are the evident meanings of self-harm for family members and therapists and do these change over the course of therapy? If so, how do they change?

2. What is the nature of the work which therapists do to bring about changes in the meaning of self-harm and associated changes in actions and family relating? What are the implications of these changes for the individuals involved?

3. Is there an identifiable process through which these changes take place and, if so, what are the contexts and conditions which influence its operation? Can an explanatory account be developed which captures this process?

Design

A qualitative analysis of video-taped material from family therapy sessions was considered to be the most appropriate way of addressing the present research questions. Alternatives, including conducting interviews with family therapists, were considered. However, as the interest was in what actually takes place during sessions, rather than therapist or client perceptions or recollections of this, video-recordings of therapy were thought to the most appropriate data. Video-recordings offer particularly rich data in this regard as body language, as well as the spoken dialogue, may be examined. As there was an interest in the process of change over the course of therapy, looking at a smaller number of whole cases was thought to be preferable to selecting a sample of sessions from a larger pool of cases.

There was originally an intention to conduct a qualitative analysis of therapy sessions followed by interviews in which therapists would discuss videotaped portions of their therapy sessions identified by the researcher as pivotal for the change process. A decision was taken to remove the therapist interview element from the study for two reasons. Firstly, the change process was found to be subtle and complex and it was difficult to determine discrete events within the therapy sessions where significant change took place. At this stage the aim of the interviews was modified from discussing video clips of the therapy to reviewing and discussing the change process model arising from the analysis. Secondly, due to delays in access to and transcription of data, it became necessary to choose between interviewing therapists regarding the model developed from the first case and developing this model through the analysis of a second case. Due to the clear rationale for targeted theoretical sampling emerging from analysis of the first case, it was decided to proceed with the analysis of a second case rather than interview therapists. Therapists were instead given the opportunity to comment on the change process model after analysis was complete (see Discussion).

Access to data – the SHIFT trial

Access to primary data in the form of video recordings of family therapy sessions from the SHIFT trial was available through the researcher supervisor. SHIFT is an RCT comparing family therapy against treatment as usual for young people (aged 11-17 years) that have self-harmed at least once before. Qualified family therapists deliver the trial intervention according to an adapted version of the Leeds Family Therapy & Research Centre Systemic Family Therapy Manual (Pote et al., 2000). SHIFT defines self-harm as "any form of non-fatal self-poisoning or self-injury (such as cutting, taking an overdose, hanging, self-strangulation, jumping from a height, and running into traffic), regardless of motivation or the degree of intention to die". The primary outcome of interest is rate of repetition of self-harm leading to hospital attendance during the 18 months following allocation to treatment or control group. Other outcomes include rate of repetition at 12 months, cost-effectiveness of intervention, quality of life measures and process measures. SHIFT commenced in December 2008, recruiting from Child and Adolescent Mental Health Services across Yorkshire, Greater Manchester and London. It reached its recruitment target of 832 young people in December 2013 and is currently in the follow-up phase, with trial data likely to be available by early 2016. All SHIFT family therapy sessions were video recorded for assessing intervention fidelity and for use in further research.

Participants

Prospective family therapist participants were approached by the researcher, with access facilitated by Paula Boston, SHIFT clinical supervisor. Three SHIFT therapists based in a local Child and Adolescent Mental Health Service (CAMHS) were approached in the first instance. All attended a meeting in which the project, and their participation, was discussed. They each read a participant information sheet (see Appendix 1) which summarised the aims of the study, what would be required of them, how data would be stored and used, and the possible benefits and risks of taking part. They were given time to consider whether they would like to take part and the opportunity to ask questions regarding the study. All three agreed to participate. At the time that participants gave their informed consent (see Appendix 2 for Participant Consent From) they were reminded that their participation was voluntary and they were free to withdraw at any time without having to give a reason.

Two of the family therapist participants were female and the other was male; all three were white British. They selected the pseudonyms 'Lydia', 'Ann' and 'Steve'. They range in age from 49 to 57 years and have an average of 7.2 years' experience as qualified family therapists. They each consider themselves to be integrative systemic therapists and report drawing from approaches including narrative therapy, collaborative language theory and dialogical therapy.

Selection of cases

Each therapist participant suggested two completed cases in which they were lead therapist. They were constrained in their selection by the fact that a limited number of cases had been digitised and placed on the trial data base at this point in time. An initial case was selected from these six using a purposive sampling method which prioritised completeness of video files and ease of transcription. No further selection criteria were applied as a theoretical sampling method was being employed and the relevance of particular cases would emerge through the analysis. Four cases were unsuitable because they had sessions with portions missing and/or video files which had been corrupted during the process of digitisation. A further case was excluded as the therapy involved a large, extended family which would have made transcription problematic. This left one case, which was selected for the analysis (see below for a description of Jess's family). Following analysis of the first case, a second family was selected using a theoretically-driven, purposive sampling method. Therapist participants were asked to suggest cases in which relationship difficulties between attending family members impacted on their engagement with family therapy. See below for further information on the rationale behind this theoretical sampling and a description of Donna's family.

Case 1: 'Jess'

The family selected as the first case is a family of four – a mother and father with two teenage daughters. The index client, 'Jess', is 14-years-old at the time therapy commences. She has a sister, 'Grace', who is four years older. Her mother ('Sally') and father ('Pete') are in their forties. The family all live together in a suburb of a northern English city. Both parents work full-time and both daughters are in full-time education. Jess and her family attended a total of 6 family therapy sessions over the course of approximately 6 months with appointments taking place between 3 and 6 weeks apart. Jess was referred to CAMHS by her GP when she disclosed self-harm. The CAMHS service conducted an assessment

appointment, following which Jess received several one-to-one therapy sessions which she attended with her mother. She was then recruited to the SHIFT trial and commenced family therapy. Jess and her mother attended all six sessions. They were joined by her father in sessions 2 to 6 and her sister in sessions 3 and 4. Lydia was the lead therapist for each session and Ann and Steve were the reflecting team. In four of the sessions both Ann and Steve took part in a short reflecting team discussion in the latter part of the session. In one session, Ann alone had a reflective conversation with Lydia and in another Steve alone did the same.

Case 2: 'Donna'

'Donna' is 14 years old and lives with her mother, 'Mandy', and her two younger brothers, 'Sam' (8) and 'Joseph' (6) in a northern English city. Mandy is of African descent and was born and raised in Africa before being taken to live in continental Europe aged 14. Here, she met Donna's father, 'Clive', who was also born in Africa and went to Europe as a teenager. Clive and Mandy came to the UK before Donna was born, settling in the south east. When Donna was around 2 years old the family moved to north east England. Clive and Mandy separated when Donna was 6 or 7 years old, however Donna was not told about this. Donna discovered that her parents were no longer together and that her mum had a boyfriend, 'Jimmy', when she was 12. Donna has irregular contact with her dad who, during the therapy, moves to the south east and then back to Donna's home town. Donna's mother has been in a relationship with Jimmy, who lives in a nearby city, for several years. Following referral to CAMHS Donna attended several sessions of individual therapy before being recruited to SHIFT. Donna and Mandy had 8 sessions of family therapy over approximately 8 months as part of the SHIFT project. Appointments were usually 3 weeks apart, although there was a 9 week gap between sessions 3 and 4. Lydia was the lead therapist, with Ann and Steve being the reflecting team. Ann acted as lead therapist in session 3, as Lydia was unable to attend due to illness. There were problems with the digitisation of the video recordings of sessions 7 and 8, meaning that around half of each of these sessions was unavailable for analysis.

Ethical issues

Video-recordings used for the analysis were stored on the University of Leeds secure drive and accessed via a password by the author. They were viewed in a private office using headphones on a monitor that was hidden behind a partition. Anonymity of therapists and

families was maintained by ascribing pseudonyms during transcription and also changing any information which could identify the participants. Completed transcripts were available to the author only and were password protected. The first case was transcribed in full by the author. The second case was transcribed in part by the author with the remainder being completed by a professional transcriber. The transcriber was asked to sign a confidentiality agreement (see Appendix 3) stating that all participant information would remain confidential.

An application for ethical approval for the project was made through the Integrated Research Application System (IRAS) via the proportionate review route. The application was reviewed by the National Research Ethics Committee North East – York, who provided ethical approval in October 2013 (see Appendix 4). Research management and governance approval was sought from the Leeds Community Healthcare NHS Trust R&D department and was granted in October 2013 (See Appendix 5).

Eligibility of children and young people for the SHIFT trial was considered by local CAMHS clinicians during their first assessment appointment. At the follow-up CAMHS appointment, eligible families were introduced to the trial. Those interested in participating were provided with an information sheet (containing information about the rationale, design and personal implications of participation) and their consent to contact by the SHIFT team was obtained. A researcher from the team then visited the family to provide further information and seek informed consent. Prospective participants were given time to consider participation and had the opportunity to ask questions and discuss the trial with their family and healthcare professionals. Written informed consent was sought from both the child/adolescent and their primary care giver. Consenting families were randomised to the family therapy intervention or treatment as usual. At this point, families were given the opportunity to consent to their data being used in future research, including analysis of the videotaped sessions.

SHIFT therapists were exposed to distressing material as part of their family therapy work. They were offered regular clinical supervision by an experienced systemic psychotherapist to allow them to explore how this may have impacted them. In thinking about potential ethical issues raised by the present study for the therapists and families, it is also important to consider the dilemmas presented by using secondary data. The most pressing issue here is

perhaps the question of whether participants would object to the way in which I have used and interpreted their data. Therapists gave their informed consent for me to use their data in a grounded theory analysis and I was able to seek their feedback on the findings of this analysis (see Discussion). Where the families were concerned, this was less straight-forward. The SHIFT steering committee asked that I did not make contact with the families, which meant I was unable to gain their further informed consent to participate. I was therefore unable to ascertain family members' perspectives on the way in which I had interpreted their contributions to the therapy cases analysed, which would otherwise have been a feature of the study. Family members had of course given consent for their data to be used in further research when they consented to participate in SHIFT.

Data Analysis

As already discussed, data were analysed using grounded theory (GT) methods. A variety of GT techniques were used to establish a dialogue with the data and to facilitate the development of conceptual thinking. These included open coding and focussed coding, constant comparison, asking specific questions of the data, memo writing and drawing diagrams. The guides provided by Corbin & Strauss (2008) and Charmaz (2014) were found to be useful. Discussion with research supervisors was also invaluable in developing my thinking and helping me to move forward when I felt stuck. Although a variety of techniques from GT were used, I became mindful as the analysis went on that I had been mistaken in regarding these techniques as the analysis itself, rather than as tools to inspire thinking. I discovered early on, for instance, that it is possible to spend a large amount of time coding in a mechanistic way without progressing your analysis very far. I agree with Corbin and Strauss (2008) that "the analytic process, like any thinking process, should be relaxed, flexible, and driven by insight gained through interaction with data rather than being overly structured and based only on procedures" (p.12). This insight helped me to spend more time on activities which acted as a catalyst to thinking (such as memo writing, drawing diagrams and discussion with supervisors), and less time mechanically applying analytic procedures.

I became familiar with the first case by watching the full therapy through several times and making notes on prominent themes and important episodes. Next, I transcribed the dialogue of each session in the therapy. The initial strategy was to transcribe parts of the therapy sessions which were most relevant to the research question. However, it soon became apparent that it was not possible to determine a priori which parts of the sessions these would be, due to the complex and sometimes subtle ways in which meaning was negotiated. Because of this a decision was taken to transcribe all of the dialogue in the therapy sessions. The lengthy transcription process helped me to further familiarise myself with the data.

First, open coding was conducted in order to explore the data. The qualitative analysis package NVivo (QSR International, 2012) was used to facilitate the organisation and comparison of coded data. There were two connected analytic foci which proceeded concurrently, which could be said to broadly represent the content and process of therapy. The content focus was on different meanings of self-harm evident in the data in addition to

other important (and related) concepts, such as 'perception of risk' and 'self-blame'. The process focus was on the nature of the work of the therapists; their actions and their impact. The initial categories generated by this coding were predominantly descriptive in character and it was difficult to elevate concepts to a more conceptual level. In order to facilitate conceptual thinking, I wrote memos by asking myself questions about the concept or process in question. The guide provided by Corbin & Strauss (2008) was helpful here. Such questions included: How are things happening? What are the consequences? What are the conditions under which this is happening? What is this an aspect of? How is this different from/similar to other categories or processes? The resultant memos described dimensions and characteristics of categories and helped me to begin thinking about how categories related to one another. This allowed me to develop a more analytic account of the processes by which meanings are negotiated.

Initial categories relating to the work of the therapists gave a rather linear view of the change process and perhaps underplayed the agency of the family members in effecting change. Even though I felt very familiar with the data at this point, it was difficult to capture the fundamental elements of a rich and complex therapy process in a way which did the data justice. In order to develop my thinking about therapy along more processual lines, I attempted to illustrate the important processes operating in the therapy using a diagram. This was a useful aid to develop my thinking. An illustration of how the change process model evolved is presented in Appendix 6. Through discussion with supervisors and returning to my data to test out developing concepts I was able to refine this model further. For instance, a process of 'joint exploration of meaning and relating' was identified which subsumed a number of existing categories (e.g. 'encouraging contemplation', 'tracking', 'checking out understandings') and seemed to be central to the negotiation of meaning in Jess's therapy. I went through successive revisions of the model, progressing through an iterative process of analytic thinking, discussions with supervisors and testing out of ideas with the data. Part of this process was looking for negative cases - examples in the data which did not fit with the developing model. This helped to sharpen my thinking about the nature and parameters of the concepts and processes under consideration. Eventually, I arrived at what I felt was a coherent conceptual distillation of the therapy process operating in the first case. As I began to delineate the model in writing, analysis continued. There was further opportunity for discussion with my supervisors and the model was refined further.

Thinking about Jess's case in terms of meanings of self-harm and processes of change allowed me to hypothesise regarding important contextual factors. For instance, I considered the degree to which the family were engaged in the process of therapy. Jess's family were well engaged from the start and worked closely together to overcome their difficulties. This gave me cause to wonder how the therapy process may differ if members of a family were not convinced they wanted to be in therapy or if there were considerable difficulties in their relationships. This thinking drove my theoretical sampling of the second case. I was interested to find a case with the same lead therapist, but with different characteristics to the first family. Specifically, a family where engagement was more of a challenge and there were barriers to harmonious family relationships which might impact on the process of change. The therapist participants suggested three further completed cases in which Lydia was the lead therapist and which met these criteria. When the tapes were viewed, there were again technical issues with the video files, meaning that each of the three proposed cases were incomplete to some degree. The most complete of these cases was selected for analysis (see details of 'Donna' and her family above).

I became familiar with the second case by viewing the videotapes several times. As described above, I had the majority of the transcription done by an external party, but I further familiarised myself with the data by reviewing the transcripts for accuracy. The aim of the next stage of the analysis was to test out how accurately the categories and processes of the change model developed reflected the process of change under the different contextual conditions of the second case. In order to do this, Donna's case was coded using the codes developed through the analysis of the first. Efforts were made to look for instances which did not fit with the existing scheme and where it was not possible to code material using the existing categories, novel codes were created. For instance, in order to reflect the therapists' management of family disagreement and conflict a new category, 'repairing relations', was created. Following this, coded material was used to elaborate components of the change model in order to more accurately capture the processes operating in the second case.

After data analysis had been completed, the results section explicating the change process model was sent to the three therapist participants for their feedback. I asked each of them to comment on how their understanding of the therapy process in these cases compared to that outlined by the model of change developed through my analysis. I also sought their opinion

regarding how well they felt the model might generalise to other families or therapists. The written feedback provided by the three therapists will be considered in the discussion section.

CHAPTER 3: RESULTS - The negotiation of meaning and therapeutic change

In this chapter I will explicate the processes through which meanings are negotiated and therapeutic change is effected in the two therapy cases. First, I will present a model of change developed from the analysis of Jess's therapy, describing the various elements of the process and the roles played by the therapist and family members. I will then examine the congruity of this model of change with the processes operating in Donna's case, which was selected for its difference to Jess's in respect of manifest family discord. Through this I will describe how the change model needs to be refined, modified or elaborated upon to encompass the broader range of circumstances and conditions encountered. The revised account of the change process presented has greater explanatory scope and theoretical generalisability. Finally, I will summarise important contextual factors which influence the therapy process.

Case 1: Jess

The model presented in Fig. 1 (below) is a summary of the processes by which meanings are negotiated and change is facilitated in Jess's family therapy. An overarching process recurs throughout the therapy in which family members' feelings and perspectives are drawn out and 'put on the table', the meaning of pertinent actions and events is co-constructed by the family and the therapist, and the implications of particular meanings and ways of relating are jointly explored. Through these interdependent processes, modified ways of acting or relating to one another are indicated. Family members experiment with these (both within and outside of the therapy sessions) and these experiences of 'trying out' can then be explored with the therapist, with changes being acknowledged and the implications of new ways of doing things evaluated. This, again, is achieved via the recurrent processes of 'putting things on the table', co-constructing meaning and jointly exploring implications for family relationships. In this way, the understandings and relational patterns of the family go through an iterative process of exploration and modification. The overall change process is one of refinement of family relating, made possible by the joint exploration of meanings and actions salient to the family's difficulties.
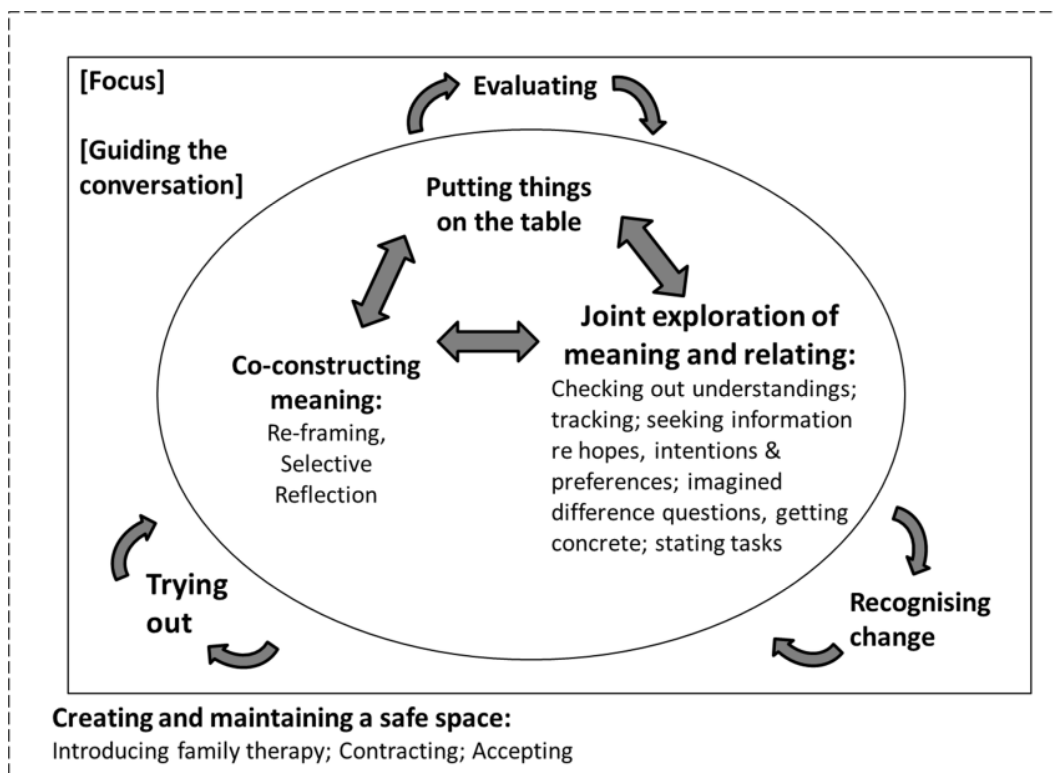
Figure 1: Model of therapy change process in Jess's case

A key of the abbreviations and transcription notation used in extracts of material from Jess's therapy is presented below in Table 1.

Table 1: Abbreviations and transcription notation used in Jess's case

J	'Jess' (index client)
G	'Grace' (Jess's sister)
M	'Sally' (Jess's mother)
D	'Pete' (Jess's father)
L	Lydia (Lead therapist)
A	Ann (Reflecting team member)
S	Steve (Reflecting team member)
[…]	Some text removed from extract
[Laughs]	Non-verbal behaviour or contextual information
italics	Spoken with emphasis
[*]	Incomprehensible speech

1. *Creating and maintaining a safe space*

Processes of exploring and re-negotiating important meanings are central to the therapy. However, it is difficult for these processes to take place if family members are not engaged in the therapeutic endeavour or if they are unclear what to expect from therapy. Because of this, the therapist must work to establish and maintain a 'safe space' in which therapy can take place. This safe space is characterised by family members: a) having an understanding of the aims, values and processes of therapy which can guide how they participate, b) feeling that their contributions will be accepted by the therapist and other family members, and c) feeling involved, in a collaborative way, in determining the focus and proceedings of therapy. A safe space cannot be developed by the therapist alone; it involves the individual and collective engagement of family members. By contributing openly and listening to each other, family members are instrumental in cultivating this feeling of safety. Lydia facilitates the creation and maintenance of a safe space in three different ways:

1.1. *Introducing family therapy*

The way that Lydia establishes the therapy in the initial sessions is important in creating a safe space. She begins by asking each family member to talk about how they came to be here, how they see therapy and what they hope to get out of it. She then incorporates their responses, including the feelings, hopes and concerns they express, into an explanation of how family therapy works. Through doing this she is enacting the verbal explanation that she gives of the process of therapy, demonstrating that therapy is collaborative and perspectives of all family members are valuable and will be attended to. Lydia describes and enacts a therapy process which has the following features: a non-blaming, non-judgemental approach which is driven by the desires and preferences of the family; an examination of feelings and patterns of relating within the family and acknowledgement that there may be a need to 'tweak' these; a focus on strengths and resources that the family posses and the rediscovering of these in order to find 'ways forward'; the acknowledgement that therapy may be difficult and the idea that all family members' perspectives are valuable. It should be noted that this is family therapy as Lydia conceives it and this approach will be shared to a greater or lesser extent by other family therapists. Below is an example of Lydia's introduction to family therapy:

L: Yeah. I think there's something about the sort of talking that we may do here... some of it will be obviously looking at incidents and things that have gone on in the family... We sort of, as therapists, don't want to feed in to any blame or guilt that's already there.

M: There... yeah, absolutely.

L: It's good to name it and look at that guilt... look at that sort of anxious feelings, or blame that may be part of what goes on in your family patterns, but a lot of it is kind of looking at those things... but actually what is it that you're wanting? What is the way forward from those, sort of, patterns or feelings? We won't be pointing the finger...

M: [laughs] Yeah.

L: ...at all. But I think therapy is hard work, you know? Sometimes, for any change, it's hard work. It takes a bit of examining and looking at. "Oh, When I do *that*, that happens". And so... you know, we've got the tissues... we do have tears in here; we do have laughter in here, we do have... you know, because we're talking about some quite hard things sometimes. But I just want to reassure you that we as therapists are not the experts on your family; far from it. Actually, it's your family, with, like you say, a lot of strengths and a lot of things... and there may be some things that need tweaking and need doing, but... Often its families who have got lots strengths and resources, something happens... erm, that causes self-harm, that causes some difficulties, that sometimes needs talking about and looking at in order to rediscover those resources as a family and move forward.

We can see that, in addition to familiarising the family with the nature of therapy, Lydia is 'selectively reflecting' (see *5.2*, below) Sally's acknowledgement that the family 'do have lots of strengths' which serves to further reinforce this.

1.2. Accepting

The interventions coded under accepting are evident throughout Jess's therapy and they represent the generous and considerate stance of the therapist. Lydia responds to the family in a way which helps them to feel accepted and safe enough to engage in the therapy. Again, these interventions embody and reinforce the values and processes of therapy which Lydia verbally conveys to the family. Accepting takes a variety of forms, such as: checking family members are happy talking about certain topics; enquiring after nerves; managing the conversation such that contributions are always met with acceptance; and taking responsibility when there is a misunderstanding or mishearing. The following are typical examples:

[Session 1]

L: Anything that I could do to help relieve those nerves a little bit, or...?

J: Err...

L: Anything that would make it less...?

J: I don't know. I sort of just get used to things.

L: Yeah. So it's kind of something about being nervous because it's new and it's unfamiliar.

J: Yeah.

L: And maybe when you get used to it a little bit...?

J: Yeah.

L: So you can tell me at the end of the session how the nerves are maybe? Just... maybe if there's anything we can do different to kind of make it easier? OK? [J nods] OK.

[Session 2]

J: I think, like, they're worried that I'm gonna hurt myself... [tails off]

L: That what, sorry?

J: That I'm gonna hurt myself, like... [tails off]

M: You're mumbling [laughs]

L: No, it's *me*, 'cause I've got one ear covered... [laughs] And I'm not the best hearer at the best of times.

[Session 5]

L: Is this alright, how we're talking at the minute?

J: [nods]

L: Are you sure?

J: [smiles] Yeah.

[Session 6]

L: OK. So, something, isn't it, about your mum and dad reacting differently? How do you feel you've sort of learned to react differently as time's gone on? Does anyone mind if I shut the window? It's a bit... chilly. [Gets up and shuts window]

J: I can't remember the question.

L: I know, it was a bit of a... a bit of a *long* one wasn't it? Erm... I suppose, you know, with time, how do you feel you're reacting differently now than you were like a few months ago?

J: Err...

L: Reacting differently to the upset? Or reacting differently to... thoughts and feelings and... stuff like that?

J: Like, basically, I used to, like, panic and stuff, and I used to, like, freak out and I used to get, like... Like... if, like, one thing happened... say, like, that happened because of that other one, like... and say that, like, I did something then I'd feel, like, stupid or, like, not good enough. I don't think... I don't really do that anymore. So that's good.

Accepting interventions can be validating or normalising of family members' experience. This helps to engender feelings of acceptance and acknowledgement in family members; that their position has been heard and therapists are empathic to their perspective. Validating

47

and normalising interventions can counter family members' self-blame and help them to feel understood. The following are examples:

[Session 1]

A: Yeah. And feeling angry about what had happened feels kind of... ordinary to me.

S: Yeah – I understand that.

A: I guess that people in that situation do feel angry or upset or worried or scared or frightened.

S: Yeah.

[Session 2]

S: One thing we noticed […] is about... goodness, how much the family have been through, you know, the *struggles* and some of the difficulties and... and hearing about Sally and some of the anxieties that she's carried for quite a long time, and *managed* on the whole...

1.3. *Contracting*

Lydia engages family members to participate in the therapy in general and discrete tasks within it. She addresses family members as active participants and does not presume their willingness to take part. Instead, she asks family members about their desire to participate and, in this way, engages them in the therapy. Contracting enables the formation of an alliance between family members and the therapist, through which they can move towards establishing and working on mutual goals and tasks. Here we can see how Lydia contracts with Jess towards the end of the first session:

L: And just, obviously we're not going have time today to go much further into it, but... how... Would you like it to change? How much would you like it to change?

J: I want... I wanna stop hurting myself 'cause I have, like... get scars and stuff... and they're not nice.

L: Right.

J: But, like, I don't know how else I can, like, get rid of it all, so...

L: Yeah.

J: ...all these feelings.

L: Yeah. So in some ways you say that you've got a lot of feelings that you're dealing with and, in some ways - I think what I'm hearing you saying is – you want a different way to actually learn how to cope with those feelings?

J: Yeah.

L: Yeah? And, that different way wouldn't involve hurting yourself and giving yourself scars. Yeah?

J: Yeah.

L: OK. [pause] OK. So are you up for, kind of, the next six months us doing work together like this? Yeah?

J: Yeah.

Having elicited Jess's feelings about change, Lydia selectively reflects Jess's desire to 'stop hurting herself' and acknowledges that other ways of coping with feelings would preferably not have the negative consequences associated with self-harm (e.g. scars). Lydia 'checks out' (see *6.1*, below) this understanding with Jess to show that she has been heard and communicate that she is an active partner in the decision to proceed with therapy. Jess's family are very well engaged with therapy from the beginning and appear unified in an effort to tackle self-harm. All family members appear to be attending to the conversation throughout and there is no talk of withdrawing from therapy or even any expressed ambivalence about attending. Because of this, the need for continued contracting is not great. In the second session Lydia asks both Jess and her parents what they would like the focus of the therapy to be, further reinforcing the collaborative nature of the therapy. She also enquires as to the family's willingness to engage in specific exercises, such as when she asks them to draw 'worry'. At the end of session 3, Lydia confirms with the family that they want to come back for the next session. These activities of contracting collectively foster a sense of collaboration which strengthens the family's engagement with therapy.

Taken collectively, introducing family therapy, accepting and contracting are the means through which the process of creating and maintaining a safe space is achieved. This process brings about the engagement of the family, which is continually renewed and reinforced by both the sustained efforts of the therapist and the continued participation of the family.

2. *Focus*

Throughout the therapy, Lydia is attempting to strike a balance between allowing the family to determine what topics are discussed and guiding the process and content of the conversation according to what she anticipates will be most fruitful. Of course, there are many topics which *could* be explored, but Lydia is active in shaping the focus. She guides the focus of the dialogue such that the content elicited is, as often as possible, bearing upon these four areas: 1) the nature and manifestation of distress in the family; 2) how distress is responded to or coped with; 3) strengths and resources that the family posses; and 4) self-harm.

3.   *Guiding the conversation*

Lydia adopts a range of conversational strategies to direct how the therapeutic conversation proceeds: 'intervening', 'showing preference', 'picking up on or returning to', 'directing to topic or speaker', and 'inviting continuation'. These vary from explicitly directive to a more subtle form of orchestration, with different strategies selected in response to the nature of the discussion in the moment. These strategies are seen throughout the therapy and are important in that they guide the conversation towards areas where joint exploration is more likely to be productive. They will be described throughout this section when they are germane to the element of the therapy process under consideration.

'Intervening' is a strategy for guiding the conversation selected by Lydia when she wishes to prevent the dialogue from continuing in a certain way. It is used to either address a concern or correct a misconception, or to direct the conversation away from a very emotive topic. In the example below, from early in session 1, Lydia is intervening to address Sally's concern that therapy could be blaming. She uses the opportunity to convey certain characteristics of family therapy (the non-judgemental stance and focus on strengths and resources), reassure Sally and normalise the family's experience of problems. All of this contributes to the creation of a safe space:

> M: I suppose I'm scared that maybe me and Pete are the cause of some of the problems. And... as a mum that's really hard, isn't it?
>
> L: OK. So does that feel... because we're thinking of *family* therapy, does that kind of make the, sort of... or query... a bit of blame on yourself come out more?
>
> M: Yeah.
>
> L: Right.
>
> M: So I feel like... Am I going to be told I'm a rubbish mum [laughs] and he's a rubbish dad and we're no good and... [laughs]
>
> L: *Right*. Right. So can I just clarify that one a little bit? The reason I love family therapy, and the reason I went into family therapy a bit later on in my career, was because it very much looks at strengths and resources that families have.
>
> M: And I think we do have lots of strengths as a family... but I think there's been a couple of things that have, you know... And things happen in all families don't they?
>
> L: Of course they do.

Putting things on the table, Co-constructing meaning **and** *Joint exploration of meaning and relating*

We have considered the way in which Lydia creates and maintains a safe space and guides the conversation toward particular foci. This work is important in that it 'sets the scene' for therapy and allows the management of the therapy conversation. We will now examine the highly inter-related and recurrent activities subsumed under the terms 'Putting things on the table', 'Co-constructing meaning' and 'Joint exploration of meaning and relating'. These three elements are what initiate therapeutic change. Their collective effect is to mobilise resources in the family and elicit their creative approaches to address the difficulties they are facing. The therapist initiates the process, which then must be taken up by the family, who actively translate the understanding they are developing into different ways of acting and relating with each other (see 'Trying out', below). This indicates that, although the therapist plays an important instigating role, therapy is an inherently recursive process where both therapist and family members are active agents. To be effective, therapy requires family members to not only put forward and attend to each others' perspectives, but also to then work together to make change happen.

Although the three elements will be discussed separately, their distinction is misleading as they are highly interdependent and often occur as part of one-another. For instance, the co-construction of meaning happens often during joint exploration.

4. *Putting things on the table*

In order for family members' understandings and relational patterns to be examined and for meaning to be renegotiated, it is necessary to identify pertinent issues and concerns and for all participants in the therapy (both therapists and family) to become aware of the perspectives and feelings that different family members have regarding these. A phrase which Lydia uses in Session 3 captures this part of the process well; 'putting things out on the table'. Pertinent understandings, feelings, actions and relational patterns are put out on the table in order that they may be reflected upon and examined. Through this process it is possible for the family members to develop an understanding of each others' concerns and preferences. Such an understanding is an important precondition for changes in action and interaction.

Putting things on the table is a reciprocal process which requires participation of both therapist and family. It enables the therapist to gain an appreciation of the meanings of each family member and therefore an understanding of the work that therapy will entail and it makes these different meanings available to all family members. Crucially though, for the process to be useful, family members must participate by attending to and taking on board each others' perspectives. If all participants attend to each other's meanings of self-harm and how they are implicated in them, this can open up a process of renegotiation of meaning. The nature of *what* is brought to the table and *how* this is done is described above in 'Focus' and throughout this section when the different strategies of guiding the conversation are considered. Here I want to share observations about the way in which the process changes over the course of the therapy. Putting things on the table, as might be anticipated, is clearly evident in the first session of the therapy, where Lydia draws out from Jess and her mother their understandings of important issues (such as self-harm, the 'holiday incident', and Jess's sensitivity to parental arguments). As therapy progresses and family members take action based on the understandings developed in therapy, the content of what is put on the table changes. Family members bring their experiences of trying out different ways of responding to self-harm and new ways of relating when they are worried about one another. This allows those present to reflect upon and evaluate any changes taking place.

The involvement of the family in putting things on the table is seen to increase as Jess's therapy progresses. At the start of each of the first three sessions, Lydia initiates putting things on the table. In session 1 she does this by inviting Jess and her mother to speak about their thoughts, feelings and hopes regarding therapy. Towards the beginning of Session 2 Lydia draws out important concerns for the family which then become important foci for the therapy. Jess's dissatisfaction with the level of her family's worry and their constant checking of her is put on the table, as is Sally's desire for self-harming to stop:

> L: So I suppose I'm sort of thinking, you know I'm aware that's what you kind of feel you're wanting with regards to self-harm, but I suppose I'm more trying to step back a little bit and think what sort of things are you wanting as a family? Or... as parents for your children? Or children for your parents? Or... what, kind of, are some of the things you... I know that's very broad, but... what are some of the things you maybe would like to be different? I'm thinking we can work together for up to six *months*. Just sort of thinking, what... what do you envisage or *hope for* to be sort of... and I suppose I'm asking all of you really.
>
> M: Can you think of anything, Jess?
>
> J: I want... I want, like, no-one to, like, worry about me, like... coming up in my room all the time.

M: I knew you were going to say that! [laughs] She can't go into her room for more than five minutes without one of us checking up that she's OK [laughs].

L: Is that right?

M: Yeah. And we both do that.

L: [to J] So you'd like people not to worry about you so much?

J: Uh-huh.

[This is explored briefly]

L: OK. [pause] So we can talk about that. Yeah? [J nods] That's something... Erm, shall we ask your mum and dad what they're, kind of, wanting as well?

M – I'd like her not to hurt herself anymore. [laughs] But I know [...] it's not gonna be an [clicks fingers] overnight thing. I know it's going to take time. But I'd like her to be able to manage her feelings in different ways.

In session 3, Lydia asks each family member for comments on the therapeutic letter she has written to the family which summarises their initial appointments. After the third session, there is a shift in the way that understandings are put out on the table. In the subsequent sessions family members initiate the process, for instance starting sessions with accounts of how things have been going and sharing their experiences of 'trying out'. In session 5, following Lydia's general opening question, we can see how Sally puts things on the table (including understandings of today's 'incident' and how the family are working together to help Jess stop self-harming):

L: Well, good to see you and, erm... just, how... […] how were you feeling about coming today? What was, sort of, going through your minds? Were you thinking "Oh *great*! We've got another appointment with SHIFT!" Or was it... What was sort of going on for you?

M: Erm... Well I was looking forward to it because I felt we had some really positives... and I think we still have lots of positives to share...

L: Right.

M: But then I've walked in and said to Pete "How are things?" and Jess has cut herself today...

L: OK.

M: ...which is... I think she's disappointed with herself...

L: OK.

M: ...yeah?

J: Yeah [nods]

M: 'Cause we've only had one other incident...

D: I think it was about... it was about eight weeks wasn't it? It's two months or... two or more months since we came back.

L: Wow... wow... Right.

M: So, she's making...

L: Wow.

M: ...we had one incident...when... we were just *aware* that there was something, and you took her in to the conservatory didn't you?

D: Yeah.

M: ...and I went in a few minutes later and I said, "Are you OK Jess?" And she... and I said, "Do you want to cut yourself?" and she said "Yes, but he won't let me". And I said, "Well, shall we try one of the things on the list?" So we got some ice... and that worked...

L: Mm-hmm.

M: And it took about twenty minutes, didn't it? Veggie mince and peas and ice in cubes...

L: And a frozen hand?!

M: Yeah. And a frozen hand... […] but it worked, didn't it?

J: Yeah.

L: Uh-huh.

M: And that was really good, 'cause we were around and we were able to sort of support her and it... it passed. And [to J] you said, didn't you, that you didn't think it would work? But it did.

J: Yeah

L: Uh-huh.

M: And then... you cut once on your own... and you were really disappointed with yourself, weren't you?

J: Yeah.

A form of guiding the conversation important in putting things on the table is 'inviting continuation'. This strategy is used when Lydia feels the material being contributed is potentially useful and worth exploring. Inviting continuation is done in several different ways. A more passive form involves Lydia simply allowing a speaker to continue their account and indicating that she is listening and interested by saying "*Hmm*" or "*Yeah*" occasionally (this can be seen in the extract from session 5 immediately above). Lydia may also invite continuation of a narrative more actively by asking, for instance, "*How did it go from there*?"

5. *Co-constructing meaning*

'Co-constructing meaning' is a process whereby meaning is jointly generated by the therapist and family members. Through the techniques of 're-framing' and 'selective reflection' new meanings may be created and new perspectives gained.

5.1.   Re-framing

Re-framing represents the more active side of co-constructing meaning. Here the therapist is presenting a new and alternative way of conceptualising experience; one which has more positive connotations for the family member(s) in question than existing meanings. The therapeutic potential of re-framing is conditional on; a) family members paying attention to the re-frame offered, and b) the re-frame having resonance for the them. In the reflecting team discussion of session 1, Steve provides a re-frame of the motivations for Jess's self-blame which, by making reference to inferred values of the importance of family, offers a more favourable understanding of her response to an argument between Sally and Pete:

> S: And I'm wondering - and I'm not sure about this - but I'm wondering about Jess's intentions too, underneath it all in terms of blaming herself, but I wonder if she's wanting to look after her mum and dad in that and say "Don't... blame yourselves."
>
> A: Hmmm.
>
> S: "Don't get angry at each other 'cause I don't want you to split up. I don't want you to have... arguments. So... perhaps it's all my fault and I can take the problem away". That's a *guess*. I could be really wrong on that. But there's something again I think perhaps about... for Jess, and I'm sure for Grace... the importance of their family is *really* important to them.

The impact of this re-frame can be seen shortly after the reflecting team discussion. We can see that it clearly resonates with Jess and that therefore it can play a role in co-constructing the meaning of Jess's actions (in this case the way that she blames herself for the argument) for her and other family members:

> L: So, just, anything that struck you, Jess, from what they were saying? From what Ann and Steve were saying?
>
> J: Erm... what... […] What he was saying about, like, how I blame myself and stuff...
>
> L: Uh-huh.
>
> J: ...I don't know. I thought it was true.
>
> L: *Ah-hah*. So... So the bit about... 'cause he was saying something about, erm... I think... 'cause what I heard – and tell me whether this is what you heard – that, actually something about your mum and dad arguing and actually if you're taking the blame then they're not taking the blame? That it may protect them from splitting up?
>
> J: Yeah.
>
> L: Is that what you took it as?
>
> J: Yeah.
>
> L: Was that a new thought, the way...
>
> J: Yeah.

L: Have you ever thought about the blame that you experience in that way before. [J shakes head, smiles] No? Uh-huh. It's interesting isn't it?

J: Yeah.

5.2. *Selective reflection*

Selective reflection involves the therapist giving a judicious summary of family members' contributions. Lydia uses selective reflection regularly throughout the therapy to do various things, such as communicate she has heard someone or check that she has understood correctly; co-construct meaning by reflecting back what is said with a certain emphasis, drawing attention to a particular element of someone's contribution or promoting a specific understanding; help family members to become aware of their thoughts, feelings or actions (e.g. when used during 'tracking'); and re-cap tasks or aims for therapy. In Session 2, Lydia uses selective reflection to help co-construct an understanding of 'arguments' as 'normal' and 'healthy'. This is a perspective which may be reassuring to Jess, who has viewed arguments as indicative of serious parental relationship problems:

> M: You know, and I've always tried to reassure that... you know, everyone has moments and sometimes...
>
> D: Sometimes you need to get it out [*]...
>
> M: ...you need to have a bit of a blowout and then you move on...
>
> D: Blow a bit of a fuse, just to...
>
> M: ...say what you need to say, and then you make up and everything is fine. But then when there's people stood at the door and you know that you're there we end up having to *stop* and things just... get... underneath and you can't... and so they just, sort of, just...
>
> D: Simmer.
>
> M: ...niggle away, simmer away... and then... and then next time there's a big argument or whatever...
>
> L: So what I think I'm hearing you both saying is that it's quite normal to blow your fuse every so often...
>
> M: *Yeah.*
>
> L: ...and actually there's something a bit healthy about... having a bit of a... let off steam.
>
> D: Mhmmm.
>
> M: Yeah – occasionally.

'Showing preference' is a way of guiding the conversation which Lydia employs to pursue one speaker's current contribution instead of another's. This can play an important role in co-constructing meaning. For example, the below excerpt from session 5 shows how Lydia is prioritising Jess's expression of what time together as a family means to her. This enables

a meaning of 'focused time' to be co-constructed by Jess and Lydia; in which the family purposefully spend time together and talk to each other. Lydia's prioritising of this allows Jess's desire for more of this focused time to be put on the table:

[Session 5]

L: ...it also sounds like, actually, what you're saying is you really like it when there is some focused time?

J: Yeah, like, I mean even... even if it was, like, once a month we did something where we went...

M: [interrupting] But, like, *tea*. We sit at the table nine out of ten times...

L: [to J] Go on...

M: ...to eat...

J: No we *don't*.

M: We *do*.

L: [to J] Go on. Finish... Finish what you were going to say.

M: Sorry.

L: [to M] No, you're alright. [to J] Just finish what you were going to say.

J: Even if it was, like, once a month, like. 'Cause, like, we've stopped going out. […] 'Cause we used to go walking and stuff. We don't do that anymore. 'Cause that was, like, a time we could talk and stuff, like. But we've stopped doing that. We just stay in the house.

M: Yeah.

J: We don't do anything and watch telly. […] Even if it was only once a month... if, like, we talked and stuff.

[...]

L: Once a month have a... a family... *date*?

J: Yeah.

L: ...or something. A family day to... talk...

J: Yeah.

L: ...and do an activity where you can talk, kind of thing?

J: Yeah.

This example captures the interdependent nature of co-constructing meaning and putting things on the table. It also gives us a sense of how, when family members are engaged with therapy, they can gain insight into potentially beneficial changes that could be made in the way they relate to one another. In this case, Jess's parents can see that making time for a monthly 'family date' could potentially enrich their relationship with their daughter.

6. *Joint exploration of meaning and relating*

Through the occurrence and recurrence of this collection of processes, understandings of pertinent concepts and actions are explored in such a way that all those present can become aware of the perspectives, preferences and wishes of others in the family. In particular, the implications that certain meanings and ways of relating have for action and emotion within the family are explored. This creates opportunities to reflect on the effects that certain ways of seeing things and doing things are having. An important aim of joint exploration is to permit shared understanding about significant issues. When shared understanding is reached and the positions of others are appreciated, this gives family members opportunities to revise their perspectives or actions. The implications that *new* meanings or actions have for family relationships can then be considered as they, in turn, are subject to this process of joint exploration. It can be seen that joint exploration of meaning is an ongoing, cyclical process. As new understandings are co-constructed and new ways of relating arise, the therapist facilitates the joint exploration of their implications for action, emotion and relationship.

Certain factors determine how effective the process of joint exploration can be. For instance, family members need to be sufficiently engaged in the therapy in order for this joint exploration to be useful. If key family members do not pay attention, or if they resist the therapeutic process, then it will be harder for the family to engage in this joint exploration and capitalise on the benefits that it offers. A related point is that the benefits that can be gleaned from this process are related to the degree to which family members have common goals and are able to work together to achieve them. In Jess's case, the family are very well engaged in the therapy from that start and are united in that they all want self-harm to stop. This is reinforced through the story of family togetherness that is co-constructed early on and repeatedly referred to. There is evident commitment to each other in the way that all family members participate in the therapy. They appear to be actively listening and contribute thoughtfully.

In numerous different ways, Lydia makes it possible for family members to become aware of their own and one another's perspectives, feelings and actions. In addition to facilitating this awareness, she encourages reflection upon the meanings and consequences of different ways of seeing and doing things. Different strategies that Lydia adopts to facilitate joint exploration are:

6.1. Checking out understandings

When other family members make statements pertaining to another's thoughts, feelings, etc., Lydia often checks out this understanding with the person in question. For instance, in Session 6, the family are discussing a previous incident of self-harm in which Jess cut her arm for the first time:

> M: So I think to come and talk about it... was... was quite positive. And... I *think*... I think Jess has learnt from cutting her arm. I don't think she'd ever cut her arm again, looking [laughs] at the way she... yeah... I don't know.
>
> L: Has mum got that right? Or wrong? Or...? [J nods] Has she? Do you want to tell me more? Or tell *us*... more?
>
> J: Erm... I just regretted doing it on my arm. 'Cause I got upset the day after as well [when friends saw the cut marks].

6.2. Tracking

This is a commonly used and productive means of joint exploration whereby patterns of action or relating are drawn out step-by-step, allowing the nature of specific incidents or generalised relational scenarios to be better understood. Whilst tracking, Lydia asks questions regarding family members' thoughts, feelings, intentions, actions and available courses of action. Tracking is used to systematically examine such things as specific incidents of self-harm, the generic pattern of how the family check-up on Jess, and the way in which Jess quashes potential parental arguments. The below exchange from the first session shows Lydia tracking the process of Jess's response to parental discord:

> L: And what do you do when you go there when your mum & dad's voices are being raised?
>
> M: They get upset.
>
> J: I think I get scared... I get worried, and, like... I like... I like, stand at the door and I listen to them and I'll come in and I'll be like "What's happened?"
>
> L: So you stand outside the door do you mean? So they're talking, their voices are raised, but you're there.
>
> M: Mmm.
>
> J: Yeah.
>
> L: So you're standing outside the door listening... and is Grace doing the same?
>
> J: Sometimes. I think she's, like... she's not as worried as I am, like, she is *worried*, but, like... she's, like, not as like... She doesn't *panic* as much as I do.
>
> L: OK. So you've got a radar out, listening... Tone of voice goes up, or speed of talking, or something...
>
> J: Yeah
>
> L: ...and then you're *there*. Yeah?

J: Yeah.

L: Outside the door listening. And then what? You go in?

J: Yeah.

L: And what do you say then?

J: Ask them [*]

M: I think you shout, actually [laughs].

L: Right. So then... so then *your* tone of voice is up, yeah? OK. 'Cause you're getting worked up about...

J: Yeah.

L: ...what's... what's going on. So you go in and you're... Are you *crying* at that point? Are you...?

M: Yeah.

J: Yeah, sometimes... I get angry.

L: So then you're getting angry and you're getting upset. Yeah?

J: Yeah.

L: And how does mum and dad respond to that?

J: They just say that it's fine and stuff. Like, what you said about... I argue with my friends.

6.3. *Seeking information about hopes, intentions and preferences*

It is important that not only the current ways of doing things is understood, but that desired or preferred ways of being are also talked about. 'Seeking information…' allows the family to reflect on, and communicate, how they would like to be with each other. Other family members can hear these preferences and use this understanding to modify their actions. Below, in session 4, Lydia is seeking information about how Jess would like her family to check up on her using text messages. We can see that Lydia helps Jess to think about what might be preferable, making suggestions along the way:

L: So, *how* would you like your mum to text you? Or your dad to text you? Or... Grace?

J: I don't know.

L: Like, would it be something like... You know, "I'm fine. I'll talk in half an hour". You know, is there something about time? About having a bit of a pause? You know, I think what we're talking about is not wanting things to escalate isn't it?

D: Mm-hmm.

J: Yeah.

L: So, having time and space, but actually not annoying and adding to that. So what would be most useful?

J: Maybe like... Don't, like... as soon as I go upstairs, like text me, just like...

M: [laughs] Give you a bit of time?

D: What, like when you get to 'top of 'staircase?! [laughs]

L: So, something like ten minutes later, or something? Or five minutes? Or half an hour?

J: Like, half an hour or something.

L: Ok, and sort of leave you for a bit, yeah?

6.4. *Imagined difference questions*

Imagined difference questions invite family members to project themselves into hypothetical scenarios, thereby encouraging them to think about new ways of doing things. Such questions are useful in that they make available the benefits of trying out (see *7*, below) without having to actually do so in vivo. Consider how Lydia uses an imagined difference question in Session 3 to explore Jess's understanding of the function of her taking responsibility for her parents' arguments:

L: Hmmm. What would it be like if you *weren't* taking that responsibility, do you think?

J: I don't know. The way I think... I don't know if it's the same... like, it probably will be the same for mum and dad, but they might, like, argue *more* because I'm, like, less worried about them.

[M laughs]

L: [leans in] Say that again.

J: Like, say, like, they were arguing and I just come in, I stop it...

L: You stop it.

[...]

J: Well, I mean... 'cause I always come in and I'm like "Stop it", like, so then they'll stop it because I'm like getting upset. Like, maybe if I didn't get like that then maybe they could like sort of like get it out of their system more. I don't like hearing it because I get like worried. Because if I let it happen, like, I feel like it's going to get worse and worse, so then I think if I stop it then I think they're just going to be alright with each other.

6.5. *Getting concrete and Stating tasks*

These two elements of joint exploration are grouped together as both help the family to consider what action they might take to address identified difficulties. Getting concrete involves Lydia asking questions which elucidate the specifics of relating. This allows family members to see more clearly what they could do differently in a given situation. For instance, the below excerpt from Session 3 shows how getting concrete can guide family members in how they might talk with Jess about self-harm:

J: I was talking to her [a friend] about it and she just like... She weren't, like, asking, like, loads of questions, like, she was just sort of, like, asking me one question and I just told her about it. Like, I'm not bothered if, like, you said something like that. It's like... I don't know. I think, if you just, like, asked me questions then I'd answer them.

L: And does it... Do your family need to read how you are before they ask you questions? Like, you know they seem to be really, kind of, acutely aware of how you are. Do they need to kind of pick a good *time*, or...?

J: Yeah [smiles, M laughs]

L: You know, like, "Is it OK to ask you a question?" Or…? Or is there any way you can say... "Talk to me, ask me", or...?

J: I think if I'm, like, in a good mood that would be, like, the best time to...

L: Yeah, to actually talk.

Stating tasks takes place when Lydia proposes issues the family might want to consider or actions they might wish to take. Early in the therapy the stated tasks are relatively vague, for instance, in Session 2, Lydia talks in general terms about what might be helpful to prevent Jess's distress from building up:

L: I suppose there's something […] you know, if there are ways, sort of, earlier on when you're struggling? And I'm hearing both mum and dad saying night or day, it doesn't matter...

M: Mmmm.

L: ...something sort of earlier on... about not being or your own, or earlier on... And I don't mean your mum and dad checking on you because you've said you don't want that. [J smiles]

M: You don't want that.

L: You don't want that... Erm, but something about what *is* helpful to you? And, you know, what helps interrupt this? And what helps things from exasperating (*sic*) and get... building up, building up, building up [J nods]. And we'll get to talk more about these in different sessions. But, there's something about, well can you think of anything earlier on in terms of just going to say to your mum or your dad...

M: Yeah.

L: "I'm struggling!" [J nods, smiles] "I'm struggling!" you know, having a cry, having a cuddle...

M: Yeah.

L: ...whatever it takes, but, you know "I'm struggling" [fast exhalation]. Because there's something about, you know, the self-harm that goes on on your own. That's often where it happens.

As therapy continues and understanding about the family's difficulties and Jess's preferences grows, the stating of tasks becomes more specific. In session 5, Lydia proposes that it would be helpful for Jess to do something to 'keep her mind off' worries and they think together about what this might be:

L: I suppose I'm just trying... thinking that... 'cause you know from *there* to *there* [indicating graph of distress they have drawn] what kind of things maybe... would have been useful, or... have you got any ideas Jess?

[…]

J: Erm... [pause] Keeping my mind off it.

L: Keeping your mind off it. 'Cause that really works for you when you talked about worries at *night* doesn't it?

J: Yeah.

L: Keeping your mind off it. So, what would help you if you got up in the morning and you were feeling a little 'nyeurgh' like that... just a little... so we're down, you know, here [points to lower part of graph], we're not here [points to higher part]...

J: Yeah.

L: What would help you keep your mind...? What would distract? What would be useful to distract if you could almost tell you were going that route?

[…]

J: I could...paint.

L: Aha.

[…]

J: …maybe if I, like, put my mind to it that would, like, keep my mind off it...

D: Mm-hmm.

J: 'Cause when I draw and stuff it keeps my mind off it.

L: So, drawing... I mean I know you've said before, haven't you, about... using your pens and so on?

J: Yeah.

Two final strategies for guiding the conversation are commonly used to facilitate joint exploration. Lydia directs the agenda of therapy continually by 'picking up on or returning to' a topic of discussion or a particular meaning that has already been mentioned. In this way, she is actively listening to the conversation for content that it may be productive to jointly explore. For instance, late on in the second session, Lydia picks up on questions raised by the reflecting team concerning how self-harm is viewed in the family:

L: I realise we've moved on to that from what Ann and Steve were talking about, but they were talking about a lot of other things. I don't know what struck you, Jess, from what they were saying? What did you think? They were talking quite a bit about the self-harm weren't they, as well?

M: Mmm.

J: Yeah. I wanna know what *they* think.

M: What *we* think about it?

L: So you want to know what your mum and dad think about the actual self-harm behaviour, what goes on? [J nods] Yeah?

There are many similar examples throughout the therapy of Lydia picking up on current or past statements to put (or keep) particular topics on the agenda. The material that Lydia picks up on or returns to is driven predominantly by the four content areas noted above, under 'Focus'.

'Directing towards a certain topic or speaker' is similar, in that Lydia is steering the conversation in a certain direction. However, this strategy occurs when Lydia is eliciting content that has *not* been touched on before. Some examples of this strategy are related to the structure of the sessions (e.g. inviting comments from the family following reflecting team discussions). Other instances involve Lydia asking about missed-out stages of a temporal process such as when tracking a particular incident. A frequently occurring type of 'directing…' involves bringing other family members into a conversation, to enhance the joint aspect of joint exploration. This is usually done by asking someone who has not yet contributed to do so, but can also involve bringing in an absent family member, as in the example below:

> [Session 6]
>
> L: If Grace was here what do you think she would say about the future?
>
> [pause]
>
> J: I don't know.
>
> [pause, J smiles]
>
> D: And Grace has obviously noticed the difference as well hasn't she?
>
> M: I think she's just happy... I think she's just happy to have her sister back...
>
> D: Mmm.
>
> M: ...how... how she was really.

7. *Trying out*

Trying out is an important element of the change process which arises from, and feeds back into, the interdependent processes of putting things on the table, co-constructing meaning and joint exploration. It involves family members using understandings developed in therapy to experiment with new ways of being and doing. Their experiences of trying out can then be brought back into therapy and the implications of new ways of relating can be examined. Family interaction and communication may be further refined, or the family may

be content with positive change acknowledged in the area in question (see 'Evaluating' and 'Recognising change', below).

Early in session 4, Jess reports that she had shared a worry with her father; something which was very difficult for her to do previously. This trying out of a different way of dealing with worry is brought to therapy and explored. Lydia summarises Jess's account, highlighting how talking helped Jess to manage her worries. She begins by asking how Jess's dad helped:

> J: Err... I don't know [laughs]. He just sort of, like, reassured me and stuff, like. He like... I don't know. He comes up with, like, ideas and stuff. And, like... things to do. Like makes, like... 'Cause when I worry about stuff I make it like proper over the top and stuff, but...
>
> L: Right, so when you worry about something it goes a bit over the top? It can get, like...
>
> J: Yeah, like, mentally.
>
> L: ...mental up here [holds hand up]?
>
> J: Yeah.
>
> L: OK.
>
> J: But he sort of… just sort of brings it down and, like... *calms* me down. But, like, I wasn't like going off on one. I was just talking about... I was a bit worried about my friend, but... like, I don't know, he sort of just like made it better... he sort of like put it, like, on a normal level.
>
> L: Right, yeah. Puts it... That's a lovely phrase; "He sort of put it on a normal level", yeah? 'Cause, I don't know about you, but sometimes worry has a bit of a life of its own sometimes doesn't it?
>
> J: Yeah. [smiles]
>
> M: Mmmm [nodding]
>
> L: You know. And what you're saying is you took the step to talk about it. And that in itself was a bit of a release. [J nods] But then actually having the comments back from your dad kind of normalised it a bit more?
>
> J: [softly] Yeah.
>
> L: Just brought it down probably another level?
>
> J: Yeah.

8. *Evaluating*

An ongoing evaluative element runs concurrently with the processes of constructing meaning and joint exploration. The aim is to move towards ways of seeing things and doing things that are preferable to the unhelpful understandings and relationship patterns which brought the family to therapy. Because of this, it is important to identify whether certain meanings or actions have more positive or negative repercussions. Evaluating is necessary as it tells the therapist whether revision of the meanings and actions being explored would

be beneficial. If meanings and actions are identified as being associated with preferable ways of being or more harmonious relationships then there is less need to modify them. In this case, the aim may be to further alter them, with the hope of further potential improvement, or the focus of therapy may move elsewhere. Alternatively, of course, a decision may be taken to end therapy.

In this excerpt from session 4, we can see the importance of evaluating in making known the feelings and preferences of family members. Jess has just drawn a sketch of 'worry', which involves her mum, dad and sister on the banister at home, looking up the stairs towards her bedroom:

> L: So, your doors open, but this is what you see on the banister? [M laughs] That's interesting. Don't pictures tell a thousand words sometimes? Do you know what I mean, I think there's something about pictures... they describe... describe what goes on.
>
> M: That is... [laughing] us all [pretends to be peering over banister] all stood there. Oh dear, Jess. I'm sorry! [laughs]
>
> L: So, what does...? What does... *that* tell you? You know, if you're feeling sad and that's there, what does that do to the upset and the sadness?
>
> J: It just *annoys* me, even more so.
>
> [Brief discussion about how family are starting to do this less]
>
> L: So there's something about... there's something about this [pointing to picture] that... makes you feel... annoyed. Yeah?
>
> J: Yeah.
>
> L: Does it increase the sadness, or decrease the sadness, or... what does...?
>
> J: It makes me angrier, so it probably doesn't... help.
>
> L: So it moves the sadness to... also feeling angry as well. Yeah?
>
> J: [nods] Yeah.

Evaluating makes the family aware of the meaning that their (albeit well-intentioned) actions have for Jess and how their checking in fact adds to her upset. Following from this and similar discussions they can make efforts to modify their checking behaviour. Again, whether they do so or not is dependent upon them acting upon the perspectives gleaned from therapy.

9. *Recognising change*

Recognising change is an important element of the therapy process that often involves evaluating. Here, the difference between the understandings and ways of relating currently being developed and those which characterised family life before is highlighted. The example below from session 5 demonstrates recognising change and evaluating and illustrates how these are important products of the process of joint exploration:

> L: What... What've you noticed that's been different with your mum and dad and Grace about... kind of how they've *handled* things? Or how they've dealt with maybe some of the upset... or...?
>
> J: Erm... they've been, like, calmer and stuff.
>
> L: Mmm.
>
> J: Like, more, like... they're, like, upset that I've done it, but, like, they're sort of more chilled out about it.
>
> L: Uh-huh. And how's that affected you, them being more chilled out?
>
> J: It's made me feel calm.
>
> L: Yeah. Yeah.
>
> J: Yeah.
>
> [Discussion continues. L enquires how M responded to an incident of self-harm which occurred shortly before today's appointment]
>
> L: Uh-huh. What difference did that make, in comparison to what your mum would have been like... a few months ago?
>
> J: Erm... it was just, like, more calm. Like, I know I've already said that.
>
> L: It's alright. It's alright. You can say *many* times. Because I think there is something about calmness that really, actually, helps, doesn't it?
>
> M: Mmm.
>
> J: Yeah. Erm... Well, she was like more calm. And then I don't know, it just sort of made me feel, like, you, like, less guilty, if that makes sense?
>
> L: Mm-hmm. *Yeah*, it does.
>
> J: It made me feel sort of less bad about it 'cause, like, she sort of, like, accepted it. And... yeah.

Associated with recognising change is 'reappraisal', where Lydia asks individuals to comment upon whether a certain understanding or issue has changed over time. This allows the therapist and the family to see if changes have taken place (and, if so, how they have impacted on relationships and action) or if this is yet to happen. Below is an example of reappraisal from session 1:

L: Hmmm. Do you still hold the same fears you had then, in terms of your mum and *dad* maybe splitting up? Or the... dad losing his *job*? Or...? Are they still... are those fears still as strong as they were then or are they changed?

J: Erm... I feel like, if, like, they had a big argument again then it could, like, sort of, like...*tip*.

L: Then it could tip... into potentially them splitting up?

J: Yeah.

L: Right.

The linked processes of trying out, evaluating and recognising change are evident from the second session of Jess's therapy. At this initial stage of therapy they are primarily related to developing a common understanding of the problem. As therapy continues, a deeper understanding of the problem is developed which informs new ways of relating with each other. Trying out, evaluating and recognising change then become more prominent as the family experiment with changes and explore their experiences.

Case 2: Donna

The model of the therapy change process developed from Jess's case adequately captures the broad processes operating in Donna's therapy. However, aspects of the process that were relatively unproblematic in the first case were revealed in the second as requiring considerably more work and the use of a range of different approaches to enable joint exploration of meaning and relating to occur. This reflected contextual differences between the cases, including how Donna and her mother differentially engaged with family therapy. Figure 2, below, summarises the change processes operating in Donna's therapy. This model can be compared with Jess's model shown above. I have portrayed the different emphases in the two therapies by making the more prominent processes larger. Below I will offer brief summary and comment where the processes of the two cases are very similar and focus more closely upon areas where modification or elaboration of the model is needed to accommodate the particularities of Donna's therapy. In the discussion of Jess's case we came to appreciate the different ways in which mutual engagement of the family facilitates the therapy process. Through consideration of Donna's therapy it will become apparent how fundamental mutual engagement is, and how, when it is absent, the primary task of the therapists is to work towards its establishment.
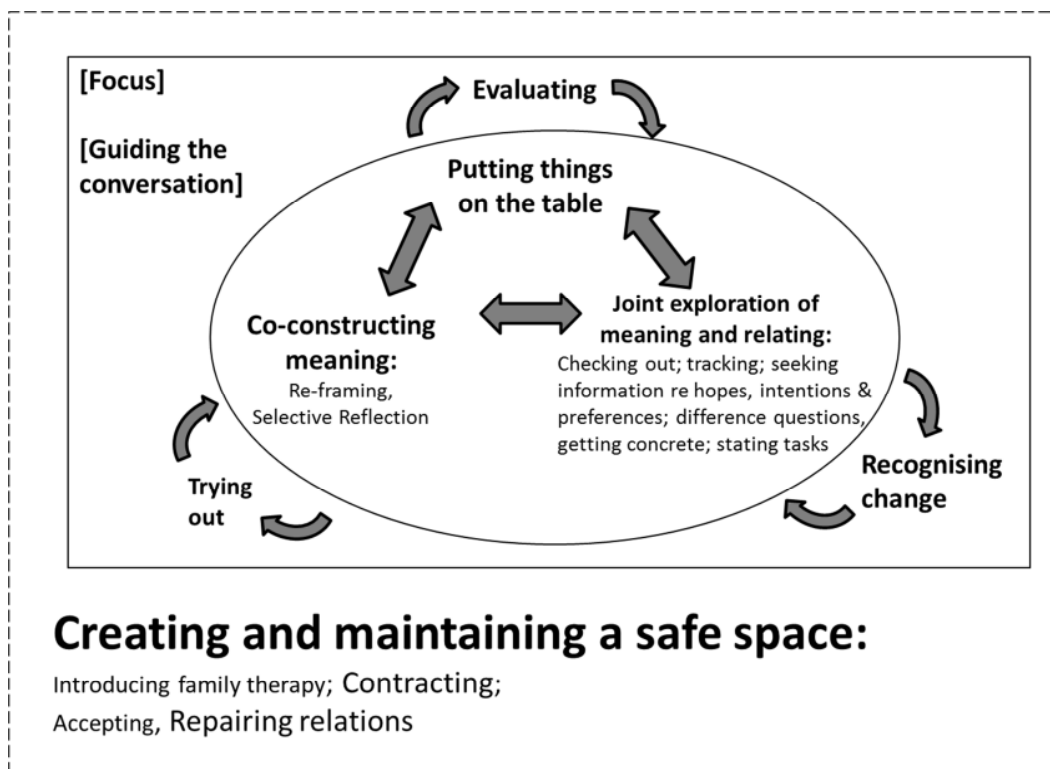
Figure 2: Model of therapy change process in Donna's case

A key of the abbreviations and transcription notation used in extracts of material from Donna's therapy is presented below in Table 2.

Table 2: Abbreviations and transcription notation used in Donna's case

D	'Donna' (index client)
M	'Mandy' (Donna's mother)
L	Lydia (Lead therapist)
A	Ann (Reflecting team member/Lead therapist)
S	Steve (Reflecting team member)
[…]	Some text removed
[laughs]	Non-verbal behaviour or contextual information
italics	Spoken with emphasis
[*]	Incomprehensible speech

1. *Creating and maintaining a safe space*

We have seen that in Jess's therapy the establishment of a 'safe space' and the engagement of the family was relatively straight-forward. This was partly because Jess's family were 'signed-up' to the idea of therapy and able to discuss important issues in front of each other from the beginning. The difficulties in Donna's relationship with her mother and her ambivalence towards attending therapy mean that greater efforts are needed towards creating and maintaining a safe space. Indeed, the majority of the work of therapy is towards mutual engagement of Donna and Mandy; that is, reaching a point where both can put forward their perspective *and have this be heard* by the other. Bringing Donna and Mandy closer together is a major task of the therapy and requires the therapy team to be creative in order to find ways to have productive conversations. In addition to introducing family therapy, accepting and contracting, additional work, which I have described under 'repairing relations', is needed towards mutual engagement.

1.1. *Introducing family therapy*

Lydia provides an introduction to family therapy in Donna's therapy, to give Donna and her mum an appreciation of what they can expect and what may be expected of them. There is also the familiar enactment of the values of family therapy. The non-blaming, non-judgemental stance of the therapists can be seen in their accepting of Donna and Mandy (see *1.2*, below) and there are regular efforts to consider the family's experience in terms of talents or resources that they possess (e.g. the creativity of Donna and Mandy is emphasised with regard to their writing poetry and songs).

1.2. *Accepting*

The same therapist interventions, including normalising and validating, which embody a generous, accepting stance, are evident in Donna's therapy. Below, for instance, we can see Lydia is accepting of Donna's use of her mobile phone and takes responsibility for Donna's inability to understand the question, adapting the question for her benefit. This helps Donna to participate usefully in the conversation:

[Session 2]

L: OK. Alright. So... And what would you put that difference down to? Can I ask you, Donna?

D: [looks up from phone] What?

L: What would you put...

M: Put your phone away please [D holds up phone, smiles at M, then puts in pocket]

L: Were you expecting somebody?

D: Nah. I need to do something with [*]

L: See what?

D: Something isn't working on my phone.

L: Oh. OK.

M: If it's not working then just leave it.

L: Urm, your mum was saying that the arguing, or the tension, has only happened, sort of, a couple of times really... and the shouting at each other. And that's... *different* than it was before. Do you remember when you came here *last* time it had been going on quite a lot the weeks before? So, I'm just wondering what, what do you put that change down to?

D: I still don't understand, like.

L: I ask big long questions, don't I? [laughs] Yeah? I think I was saying, do you think there's been a difference in how you're, kind of, talking and arguing together? [D nods] Yeah? What difference have you noticed?

D: Just lower voices.

1.3. *Contracting*

The sort of contracting seen in Jess's therapy is also evident in Donna's, in that Lydia collaboratively plans the focus and goals of therapy, and how it proceeds, with the family. However, whereas the process of contracting was unproblematic and readily established in Jess's therapy, it is more protracted in Donna's case and becomes an ongoing focus of the therapy. This is related to Donna's ambivalence about attending therapy and the in-session discord between Donna and Mandy. As Donna finds it hard to speak in front her mum and is at times unwilling to contribute, negotiation is needed to find a way to proceed. Therapists take part in contracting to arrive at arrangements acceptable to the family, such as Donna and Mandy talking to separate therapists in different rooms. Here we can see how Ann is contracting with the family regarding this in session 3, given that Donna is unwilling to speak in front of Mandy:

A: So that might fit with a bit... just her [D], today, and a bit of time on her own just to begin to think it over, see where we get, yeah? Would that be OK, to have a go at that? Erm, and that means you [M] could have some time talking with Steve.

M: [nods]

A: We can do it in different ways here - we can have something completely separate, so you [M] can have a separate room with Steve, erm there's a different room so you [D] and me talk, Steve and you talk, and then we can have, sort of, five or ten minutes at the end where we just think "What do we want to bring together? What do we want to keep separate?" *Or* your mum could be behind there with Steve just listening to us talking. What would you prefer?

D: I don't have anything to talk about...

A: You don't have anything to talk about? OK, can I ask you some questions if we have some time? If it sounds like you're not really sure about doing any talking? [pause] Maybe if you can go along with me asking some questions about stuff...

D: [hand covering mouth] Yeah

A: ...that would be good.

The therapists are also required to manage Donna's ambivalence about attending therapy. If Donna expresses unwillingness to attend, the therapist generally normalises this and explores it further. When Donna says she feels therapy isn't helping, this is acknowledged and the therapist explores whether there *is* something that Donna would like help with. When Donna persists, efforts are made to encourage her to attend. For instance:

[Session 3]

D: I still don't really wanna come though.

A: [pause] Yeah. Well, I think you don't know... you probably don't know how things... might go with you and your mum. You don't really know if it would work. *We* don't know if it would work... *but* there's a lot of families that we work with where people start off thinking "This is a bit impossible*"* but we do... they do get somewhere. [D blows nose] And things can change a bit. So maybe, if you were prepared to give it a *go...*? [D is looking down] And if it's not working you don't have to stay. You have to keep... keep saying, because there's no point... and then we've got to know that. So you can think, well... So look, if we get back together with your mum is there *something* that would make things a little bit easier between you and your mum? [D shrugs] If you can think that could make your feelings a bit easier?

D: [shrugs] I don't know

A: The stuff that we've talked about, would you want her to know something about... would you be...?

D: Just the things about my dad

A: Yeah, for her to know a bit about that. Would you like *me* to speak about that or you to speak about that?

D: [points to A] You.

A: OK, erm... I can certainly do that, erm. Is there anything you've said about your dad that you wouldn't really want me to pass onto your mum or are you OK for me just to talk about what I've understood [D nods] Alright. Shall I go get her?

D: Yeah.

On this occasion Ann suggests that therapy may be helpful despite Donna's doubts (and encourages Donna to say if these doubts continue) before returning to the topic of Donna's relationship with her mum and how the content of their preceding private conversation might be shared. It is apparent that the process of contracting is complicated by ambivalence towards therapy and family discord. In such circumstances, therapists are required to persevere with efforts to 'sell' therapy and find ways of holding conversations that are

acceptable to all family members. Validation of family members' perspectives seems to be a useful way of soliciting engagement when therapy is under threat.

1.4. Repairing relations

The in-session discord between Mandy and Donna presents an additional challenge for the therapists which they do not encounter in Jess's therapy; the need to repair relations. This arises as a result of a) Donna's ambivalence about therapy and her reluctance to engage with it, b) her mother's own needs and frustrations with Donna, and c) their mutual inability to put things on the table, listen to and hear one another. Consequently, some conversations are marked by blame, criticism, and disengagement and this clearly jeopardises the establishment of therapy as a mutually safe space. The therapists must therefore focus on repairing relations; creating a safe space for Donna and Mandy and, linked with this, facilitating 'putting things on the table' so that they can listen to and hear each other. This work comes in two forms: 'Bridging discord' and 'Enhancing empathy'.

1.4.1. Bridging discord

In most cases of disagreement or conflict, the therapist responds by acknowledging the perspectives being expressed and attempts to bring the conversation back to topic or use the opportunity to move to another topic (using the strategies of picking up on or returning to, or directing to topic or speaker). For instance:

> [Session 1]
>
> D: No I didn't have knives in there.
>
> M: Yes you did.
>
> D: No I didn't
>
> M: You did.
>
> D: [smiling] It was a butter knife to open the door!
>
> [M exasperated laugh, looks to L]
>
> L: So I suppose I'm hearing that your mum felt she needed to check quite a lot, and, and at the same time that was sort of, maybe, taking away some of your privacy.
>
> M: Privacy, yep, yep.
>
> D: [nods]
>
> L: Is that right? Which, I'm hearing that you like your privacy 'cos you like to write and that is really useful for you and... yeah?
>
> D: [nods]

[Session 3]

M: Why don't you tell them?

D: [makes irritated noise]

A: What? Say it again?

D: I don't have to tell everyone y'know.

M: You told... people and I was the last one to know.

D: No you wasn't.

A: You were the last one to know...?

M: Something that she did and she told everybody about it...

D: No I didn't.

M: ...and I was the last...

D: No I didn't.

M: ...to find out about it.

A: Something that you said... *was*... that maybe you would talk to your mum about some things but about things that were really hard or difficult, or sensitive, your mum wouldn't be the first person you would talk to… you wouldn't talk with...

D: Because of how she reacts.

A: Because of how she reacts? [Goes on to explore how M reacts]

When the conversation becomes heated, the capacity of Mandy and Donna to hear each other is further compromised and there is a need to bring down the emotional tone in order to try and instate a mutually-engaged conversation. Here we see how Lydia uses intervening to direct the conversation away from a very emotive topic in session 5:

M: I've talked to her. I told her, I'm fed up because, you know, at the end of the day I'm the one that's there twenty-four seven, and, you know... *possibly* not able to give her everything that she wants but then, I *can't*. I got three kids, you know, I got… I get no help from nowhere, I work and I have to pay for everything myself, and to her it's like you need to give me money, you need to give me this, but she don't do nothing in return, you know, and, you know, it's, what's the point? If I ask her to do something, I have to ask a million times before she decides to it, and the way she does is kicking and stuff and what she did to her brother this morning, it was, like, *disgusting*.

L: OK, let's just pause there, 'cos it sounds like you're really upset at the moment and there's a lot going on and feeling pretty overwhelmed right now with things, yeah? Have I read that right?

M: [Nods, wiping away tears]

L: Yeah.

[pause]

L: I suppose I just want to, I just I want to step back a little bit before getting into things straight off. Because I'm just… I'm just aware of what went on down in the waiting room and I kind of thought, I wonder how you both feel about being here today.

Early in session 3, Mandy voices dissatisfaction with Donna and Donna withdraws from the conversation. Ann's attempts to re-engage Donna are unsuccessful and the session seems to have reached an impasse. This situation provokes a more radical approach to bridging discord which involves separating Mandy and Donna. They spend time talking to different therapists in different rooms before coming back together at the end of the session. When they are re-united, a productive conversation can take place in which Donna's feelings about her father moving away are put on the table (albeit by Ann rather than herself). This manipulation of boundaries and space is one means of bridging discord and it also functions to enhance Donna and Mandy's empathy for one another (see *1.4.2*, below).

1.4.2. Enhancing empathy

Therapist efforts to encourage Mandy and Donna to have empathy for one another are prominent in the second case and play an important role in repairing relations and facilitating mutual engagement. Different tactics are employed by the therapists to encourage family members to give greater consideration to one another's experience and point of view. For instance, in Session 1, Lydia asks both parties what they have each been through in the day before they return home and arguments start, serving to show each that they have both had busy, stressful days. Lydia's questioning of Mandy in session 5, where Donna is listening from the reflecting team room, serves the purpose of enhancing empathy. Lydia's questions encourage Mandy to reconnect with the care and affection that she offered Donna when she was a small child suffering with severe eczema. Mandy's telling (and Donna's hearing) of this appears to cause a shift which enables increased empathy for one another. Donna is prompted to re-enter the therapy room and speak out against the 'story' of Mandy being to blame for Donna's eczema. A further example comes from session 6 when Lydia conducts an 'internalised other' interview of Mandy, asking her to respond to questions as if she were Donna. Following this, Donna reports being surprised by how well her mum understands her point of view and Mandy comments that the conversation helped her to better appreciate Donna's situation. These different methods of enhancing empathy contribute greatly towards the mutual engagement of Donna and Mandy and make it possible for them to have conversations which catalyse positive changes in their relationship.

The way in which the meaning of Donna and Mandy's relationship, and the problems within it, are co-constructed in the sessions is also important in the enhancement of empathy. This will be further discussed under co-constructing meaning (see section 5, below).

2. *Focus*

The same foci evident in Jess's therapy are also prominent in Donna's: 1) the nature and manifestation of distress in the family; 2) how distress is responded to or coped with; 3) strengths and resources that the family posses; and 4) self-harm. There is less talk of self-harm given that Donna is no longer doing this. The nature and manifestation of distress and how this is coped with are discussed primarily with regard to the relationship difficulties reported by Donna and Mandy, whereas in Jess's therapy, these topics related to anxiety and worry.

3. *Guiding the conversation*

The strategies for guiding the conversation discussed in relation to Jess's therapy are also used by the therapists in Donna's case ('intervening', 'showing preference', 'picking up on or returning to', 'directing to topic or speaker', and 'inviting continuation'). Several of them will be mentioned in this section where they have particular relevance to the element of the change process under consideration.

4. *Putting things on the table*

As Donna is often reluctant to speak, the way that perspectives are put on the table looks different. Firstly, the majority of content being put on the table comes from Mandy, and there are times when this takes the form of a diatribe against Donna. This means that the conversation can often be asymmetrical in favour of Mandy's perspective, which risks further alienating Donna, especially when Mandy is listing her perceived misdemeanours. The second difference, perhaps a result of efforts to correct this imbalance, is that the therapist is more active in facilitating the articulation of Donna's perspective. For instance, when Donna is reluctant to contribute, Lydia modifies her style and becomes more directive in suggesting what Donna may be thinking or feeling. For example:

> [Session 5]
>
> L: I just wonder *how* is it coming here today? What was your thoughts about coming here today? I know it's all started about Donna and so on, but for you, what was your thoughts about coming here today?
>
> D: [shrugs]

76

[pause]

L: I mean as we're sitting here, I'm thinking I could really imagine that you didn't want to be here today. Because you know, if I was you and coming here today, you know, and I was aware of how my mum was thinking and feeling then I know my mum would talk about this and that would be quite hard, actually, as well, to be... sort of having to talk when, I know for you, Donna, you've said before how hard you find it to talk in this sort of place. So sometimes you come here and maybe it's... an opportunity to get things out, Mandy, for you in terms of the difficulties, but also I'm aware for Donna that's quite hard because you don't like to talk in this kind of environment but actually you're hearing quite a bit of things too?

In this way, the therapist is acting almost as an advocate to allow the less prominent voice to be heard. Another striking way in which this is achieved is in Session 3 when Mandy and Donna are brought back together after they have been speaking in different rooms with Steve and Ann, respectively. Ann, with Donna's permission, puts on the table Donna's great sadness regarding her father moving away, which allows Mandy to appreciate the current significance of this for Donna.

Another technique that Lydia uses to maximise Donna's presence in the conversation is 'showing preference' for her offerings when she does make a contribution. For example, in session 6 Lydia shows a preference for Donna's response to her question which she then reinforces by summarising her answer and stating that to 'forgive and forget' and 'let things go' seem like important things:

[Session 6]

L: …in terms of, you know, no longer sort of *wanting* blame, what does that say about you as people, in terms of *who* you are and what... who you will become?

D: Erm…

M: I've...

L: Go on Donna, what were you going to say?

D: Erm, just able to let things go more.

L: *Ah ha*.

D: Just forget… forgive and forget.

L: Forgive and forget and let things go now.

M: [nods]

L: So […] being able to forgive and forget, yeah, rather than sort of holding onto grudges and keep on at *this* [picking up paper hand which symbolises blaming], yeah? To let things go seems really important, yeah? And that's the sort of person that you want to be and that you *are*... becoming.

D: Yeah.

L: That sounds like that's a really important quality to have.

Donna's therapy demonstrates clearly that, to maximise therapeutic benefit, putting things on the table needs to occur in the context of mutual engagement of key family members. It is of little use if things are put on the table by one person when other family members are unable to hear or heed what is being conveyed.

5. *Co-constructing meaning*

Just as the therapists are required to play more of an active role in putting things on the table, greater involvement from them is evident when it comes to co-constructing meaning. For instance, the therapists make concerted efforts towards re-negotiation of the meaning of relationship problems reported by Donna and Mandy. In session 1, for example, Lydia uses selective reflection to co-construct an understanding of arguments and tension as related to worry caused by difficult life events:

> L: [to D] So, it sounds like..., from what your mum's saying, is that some of the events that happened in the last year put the getting along a little bit, down the priorities a little bit, yeah?
>
> M: Yeah. Because we were focussing on... you know focussing on worrying about things... instead of concentrating on, kind of, each other really.
>
> L: Right. So it sounds like worry got in the way of enjoying each other and...
>
> M: Yeah.

Re-framing is used in session 3 to co-construct an account of discord which is 'nothing personal', but rather related to factors outside of the relationship (e.g. Donna's anger regarding her dad moving):

> A: You know what might happen is that because you're there... who can Donna get angry with about that?
>
> M: *Me*. [laughs]
>
> A: The funny thing is that it doesn't mean that she thinks it *is* your fault...
>
> S: It's not personal.
>
> [D is fiddling with a tissue, fussing with her ears]
>
> A: But what do you do with the angry feelings?
>
> M: Hmmm.
>
> A: You know, you can hurt yourself or you can just try to get rid of those feelings, maybe that's something that happens?
>
> M: Hmm.

By session 6, arguments between Mandy and Donna have reduced and the preceding period of tension is co-constructed as having resulted from the mother and daughter needing time to adjust their relationship to Donna's growing up:

> A: And I think it might be something to do with, or Mandy said something about... she's not a kid anymore and I'm not getting any younger…
>
> S: Mmm. Mmm.
>
> A: …I don't know, whatever…
>
> S: Mmm.
>
> A: …but something about time passing and so, Donna's moving out of the being a kid…
>
> S: *Yeah*, yes.
>
> A: …into, you know… So what happens to mums and daughters at that level? Something's really changing and maybe… maybe a little while ago they were like… it wasn't *fitting* very well because...
>
> S: Mmm.
>
> A: ...Donna was becoming *not* a kid and...
>
> S: Yeah.
>
> A: …erm, but, you know, they hadn't quite worked out how to be.
>
> S: Yes.
>
> A: But now they… they… they've got a much more worked out way of how to be and like Donna was saying it's forgive and forget, so...
>
> S: Yeah.
>
> A: ...she's… so… and she's given a bit of time that she's doing stuff that her mum asks her to do some of the time... so I think somehow that there's a big age... there's a big sort of change because she's becoming a young woman and her mum recognises her as one.
>
> S: *Yes*, yes, yes.
>
> A: So a big change.

In addition to these examples, Donna and Mandy's difficulties are spoken about as associated with a lack of quality time spent together, and related to them each having had stressful days prior to arguments. All these different ways of understanding discord, which are co-constructed by the therapists and the family, are more hopeful than alternative ways of seeing it, in which difficulties are inherent to the relationship, perhaps being due to a lack of love or respect for one another.

An important re-frame takes place in session 5, when Mandy's self-blame regarding Donna's eczema in infancy is re-framed as a 'story', as opposed to a 'fact' or something 'real':

L: So that *story* of... "It's your fault", or... what else would that story contain, that other people are saying? Or *did* say?

M: It was just like, well, just like *blaming* me, like, in general for what was happening to her and er...

L: That's hard, that's a hard story to...

M: Trying to find an answer and then until the doctor said it's, sort of, you know, it's a skin problem...

L: It's a skin problem.

M: ...it's not...

L: Exactly

M: Because I thought I, I even went to the hospital once to check if I got any, erm... like disease or something that I passed on to my child

L: And...

M: But it was nothing. It's not even like that contagious or anything

L: And did that, getting that knowledge, i.e. you know, it's nothing. Did that help you *change* that story in terms of what you're saying, how 'it's my fault' and…

M: Well, not all... not really 'cos like the constantly *hearing*, you know, it doesn't matter, it's still your fault, you know, you're doing this and it's because you didn't feed her *this* or because you feed her like *that*. It's the *nappies*, it's the clothes that you're *buying*.

This way of speaking (about different 'stories') becomes an important vehicle for change in subsequent appointments. Mandy and Donna go on to discuss the differences between 'old' and 'new' stories about themselves and their relationship and what is helping them to move away from the former and towards the latter.

One final observation regarding the different way in which meaning is co-constructed in Donna's therapy concerns the way in which selective reflection can go *beyond* what has been put forward by family members. At times this takes the form of developing a family member's contribution along similar lines, which can serve to reinforce statements or further elaborate meanings. This offers family members an account which is based on a summary of their words, and so perhaps feels like their perspective, but is richer or more fully developed than the account they give. Consider this example from session 6, where Lydia elaborates Donna's statement about how relations with her mum have come to feel easier:

L: What's made it easier *now*... than then?

D: Talking... and... listening.

L: So talking and listening has helped you to feel more confident that your mum will be fine if you have a difficulty and that actually that it would be useful for you to tell her any of your difficulties, yeah? So there's something about having time and space to talk.

80

Interestingly, there is one occasion where selective reflection embellishes the contribution of family members in order to co-construct a particular meaning. In session 5, relations between Donna and Mandy are particularly strained and Lydia uses selective reflection in an attempt to co-construct a mutual desire for reconciliation:

> L – Can I just, again before we get into particular details, I think, Donna I'm... I'm trying to think, you know, for *you*, erm... how, well, the fact that coming here is quite difficult, isn't it? But I, I'm also wondering, are you, amidst whatever has gone on, are you able to hold onto the fact that you were wanting a better relationship with your mum? Is that still... something... that you're able to hold on to? Or are you not so sure? [pause] Does that mean you're not so sure... at the moment? [D small nod] OK. And what about you Mandy, is that something you're holding onto? That you're wanting a better relationship?
>
> M – Well, yeah, she's my daughter, I'm always going to be there for her, I love her.
>
> L – You're holding onto that too.
>
> [Approx. 5 minutes later. L talking with M in therapy room. D listening from reflecting team room].
>
> L: ...I'm just conscious that, you know, as we've talked there's… there's hurts, there's things that have gone on. I'm also aware that you're both... you know, *wanting* a closer relationship, and I suppose part of me would love to sort of track back and think about your relationship when Donna was younger... [Goes on to explore M's recollections of Donna's early life]

We can see that Lydia proposes that *both* Donna and Mandy want a better relationship, when Donna has in fact not stated this clearly in the preceding discussion. This occurs at a crucial point in the therapy, where relations are most strained, which might explain why Lydia feels the need to go beyond the stated words in her selective reflection.

6. *Joint exploration of meaning and relating*

Compared to Jess's therapy, the degree and type of joint exploration in Donna's is constrained. There is some joint exploration in the first two sessions, when conversations take place about arguments at home and both Mandy and Donna appear relatively well-engaged. However, this cannot continue in the way that it does in Jess's therapy because of the discord between Mandy and Donna which characterises sessions 3 to 5. A large proportion of these appointments is taken up by working towards creating a safe space and trying to establish mutual engagement. From the latter part of session 5 onwards there is more evidence of joint engagement and there are opportunities for joint exploration in sessions 6 to 8. The nature of joint exploration in Donna's case is influenced by the fact that Donna is often unwilling or unable to put forward her point of view. This means that her perspective is often not put on the table and therefore cannot be jointly explored. When

Donna does speak in front of her mother, her contributions are often short with little elaboration, again restricting the possibility for joint exploration.

6.1. *Tracking*

Tracking happens just once, in the first session, where Lydia tracks the common proceedings of arguments between Donna and Mandy. Tracking may be less apparent in Donna's case as more time is taken up engaging the family and therapy simply doesn't 'get around' to it. The relative infrequency of tracking could also be because no current incidents of self-harm are reported during Donna's therapy, and these are a prominent target for tracking in Jess's therapy.

6.2. *Checking out understandings*

Checking out understandings takes place in Donna's case as in Jess's. However, to accommodate interventions used often in Donna's therapy, this concept needs to be expanded. Previously, this was simply about checking whether a family member agreed with what another had said. However, a broader process is operating in Donna's therapy. Lydia often checks out other things, e.g. whether certain things have been talked about, whether one family member has heard another talking in the present way, etc. The benefit of this is that the therapist becomes aware of what has been shared between family members. This acts a measure both of the quality of communication between family members and of their current understanding of key issues. 'Checking out' also allows the therapist to capitalise on occasions where novel understanding takes place between Donna and Mandy. In this way, checking out can be used to enhance empathy. For instance, in session 2, both Donna and her mum talk about having written songs or letters for each other. By checking out, Lydia establishes that neither knew about these pieces of writing and both appear to be touched that the other has thought about them in this way.

6.3. *Seeking information about hopes, intentions or preferences*

Seeking information about hopes, intentions or preferences is used in the same way in Donna's therapy. In session 5, it allows all present to hear about Donna's hopes for her relationship with her mum:

> L: Mm hmm. You know how we've talked about that story with your mum hearing blame so much, and we talked about actually writing a new story, instead of the *blame* story, if you could write a new story instead of blame, what would you like to hear... instead of blame?
>
> D: [softly] Comfort and encouragement.

L: Encouragement? [D nods] What did you say first of all?

D: Comfort.

L: Comfort. That's a beautiful word, comfort, I think. What does comfort… [Donna is playing with 'playdo' - it makes a popping sound] Ooh, that's a great sound isn't it? What does comfort... mean to you? And what would comfort look like to you?

D: Just caring.

L: Caring.

6.4. *Difference questions*

Following analysis of Donna's therapy, the joint exploration strategy previously called 'imagined difference questions' is changed to simply 'difference questions'. This is because the fundamental element of this strategy is to get family members to think about ways of being or doing things other than those which have been identified as problematic or undesirable. It is less important whether these different actions, feelings, patterns of relating, etc. are remembered past ones or imagined present (or future) ones; the key thing is about reflecting on how things might occur *differently* and the implications that this might have for the family members. In the below extract from session 1, 'Can you think of a time when you did get along?' Is a difference question which brings about talk of a different way of relating that Donna and Mandy are capable of:

> [Session 1]
>
> L: But it sounds like you're wanting the same as... wanting the same as what your mum was saying. Do you want to say that in *your* words instead of your mum's words?
>
> D: Just no more shouting and stuff […] Just to get along.
>
> L: To get along? [D nods] To get along. Yeah, yeah. Can you think of a time when you did get along?
>
> [Pause] When you got along a bit different than you are doing now?
>
> D: [Pause] Erm, like... When we were out as a family... when I was young.
>
> L: So when you went out as a family, when you did things together, kind of thing, when you were younger, yeah? [D nods] OK, and what does 'getting along' look like to you, how do you know you're getting along?
>
> D: No one's shouting at each other and everyone's laughing and smiling with each other.

6.5. *Getting concrete*

In Donna's therapy, as in Jess's, getting concrete is used to help family members gain further insight into what they are doing and why this may be helpful. For example, in

session 2 it helps Mandy and Donna to see what they are doing to help ease tension and arguments:

> L: Lower voices, right, so the volume's... gone down, yeah? OK, what's helped you keep the lower voices?
>
> D: [pause] Well... if my mum shouts, yeah? Or if I think she's shouting I say 'Mum, stop shouting' and she says 'I'm not shouting' and then the voices just go lower [smiling].
>
> L: So, just the fact that you're acknowledging actually there's shouting *there*... does that make you both aware of it and...?
>
> M: It does [makes 'bringing down' motion with hands].

6.6. Stating tasks

Stating tasks is also used as previously described. In session 3, Lydia states a task for Mandy; she should take a leaf out of Donna's book to help her move past the 'blame story':

> L: And I just wonder what it would take for you to... what was Donna's words, what did she do with blame? What does she do with blame stories? [pause] What does she do? Ignores them and...?
>
> M: *Bin it*! [laughs]
>
> L: And bins it! Where's the bin?! She bins it. So, you know, I don't know whether today's been useful in terms of thinking about ignoring that one now, and binning it... and actually move on to some new stories here. You know for you as a mum, that, that blame about eczema is not part of it anymore, and, and it's a bit 'dumb', to have that story, yeah?

The team are more directive with Donna's family than with Jess's in stating tasks and offering ideas for the family to try out. This more active involvement could be driven by the greater interpersonal difficulties seen in Donna's case and/or the perception that Donna's family don't have the same resources or ways of coping that Jess's family demonstrate.

7. *Trying out, Evaluating, and Recognising change*

Again, as with other parts of the therapy process, there is less evidence of these three elements in Donna's case. This is, again, likely related to the focus of the therapy more often being on creating a safe space. There are still, however, several examples of the family bringing new ways of doing things in to therapy for consideration. In session 6, for example, Mandy talks about trying out a new way of interacting with Donna regarding responsibility and household chores: "You know it's there to be done so it's up to *you* to make that choice of doing it, so instead of asking her constantly to do things she just gets on with it". Lydia then explores this further:

L: Ah ha. So what happens now when Donna doesn't do it in that time scale?

M: I'll just go and I'll do it myself, and then sometimes… and then without even realising at all I'll just go and do it and next time I'll do it without her sort of asking because it's like a simple thing like doing the dishes.

L: Ah ha.

M: You know, same thing with, like, tidying her room. And *she* knows it's untidy, so it's *her* choice to, you know, tidy it up, so...

L: So it seems a bit more, sort of, give and take?

M: Yeah.

L: A little bit? [M nods] Yeah.

The relatively little evaluating taking place in Donna's therapy could simply reflect that fact that there is less change to evaluate. When change is reported, however, evaluating is used to see if new meanings or actions have positive or negative effects. E.g. Lydia evaluates the decrease in shouting reported by the family in session 2:

L: Yeah, OK. Um, what difference has not having as much shouting made to your relationship together?

M: It's much better, because at least, you know, coming in... you know, if there's not that tension in the house, everybody can just get on with... doing their own things without worrying that, you know, someone will shout and... Like before she used to be out all the time...

L: Right.

M: ...and she hasn't been... out at all.

L: So has it been... has it been nicer to be at home? [D nods]

Following this discussion on decreased shouting and arguments, the therapists pick up on the change in their reflecting team discussion. The significance of recognising change here is seen by Mandy's response to this:

[Session 2]

L: OK. And anything else they [the reflecting team] said?

M: Also about the, you know, the *positive change*... you know, between us and things like that.

L: How does that make you feel when you hear somebody acknowledge the positive change in terms of what else is possible?

M: It makes me feel *good* and it makes me feel that, you know, things actually... can happen... It can be done. Because, like, my entire life all I've heard is, like, you know, "You're not good enough. You're not gonna do this. You're not gonna go there" and then... for...

L: Your entire life?

M: Yeah, well mostly. And then for someone to say, actually, there's good things... it matters. It makes me feel like, you know, I am... you know, *change* can happen, actually.

There are two instances towards the end of the Donna's therapy where *reappraisal* helps those present to recognise the change that has taken place. In session 8, reappraisal concerns Mandy's belief that she is a good mother. In session 6 it is regarding Donna's confidence about sharing worries with her mum:

L: If you wanted to take a difficulty to your mum, how confident do you feel that you could... do that?

D: [shrugs] I don't know... *Now*?

L: Yeah.

D: About 70%.

L: 70%?

D: Or 80% [M laughs]

[…]

L: 70 or 80% you feel confident that you *could* take a difficulty to your mum?

D: Yeah.

[…]

L: When you think about when you *first* came here or *before* you came here, it sounded like that wasn't… the levels weren't as high as that, so you didn't feel that confident to be able to take difficulties to your mum. So what would you, what would you have put it at 6 months ago?

D: 50/50.

L: 50/50. *Wow*. [to M] So how does that feel when you hear Donna saying that?

M: [Nods] Good, cause she… I… This is something that I always said, you know. She can always talk to me and even with... the everything that was happening before I tried...

L: Mmm.

M: ...to speak to her, I tried for her to talk to me, but she wouldn't.

Contextual factors influencing the process of change

1. *Level of mutual engagement*

The most striking refinement of the change process model following analysis of Donna's case relates to the fundamental importance of mutual engagement of the family. At the least, mutual consensus around a common purpose for therapy is needed, even if at the beginning this is as general as wanting things to change. Family members may show various levels of engagement with therapy or commitment to change and they may disagree on how to effect

change, but unless there is some agreed common purpose to work with, therapy won't proceed. The vital significance of mutual engagement was obscured in Jess's case because of the very fact that it was present. Its absence in portions of Donna's therapy exposes how therapy is constrained when mutual engagement is missing.

Mutual engagement describes a scenario in which all significant family members feel safe enough to participate in discussions pertinent to their current difficulties or concerns. By 'significant' family members I mean those invested in the problems that have brought the family to therapy. 'Participation' in this sense requires *both* being able to put forward one's own perspective *and* being able to hear and take on board the perspectives of others. It is apparent that when mutual engagement is established and maintained (as it is in Jess's therapy) the processes involved in examining and refining family relating are greatly facilitated. It could be said that mutual engagement is a *necessary but not sufficient* condition for therapeutic change because meaningful joint exploration cannot take place without it. However, this is does not mean that when mutual engagement is established that beneficial change in reported problems automatically follows. Depending on the nature of such problems, focused effort on the part of the family may still be required to bring about such changes.

Identified threats to mutual engagement include relational difficulties within the family and unwillingness to attend therapy. When mutual engagement has *not* been established, the processes of therapy are altered in terms of the work they require of the therapist and the content which is important. More sustained efforts towards contracting with the family are necessary, which requires flexibility and creativity from the therapists, for instance regarding the physical arrangements of the session. Ambivalence must be addressed when it arises and validation of the client's perspective seems important here. Efforts to repair relations through bridging discord and enhancing empathy may be needed. A lack of mutual engagement is characterised by reluctance to contribute in one or more family members. To correct an imbalance here (i.e. in what is being 'put on the table') therapists may take a more active role in which they advocate for the marginalised party. Finally, as greater time is taken up with the above, there is less opportunity for joint exploration of meaning and relating, trying out, evaluating and recognising change.

It must be acknowledged that although mutual engagement is being discussed as a condition for positive change for the family, its achievement may represent, in and of itself, therapeutic improvement. The ability to communicate with one another and pay heed to others' perspectives (including the attendant empathy this involves) may mark a significant shift for families such as Donna's in which relationships have deteriorated. I propose that if the establishment of mutual engagement is achieved in a family previously characterised by relational conflict then the therapy should be considered a success. However, as stated above, difficulties such as those associated with self-harm, which may be very entrenched, may require further efforts (once mutual engagement has been established) in order to realise positive change. As Donna is no longer self-harming by the time her family commences therapy, and as Jess's family already demonstrate congenial relationships when their therapy begins, the analysis of these two cases provides limited insight into this scenario.

2. *Self-harm*

Donna's therapy provides us with valuable insight into the importance of creating and maintaining a safe therapeutic space, but it also begs the question; How would ongoing self-harm have changed the process of therapy? It is hypothesised that, were Donna still engaging in self-harm, this would have altered the process. For instance, given the relationship problems between mother and daughter, the therapists would have a responsibility to consider whether these problems were detracting from Mandy's ability to keep Donna safe. As Jess's family seemed capable of keeping Jess safe and as Donna was no longer self-harming, the two cases are limited in what they can tell us about how the requirement to manage risk impinges upon the identified therapy processes. Presumably, the level of risk in Donna's case was assessed by the therapists and was not considered to be high enough to require further attention. Further elaboration of the model with regard to the impact of ongoing risk of serious injury would require theoretical sampling of cases to ensure inclusion of those that demonstrate high risk of injury and low engagement as well as high risk and high engagement.

3. *Perceived resources of the family*

The greater involvement of the therapists in Donna's case in putting things on the table, co-constructing meaning and stating tasks suggests that therapists regulate the degree and type

of their involvement according to the resources they perceive the family to have. Because of the difficulties and stresses being reported by Donna's family, there was perhaps a judgement that the family did not currently have abundant coping resources. Consequently, the team may have adjusted their therapeutic style to be more directive. For instance, during joint 'exploration' they may be more prescriptive in 'stating tasks', offering ideas or making suggestions more readily than usual. The situation is different in Jess's case. Through the way that they engaged with therapy and used the therapy sessions to make changes, it could be assumed that Jess's family were regarded as having available resources to cope with and overcome problems. As a result, the therapy team can afford to be less directive and allow the family to come up with more ideas themselves. This notion of adjusting the therapeutic stance according to the perceived resources bears a resemblance to Vygotsky's concept of 'zone of proximal development' (ZPD; Vygotsky, 1968). The therapists are offering greater or lesser support in much the same way that Vygotsky proposed teachers provide 'scaffolding' appropriate to the ZPD of the pupil.

CHAPTER 4: RESULTS - Meanings of self harm

There are a variety of different meanings of self-harm evident in the talk of the families and therapists across the two cases. In this chapter I will consider these different meanings, the changes that are apparent in them over the course of therapy and how the therapy process operates to bring about these changes. A stark contrast between the cases is that Donna is no longer using self-harm, and indeed never habitually did so, whereas Jess has been self-harming regularly and reduces this over the course of therapy. Consequently, there is much less talk of self-harm during Donna's therapy and the findings and interpretations below are drawn primarily from Jess's case.

I will discuss several related changes in the meaning of self-harm which take place. At the beginning of Jess's therapy, self-harm is performed in secret and not discussed at home. For Jess's family, self-harm is highly anxiety provoking and difficult to understand. Over the course of the therapy, however, self-harm becomes something which the family can and do talk about. Understanding of the function it serves for Jess grows and by the end of therapy it is generating much less anxiety within the family. I will describe these changes in meaning, offering illustrative extracts from the therapeutic dialogue. I will then consider how the elements of the therapy process presented in the previous chapter operate to facilitate these changes. We will see that the adoption of an understanding of self-harm as a means of managing overwhelming, unwanted feelings plays a key role in this.

The apparent importance of affect regulation in families in which self-harm has taken place will be highlighted. The therapists do significant work to help both families manage difficult feelings, although this looks quite different in each family. In Jess's case, management of emotion is in terms of anxiety, guilt and parental over-responsiveness, and therapy helps the family to better understand and modify how they do this together. In Donna's case the role that therapists play in handling within-session affect is fundamental in securing Donna and Mandy's mutual engagement in therapy and facilitating meaningful dialogue between them. Here management of emotion is in respect of anger and parental under-responsiveness.

Self-harm as secretive, risky, unmanageable and incomprehensible?

Jess initially kept her cutting secret from her family and her mother found out about it at their first appointment with CAMHS, prior to commencing family therapy. This marked the

beginning of a dialogue about self-harm between Jess and her family. However, early on in the therapy we hear that the family find it difficult to talk about self-harm outside of appointments. Jess does not like to share her worries with her family and her parents report feeling that talking about self-harm when Jess appears to be in a good mood might 'bring her down' and make things worse. Early on in the therapy family members talk about self-harm as a very distressing phenomenon which provokes strong reactions. In the first session that Jess's sister attends, for instance, she describes being 'panicky', screaming, crying and feeling 'physically sick' following an episode of Jess's self-harm. In the same session, Jess's mum articulates a feeling of helplessness surrounding their ability to cope with self-harm:

L: Does it feel like "Oh gosh, what do we do?"

M: Yeah. Yeah. That's how it feels. I just think... "Oh god! What can we do?"

The feelings of anxiety and helplessness seem to be associated, for Jess's mum at least, with a belief that cutting puts Jess at risk of significant harm. Sally is clearly concerned that Jess's self-harm behaviour might escalate:

[Session 2]

J: ... I told my mum "Ah... I just burnt my hand [on the kettle]" and she was like "Oh, you didn't do it on purpose did you?" So...

M: Yeah, I did say that. […] But that was my reaction, I was like "Oh gosh has she... has it gone up a level?"

[Later in session 2]

M: At least a razor's clean and superficial but she's used things that *aren't* clean and *aren't* superficial...

L: Mm-hmm.

[…]

M: And I just think that... there's the potential to go deeper and... make a bigger...

L: Mmm.

[…]

M: It's just mainly the *risk*, isn't it?

L: Mm-hmm. Mm-hmm.

[…]

M: That worries me Jess, that you're gonna do some real damage to yourself.

Towards the beginning of therapy, Jess's family speak of finding it very difficult to understand why Jess self-harms. Pete and Grace in particular report struggling to understand this:

[Session 2]

D: I find it difficult to... I don't know, difficult to sort of understand, why you do that, 'cause it's just, sort of, something so totally... alien to my way of thinking. I'm just, sort of... really laid back and I just... nothing really... I don't really get troubled by much at all...

L: Mm-hmm.

D: ...you know, whereas, sort of, going into your room, or going into bathroom and doing something like that is just, you sort of think, you know, "*Why*?" It's...

L: OK... So it's hard for you to understand why...

D: Yeah.

L: ...and it's...

D: Yeah...

L: …it's kind of alien...

D: Mmm.

L: ...to what you would do...

D: Yeah. Yeah.

L: ...if you were struggling with difficult... feelings?

D: Yeah.

[Session 3]

G: So, like. Jess... seeing it as... like... like, I think, like, it like [makes air quotation marks] "*calms her down*". It's like the other week, we were all sat in your bedroom and you were, like, talking about how it's the only way you can let it out. And... I dunno, I don't understand. I find it difficult to... get.

L: Mmm.

G: If that makes sense? I don't know.

L: And have you talked about it? I mean she's obviously told you that hasn't she?

G: Yeah. A little bit. But, I dunno... I just don't... I *struggle* to understand it.

It is apparent that self-harm is initially seen by the family as highly risky, overwhelming, difficult to understand and hard to talk about. However, over the course of therapy, the meaning of self-harm for Jess and her family changes significantly. Self-harm becomes something which is talked about at home and Jess becomes increasingly able to share her worries with the family. By the final session, there have evidently been significant changes

in the level of anxiety that self-harm generates within the family and how able they feel they are to manage when it does take place:

[Session 6]

M: I don't think there's that anxiety any more...

D: No, not at all.

M: ... for us.

L: Right. So the anxiety's... What's happened? Where's the anxiety gone?

[…]

M: I don't know...

D: I... I agree it's just not...

M: ...but we can deal with it.

L: Uh-huh.

M: But we do deal with it... and...

L: So it's replaced with the confidence of actually... we're dealing with this...

D: ...that we can sort it out, yeah.

M: And it's not the end of the world.

[Later in session 6, discussing a recent incident of self-harm]

D: I sort of just come home and I just... whereas to start off with I'd have been "Oh my god, what do I do?!", whereas then it was it was just a case of "Come on, it's alright... it's not a problem, we can sort it out"

M: Yeah.

L: Yeah.

D: "Let's just keep calm. Let's just think about it."

L: Yeah.

D: "Let's just talk about it."

M: I think that's the right way - it's not a problem.

D: Mmm.

L: Yeah.

M: Whereas before it was a problem.

L: Yeah.

M: It was a *big* problem.

In the penultimate session, Pete indicates that therapy has helped him to understand more about self-harm. It appears that his insight has come less in terms of understanding Jess's *reasons* for self-harming and more in terms of *how to respond* when Jess has harmed:

> D: I sort of, find that we're getting quite a lot out of it [family therapy], helping... I mean it's... it's just really helped me... to understand what Jess is going through and cope with it... so it...
>
> L: Uh-huh. And what in particular has helped? You know, what's kind of... you know, what's...?
>
> D: It's just, I mean... I've... I've sort of thought, in the past, you know, it's... "Why... why... why do it? Why have you done it?" But then instead of sort of thinking that I just sort of... hanging back and thinking "There's obviously a reason why she's doing it" and it's... it's... I'm not saying it's foreign, but it's totally... goes against my way of, sort of, thinking sort of just... hurting yourself. But anyway, just, everybody's... totally different...
>
> L: Mm-hmm... Mm-hmm.
>
> D: ...and it's, sort of, sit back and think, you know, you can't be cross with Jess, you've just gotta, sort of, sit there and listen...
>
> L: Mm-hmm.
>
> D: ...to what she's got to say and sort of... er... you know, give her a few, sort of, positives or things maybe to... sort of, to work on.

Sally too reveals that she feels her understanding has improved and we can see that her perspective regarding the risk that self-harm presents has changed drastically:

> [Session 6]
>
> M: You know... and I think just having a bit more understanding as well... 'Cause my fear with Jess in the early days... in the early days of finding out she was self-harming was that... you know I was... she was going to kill herself.
>
> L: Mm-hmm.
>
> M: That was like my worst fear that, you know. And... that's not the case. She just gets... frustrated and doesn't know how to handle things.

How is change facilitated?

Having gained an appreciation of the nature of the changes in meaning of self-harm which take place during Jess's therapy we will now consider how these are brought about by the work of the therapists and participation of the family. Central to these changes is the adoption of a shared understanding that Jess uses self-harm as a way to regain control when she is overwhelmed by strong, unbearable feelings. I will consider how this shared affect regulation understanding of self-harm is established and the work of therapy which follows

from this, highlighting how the therapy process is associated with the changes in meaning outlined above.

Self-harm as affect regulation

An 'affect regulation' understanding of self-harm is evident from the first session of Jess's therapy. Lydia gives the family the opportunity to 'put out on the table' their current concerns and, by guiding the conversation (using 'picking up on or returning to'), encourages joint exploration of the meaning of self-harm and the 'holiday incident' (in which Jess witnessed an explosive argument between her parents, which provoked fears in her that they might split-up). Through this, Sally and Jess connect self-harm with anxiety and difficult thoughts and feelings. Lydia uses tracking of a recent incident of self harm to jointly explore this further. As she does so, she selectively reflects Jess's understanding that self-harm is about feelings needing to 'come out' and together they co-construct an understanding of self-harm as a way of coping with strong, built-up feelings:

> L: So, hitting... hitting your head and scratching yourself. Yeah?
>
> J: Yeah.
>
> L: Because of such built-up, strong, feelings. Yeah?
>
> J: Yeah.
>
> […]
>
> L: …and would you say it's often been feelings are building up...
>
> J: Yeah.
>
> L: ...and then it's like... a lot of feelings need to come out in some ways?
>
> J: Yeah. […] I want... I wanna stop hurting myself 'cause I have, like... get scars and stuff... and they're not nice.
>
> L: Right.
>
> J: But, like, I don't know how else I can, like, get rid of it all, so...
>
> L: Yeah.
>
> J: ...all these feelings.
>
> L: Yeah... So in some ways you say that you've got a lot of feelings that you're dealing with and, in some ways - I think what I'm hearing you saying is – you want a different way to actually learn how to cope with those feelings?

Self-harm comes to be referred to as a 'strategy' for managing emotions; a way in which Jess can exert her agency in order to deal with feelings she cannot otherwise control. Additionally, and importantly, it is a strategy which Jess reports she does not want to

continue to use. The affect regulation function of self-harm becomes established as a shared way of understanding self-harm. The focus of therapy consequently becomes to explore what causes or exacerbates unmanageable feelings, to gain a deeper understanding of how self-harm reduces these for Jess, and to consider how overwhelming feelings might be avoided, reduced or managed without the use of self-harm.

There are numerous changes in meaning (and associated changes in relating) which occur for the various participants of therapy and interact to collectively contribute to the positive outcomes seen in Jess's case. In addition to the adoption of a shared understanding that self-harm is a way of managing feelings, there are four changes which are of particular importance: modification of the family approach to checking that Jess is safe; revision of Jess's perspective on the security of her mum and dad's relationship; changes in how the family respond when self-harm occurs; and a shift in Jess's willingness to share her worries and talk about self-harm within the family. Due to limitations on space I have selected one of these to further illustrate how the process of therapy operates to bring about changes in meaning and relating. I have chosen to describe how the therapy process facilitates changes in the meaning of family members' checking of Jess and associated changes in their actions and interaction. This example gives us an appreciation of the reciprocal nature of changes in meaning and relating which occur for different family members regarding different issues. For instance, we will see how Jess's willingness to share her worries with the family is reciprocally related to the level of checking they engage in.

Checking

At the beginning of session two, Lydia invites the different family members to say what they would like to be different. By seeking information about family members' hopes and preferences she is enacting the values of therapy that she describes when introducing family therapy. Jess states that she wants people to worry about and check up on her less and Sally acknowledges that this checking happens regularly. Jess's dissatisfaction with the level of checking is put out on the table and we see that Sally hears this, meaning that she is able to use this knowledge to inform her future actions.

In the reflecting team discussion of session 2, Steve proposes that checking might make Jess feel worse, as if she is not trusted:

S: And sometimes the natural response is to check and double check and treble check. And it makes sense when you *are* really worried. But actually when the young person's beginning to recover, and making different decisions, or is less worried about the self-harm themselves,... that checking, double, and treble checking can make them feel worse again, or can make them feel that nobody trusts them or they're not doing so well.

With this re-frame, Steve offers an understanding of checking as potentially *increasing* the likelihood of self-harm, which is further developed as therapy continues.

In session 3 there is joint exploration of checking and what it means for those involved. Grace describes Sally and Pete's reaction when worried about Jess as "lock-down panic mode". Grace feels Mum and Dad "feed off each other" and anxiety builds, which motivates "constant" checking of Jess:

G: You both feed off each other...

L: Uh-huh.

G: ...and worry... *together*.

L: So, what do you notice? Is this alright, us talking about it like this? [All say 'yeah' or make assenting noises] 'Cause I think it's... Yeah? So what... what do you notice? So your mum tells you, and then you're noticing...

G: You...

L: 'Cause sometimes it's great to step back.

G: Like, if she's in the shower [point at J]... like, if she goes upstairs, you're constantly [pointing at M] "Are you alright Jess? Will you go and check on Jess? Will you go and see if Jess is alright?"

L: Uh-huh.

G: *Constant*.

M: Yeah.

L: And how does that feed in to... the worry? Does that feed in... does that make your dad...

G: And then you do it [pointing at D]. And then you worry me, 'cause I'm like "Should I be checking on her? Should I be?"

Lydia is using tracking to encourage mutual exploration of the familiar pattern which checking follows. This allows the family to reflect on their actions and the effects they might have. Later in the session it is established that Jess would like to talk more about self-harm and worries at home between sessions. After this is 'put on the table', Lydia explores Jess's preferences regarding this, allowing her to express that others asking if she is OK 'over and over' is not helpful. Joint exploration of Sally's checking behaviour and the co-

construction of excessive checking as counter-productive culminates in Sally wondering if she needs to "take a step back":

> J: Yeah. Like, you can ask me if I'm alright and stuff, but if you ask me over and over again, that's when I feel like... Like, if I... you could ask me a few times, but then that time you asked me like *all* the time. Like, *every* single minute.
>
> M: And was that *me*, or was that both of us?
>
> J: It was mainly you.
>
> M: [laughs] Mainly me. Sorry.
>
> J: But, I don't know, just...
>
> M: Just tell me to chill out [laughs]. Say "Mother, get a grip"
>
> […]
>
> M: I just want them to talk to me.
>
> L: You know, *If*... If there were times when you knew that was, sort of, counterproductive...
>
> M: Mmm. Then I'd stop.
>
> L: ...would that change things?
>
> M: Yeah. And it obviously is, because they both tell me to stop, so maybe I have to take that step back.

The possibility that Sally needs to take a step back is reinforced when Lydia states a general task for the family; to "take a different position" regarding worry rather than "feed in to it" or let it "carry on and carry on and perpetuate". This is further reinforced by a reflecting team discussion in which Ann and Steve present a role play entitled "confidence – chicken and egg". They introduce it as a family therapist's supervision session, with Ann role playing different supervisor responses to risk and uncertainty. This gives the family an opportunity to reflect on different ways of being which may encourage or reduce Jess's confidence that she can manage. It can be seen that the role play and subsequent discussion contains suggestions of how the family might respond to worry or uncertainty:

> S – I think we realised. And, doing it... it makes you realise –and I'm sure you've lived this and we all do in our families – that there are times when confidence is *lost* because we keep... asking questions or *keep* looking to find an answer, or *keep*... getting upset and worried about things that we lose our confidence.
>
> A: Yeah, and as workers, 'cause we... we have supervision and... we really... I suppose we have to remember that... I can do things to make Steve really anxious about his work...
>
> S: Hmmm.
>
> A: Or I can do things that help him and he, you know, likewise, he...
>
> S: Hmmm.

A: So we... we try... and it's *always* a bit of a… *balance*. It's, you know, we sometimes get it... like, good and we sometimes...

S: The most helpful thing you said to me there was "You've done this before, haven't you?"

A: Right.

S: "And you know what to do" And I thought "Oh yeah, I do. Thank you. Yeah, we've been through this a few times in the last couple of years".

A: Yeah.

S: So there was something about the *right* question at the right time there, wasn't it? And you didn't ask me lots and lots of questions. You let me...

A: Yeah.

S: ...do some talking. And maybe it's that idea of... *listening* and expecting people to have some of their own answers... encourages confidence.

A: Hmmm.

S: And giving people *time* to think and come back with answers, or...

A: Hmmm.

S: ...letting people try things and sometimes they work, sometimes they don't.

In session 4, Lydia returns to the topic of checking and managing worry. In presenting an exercise where the family draw worry together, Lydia summarises what now feels like an established understanding of worry and checking perpetuating anxiety, rather than alleviating it:

L: So, I was thinking about, last time we talked a bit about, you know, sort of... when there is the *worry* or when there is the *upset* around, how... sometimes that kind of feeds off each other in the family...

M: Hmmm.

L: ...*because* there is a lot of care and concern for one another...

M: Mmmm.

L: …there's something about, erm... everyone getting in on the game almost. That's the wrong word, but everybody getting sort of concerned and anxious and then... checking each other and so on and so on. And that sort of, always building up in the family. […] So there's something about, you know, you each experience worry, concerns, upset in different ways. I think what we've talked about, you know, is obviously that upset, when that sort of builds up for you, Jess […] …everybody else around you getting quite upset and concerned as well... and that, sort of, building up, building up, building up.

Once the understanding that excessive checking can perpetuate worry, which has been co-constructed by the family and the therapists, is established, therapy goes on to jointly explore how checking impacts on Jess and how things may be done differently. The family collectively drawing 'worry' is one way of facilitating this and leads to tracking of family checking from Jess's perspective. Jess represents worry with a drawing of her family

peering over the bannister up at her room. She expresses how too much checking annoys her and makes her angry. Again, this allows the other family members to hear how their efforts might be increasing Jess's distress (and so the likelihood of self-harm):

> L: So, your doors open, but this is what you see on the banister? [M laughs] That's interesting. Don't pictures tell a thousand words sometimes? Do you know what I mean, I think there's something about pictures... they describe... describe what goes on.
>
> M: That is... [laughing] us all [pretends to be peering over banister] all stood there. Oh dear, Jess. I'm sorry! [laughs]
>
> L: So, what does...? What does... *that* tell you? You know, if you're feeling sad and that's there, what does that do to the upset and the sadness?
>
> J: It just *annoys* me, even more so.
>
> […]
>
> L: So there's something about... there's something about this [pointing to picture] that... makes you feel... annoyed. Yeah?
>
> J: Yeah.
>
> L: Does it increase the sadness, or decrease the sadness, or... what does...?
>
> J: It makes me angrier, so it probably doesn't... help.
>
> L: So it moves the sadness to... also feeling angry as well. Yeah?
>
> J: [nods] Yeah.

By asking Jess what she would like her parents to do when they are concerned ('seeking information…'), Lydia allows the whole family to hear Jess's preferences. The family learn that she wants them to listen to her and stop checking on her if she says she's alright:

> L: So she's wondering... she's getting a bit concerned... thinking, you know, "What's going on here?"
>
> J: Yeah.
>
> L: What would you like her to do at that point?
>
> J: Sort of, like... Like, come up to me, and, like, ask me if I'm alright... and then, like... if I am, I'll tell her. But if I say I am alright, like, sort of, like, just be like "OK".

Through this joint exploration through tracking we also learn that Jess would prefer her parents to come closer to her and perhaps sit on her bed, rather than asking if she is OK from a distance. Also, when both Mum and Dad check up on Jess and talk to her at the same time this can be confusing or overwhelming, being experienced as "mixed voices". Lydia provides a summary in which she selectively reflects that too much checking can be annoying and re-states the task for the family; addressing the situation in a different way and

"changing it… before it builds up". In the reflecting team discussion, Steve suggests other ways that the family might elicit care from each other or check when they are concerned, such as using text messages or use of a 'code phrase' like "I need a cup of tea". The family respond well to the idea of texting and Lydia explores with them how this might work, showing how getting concrete can enhance mutual understanding about Jess's preferences. Moving from the abstract idea of texting to show support to the concrete actions that family members can take helps the family to know what Jess would like them to do. Interestingly, we can see that Sally is seeking information about Jess's preferences, asking the sort of questions that Lydia has demonstrated during sessions. This is a form of 'trying out', as a new way of negotiating how the family relate to each other is being practiced:

> J: So I'd probably like, if they, like, texted me and weren't coming and checking up on me all the time probably...
>
> L: That would probably hel-... help?
>
> J: [nods] Yeah.
>
> M: So, to text you... rather than...?
>
> J: Yeah.
>
> L: Mmmm.
>
> M: And what do you want us to say? "Are you OK?"
>
> […]
>
> L: Hmmm. So, *how* would you like your mum to text you? Or your dad to text you? Or... Grace?
>
> J: I don't know.
>
> L: Like, would it be something like... You know, "I'm fine. I'll talk in half an hour". You know, is there something about time? About having a bit of a pause? You know, I think what we're talking about is not wanting things to escalate isn't it?
>
> D: Mm-hmm.
>
> J: Yeah.
>
> L: So, having time and space, but actually not annoying and adding to that. So what would be most useful?
>
> J: Maybe like... Don't, like... as soon as I go upstairs, like text me, just like...
>
> M: [laughs] Give you a bit of time?
>
> D: What, like when you get to 'top of 'staircase?!
>
> L: So, something like ten minutes later, or something? Or five minutes? Or half an hour?
>
> J: Like, half an hour or something.

When Lydia enquires about checking in session 5 the family say that this is no longer happening as much, because they have not felt the need to do it. Lydia reflects the

differences being reported in how the family are relating to each other and, in so doing, is recognising the change which has taken place. Lydia facilitates joint exploration regarding what reduced checking means for Jess, who says that this is related to trust and feeling like her parents have more confidence in her. She talks about how perceiving more trust in her means she no longer feels the guilt she used to feel for having 'made them worry'. Lydia is selectively reflecting (and so co-constructing) the meaning of this trust:

> L: Tell me more about that trust and why that's important to you.
>
> J: Like... *before*, like, when they'd come and check on me, I kind of felt bad that I'd, like... I'd made them worry about me. I felt, like, I'd, like, I'd made them worry about me and come and check on me and stuff, so... I felt, like, guilty for making them feel like they can't trust me and so I think it's good that they can trust me, or I feel, like, better because they're not worrying about me and getting all upset and stuff.
>
> L: So their kind of worry before... was making you feel... you were already feeling a bit bad, but it made you feel bad and made you feel guilty and then that worry didn't help you and that... made more worry. Yeah?
>
> J: Yeah. [smiling]

In session 4 and 5, we hear that Jess is more willing to talk to her parents about concerns and worries. This 'trying out' is brought back to therapy and jointly explored, revealing that Jess feels reassured and calmed by sharing worries with her parents. In the final session, Sally indicates that Jess's increased ability to share worries with them has played a role in decreasing the anxiety they feel and has therefore reduced their need to check:

> L: …it really sounds like you've kind of mastered something here in the family, haven't you?
>
> M: Yeah, I think we have. And I think the fact that before Jess struggled to share things and so that made us worry even more. Whereas, if she'd just said it, 'cause nothing is, you know, nothing is un-sortable. Everything can be sorted. You know, before, when she didn't share things I think that made us, like... you know that level of anxiety for us got higher and higher and higher.

This is a good example of the interdependent and reciprocal nature of changes in meaning and relating which occur during the therapy. Jess's increased sharing decreases anxiety and checking. Decreased anxiety and checking in turn increases the likelihood that Jess will share worries. A question from the reflecting team and Lydia's selective reflection clarifies how this process works:

> L: Hmmm. So, what... A question from [the reflecting team] Jess, is... what are you seeing in your parents now that is allowing... that is allowing you to let them in more?
>
> J: Erm... They're not like... they're not as, like, panicked and, like, that sort of like... calms me down more... sort of, like, calm enough to tell them, if that makes sense?

L: Yeah, it does. It makes a lot of sense. So, because the panic's not there... Yeah?

J: Yeah.

L: Then it's almost like you can trust them with what you wanna say?

J: Yeah. Yeah.

L: Yeah?

J: Yeah [smiles].

We hear that there is much less concern from Mum and Dad that Jess is at risk of self-harming and therefore there is much less checking going on. Lydia selectively reflects this progress, recognising the changes that have taken place and reinforcing these by saying "We've moved a long way". The changes are also recognised and further reinforced by the reflecting team, who offer a story of mastery and confidence in coping with difficulties:

> S: …what we're hearing here is a story - a really important story - of a family who've *seen*... anxiety and seen panic take a central stage in their life, because of real incidents and real worries, but they've then learnt and decided they can move past it and leave it behind. So they've then moved on into a *different* stage of life, where... the panic and anxiety could still be on the edge of life sometimes but *most* of life is the bright, blue sky. Most of life is "We're OK, we can manage, we can deal with difficulties as they come along".

The above illustrates how the elements of therapy outlined in the change process model operate to bring about changes in the meaning of checking, and a shared understanding of the impact that established family patterns of relating were having on their ability to collectively manage difficult feelings and deal with self-harm. The meaning of checking is renegotiated and a shared understanding of checking as counterproductive is developed. Jess and her family then try out new ways of acting which are drawn from this shared understanding. Therapy is a forum where experiences of trying out can be jointly explored and evaluated and changes can be collectively recognised. New ways of relating which are preferable to the family and help them to reduce self-harm are established and reinforced.

It is important to note that parallel changes in meaning and relating interact with those seen in regard to checking. We have seen how Jess's increasing ability to share worries was reciprocally reinforcing of reductions in checking behaviour. There are further examples of such reciprocal influence, for instance as Jess becomes more sure of the strength of her parents' relationship (and the self-blame she had been experiencing related to the perceived marital difficulties decreases) risk of self-harm decreases and need for checking decreases

correspondingly. As Jess's family start to respond more calmly following self-harm, Jess's guilt related to harming decreases and therefore so does the risk of further self-harm. Again, there is an attendant decrease in the need for checking. Hopefully this gives a flavour of the complex and reciprocal nature of the changes in meaning and action that take place.

Meanings of self-harm and affect regulation in Donna's case

As Donna is no longer harming when therapy commences there is very little talk of self-harm during her family therapy. Although Donna indicates that she tried self-harm as a way of coping with difficult feelings when she was experiencing bullying at school, she reports that self-harm never became a habitual act. We can infer that the pain she experienced when she cut was one reason for this, another being that self-harm 'didn't change anything' and so was seen as an ineffective way of dealing with her problems:

> [Session 1]
>
> L: Is self-harm present at all... now?
>
> D: No.
>
> L: No. So what's shifted for you Donna? What's shifted from doing it then to... not doing it now?
>
> D: [pause] 'Cause it's not going to solve my problems.
>
> L: Right. So it's not going to solve your problems. And how did you come to that conclusion? 'Cause that's a pretty mature conclusion.
>
> D: 'Cause it didn't change anything, so what's the *point*?
>
> L: Right. So doing it didn't change anything for you. Did it give you anything... doing it?
>
> D: There was the fact that it *hurt*, but...
>
> L: It hurt, right. So the fact that it hurt you, but it didn't... it didn't... didn't solve anything.

Although Donna is no longer self-harming, the management of emotion is also a prominent issue in her family therapy. As discussed in the previous chapter, in-session discord between Donna and Mandy impedes the progress of therapy on numerous occasions. At these times, there is too much anger for the family to speak to or hear each other in a helpful way. There is therefore a need for the therapists to moderate the affective tone in order to facilitate mutually engaged conversations. As we have seen, they adopt several approaches to bridging discord, such as separating Donna and Mandy and bringing them back together when appropriate. These approaches demonstrate the important role that the therapists play in the systemic management of affect. When family members are unable to regulate their own emotions, therapists intervene and assist in this process.

104

Summary

We have seen how the processes of change detailed in Chapter 3 operated in Jess's therapy to bring about significant changes in the meaning of self-harm and associated changes in the way that the family manage worry together. The adoption of an understanding of self-harm as serving an affect regulation function for Jess was important in this. It is also apparent that Jess's therapy was characterized by a number of interconnected and reciprocally influencing changes in meaning and action. The management of affect also played an important part in the changes which occurred in Donna's therapy. In her case, the way in which the therapists responded to in-session anger was fundamental in helping Donna and Mandy reach a place of mutual engagement in therapy.

CHAPTER 5: DISCUSSION

I will present the main findings of the research before going on to discuss these in the context of relevant literature and consider their implications for clinical practice. I will then discuss the strengths and limitations of the study and offer reflections on the research process, ending with some suggestions for further research.

Summary of findings

The study set out to investigate how therapists negotiate the meaning of self-harm during family therapy. A model of the processes through which changes in meaning and relating take place was developed and refined via a grounded theory analysis of two full cases of family therapy. Perhaps the most prominent finding to emerge from the analysis is that, in both cases, the engagement of key family members is critical to starting the process of joint exploration of meaning and relating. In Jess's case this took place without problem as her family were prepared to listen to one another's perspectives and try out different ways of acting in relation to Jess's self-harm from the outset (this does not mean, however, that they understood the reasons for Jess's self-harm or that it did not cause great anxiety for them). In Donna's case, joint exploration of meaning and relating was not possible for periods of the therapy because Donna and her mother could not listen to or hear each other. Because of this, much of the work of therapy was geared towards helping them reach a place where they both could attend to, and take on board, each other's concerns. The analysis suggests that engagement of family members in joint exploration is not a 'one-off' achievement. It can be lost or compromised and requires work on the part of therapists, and willingness on the part of family members, to preserve it. Once family members are engaged in the joint exploration of meaning and relating, meaningful work can be done to negotiate meanings and refine patterns of family interaction.

Through the interdependent processes of 'putting things on the table', 'co-constructing meaning' and 'joint exploration of meaning and relating', changes in understanding and family relating can take place. Family members can come to more fully appreciate their own and one another's perspectives and preferences, they can examine commonly occurring patterns of interaction and better understand the implications that these have for those involved, and they can gain insight into ways in which family relating might be enhanced. Informed by understandings gained in therapy, they are then able to try out new ways of

being and doing things outside of the consulting room. The analysis shows that, even though changes in meaning are important in and of themselves, their real significance is in the way they catalyse and shape changes in action and interaction in the family. The active involvement of family members is crucial here as they take away their understandings and use them to try out new ways of interacting with one another. Their experiences of this 'trying out' can then be brought back to family therapy and jointly explored. Implications of changes in meaning and action can be examined and new ways of seeing and doing things can be recognised and evaluated. Through these processes, relating may be modified in such a way that the family become better equipped to manage the difficulties they face.

The changes which occur in the way that self-harm is talked about and understood are summarised in Chapter 4. In Jess's therapy, the meaning of self-harm changes from something which is hard to understand, difficult for the family to talk about, risky and highly anxiety provoking, to something which the family can talk about and feel confident in managing together; something which no-longer provokes extreme reactions in family members. This does not necessarily mean that individual family members are equally confident or free from anxiety, but rather that they have reached a way of coping with self-harm together. Of central importance to these changes is the formation of a consensus amongst the therapists and family members that self-harm serves an affect regulation function for Jess. An understanding that Jess uses self-harm to assert her agency and gain control when she is overwhelmed by unpleasant emotions is established. This guides the work of therapy towards making changes in how the family manage worry and anxiety together. Affect regulation is also an important theme in Donna's case, even though self-harm was not a primary focus of the therapy. In Donna's family therapy, the efforts of therapists to manage emotion within the sessions are instrumental in repairing the mother-daughter relationship and so helping Donna and Mandy reach a place where they can hear and heed each other's concerns. This allows them to begin a process of joint exploration.

How do the findings relate to the literature?

The prominent importance of affect regulation in the present study is in keeping with literature which identifies managing difficult emotions as a major function of self-harm (e.g. Klonsky, 2007; Nock, 2009). The studies reviewed by Klonsky (2007) suggest that acute negative affect normally precedes self-harm, decreased negative affect and relief generally follow it, and most individuals report a desire to alleviate negative affect as a reason for self-

harming. These three elements are apparent in Jess's reports of her own self-harming behaviour. The difficulties Donna and Mandy have in relating in a calm manner also point towards problems in regulating feelings together, which likely played some role in Donna's decision to try self-harm. The present analysis suggests that an affect regulation understanding offers a way of making sense of self-harm which is acceptable and helpful to young people and their families. Furthermore, it also logically points towards systemic interventions which address how family members experience feelings and cope with them together.

Although the present analysis supports an affect regulation function of self-harm, it also suggests that this conceptualisation only offers a partial explanatory account of such behaviour. It seems important to consider the way in which the potential benefits of affect regulation are balanced against other advantages or drawbacks associated with self-harm. For Jess, the drawback of scars is seemingly outweighed by the relief which self-harm brings from overwhelming feelings. For Donna, the pain of self-harm is an important disadvantage and it is unclear whether self-harm brought her any relief from unpleasant feelings. Although important in Jess's case, managing feelings is not the only reason adolescents cite for their self-harm (Klonsky, 2007; Nock, 2009). It may offer other potential benefits, such as eliciting help or care from others. This may have been a factor for Jess and Donna, as in both cases self-harm brought the families to therapy. Self-harm can also be a form of self-punishment or may represent an earnest attempt at suicide. In such instances, family therapists would need to be responsive to working with these other meanings of self-harm. The way in which high risk of harm or suicide might shape the therapy process is discussed below.

The importance of mutual engagement for joint exploration, and the finding that mutual engagement must be maintained through the continual participation of therapists and family members, highlight the value of existing process research which has prioritised the study of sustained engagement in therapeutic conversations (Couture & Strong, 2004; Avdi, 2005; Friedlander et al., 1994; Higham et al., 2012). Whereas the present research examines the process of change over the whole of therapy, these investigations selectively focus upon specific elements or episodes within it. This can be useful in deepening our understanding of important aspects of the family therapy process. However, a global perspective, which looks at the whole therapy process, is also important as it offers insight into the ways in which

sub-processes of therapy relate to one another. In this way, the present study can help us to understand how the level of engagement of family members impacts upon other elements of the therapy process. For instance, we can see in what ways processes such as 'putting things on the table' and 'joint exploration of meaning and relating' are constrained when mutual engagement is lacking.

Prior research on alliances in family therapy (e.g. Friedlander et al., 2006) offers a useful vocabulary for thinking about the therapy relationships seen in the two cases. The discord between Donna and Mandy is indicative of a poor 'within family alliance'. There are periods in which there is clearly not a 'felt unity' between Donna and Mandy with regard to the therapy and there is some within-family blame and defensive responding. Jess's family, in contrast, show a stronger 'sense of common purpose' and a stronger 'sense of safety'. This is evidenced by such things as the family asking each other about their perspectives and their ability to talk about difficult things and be vulnerable with each other. It should be noted that there is also some evidence of a weaker sense of safety in Jess's case, such as Sally's worries in the first session that therapy might be blaming. The key difference is that Jess's family come quickly to a position of listening and hearing each other, whereas in Donna's case further work, involving management of different alliances, had to take place to achieve this. Beck et al. (2006) made a tentative link between stronger within-family alliances and more positive family therapy outcomes. Although neither alliance nor outcome were formally measured in the present study, it is fair to say that a stronger within family alliance was apparent in Jess's case and that this was associated with a more straight-forward (and more productive) therapy process.

The definition of 'sustained engagement' offered by Friedlander et al (1994) is very similar to the concept of mutual engagement which arises from the present analysis. They define sustained engagement as "a sequence of speaking turns in which family members are observably willing to disclose thoughts or feelings on the designated topic, to share or cooperate, to show interest and involvement in the discussion, or to be responsive and attentive" (p.442). This definition captures both the reciprocal, collective nature of mutual engagement seen in the present analysis and also the fact that 'putting things on the table' requires a 'responsive and attentive' audience in order to contribute towards helpful joint exploration.

Establishing universal consensus concerning the purpose and goals of therapy has been suggested as a strategy for enhancing trust between family members and the therapist, and therefore a means of strengthening the within-family alliance. Kindsvatter & Lara (2012) propose that universal consensus is a useful starting point to which the therapist can return if the alliance is threatened. In both cases Lydia establishes universal consensus about the aims of therapy with the families. This seems to be particularly important in Donna's therapy, in the way suggested by Kindsvatter & Lara (2012), as Lydia returns to the shared aim of therapy (to work towards a better relationship with one another) when relations become strained and the continuation of therapy is jeopardised.

Several studies suggest the utility of acknowledgement and validation of family members' perspectives in establishing or reinstating engagement (e.g. O'Reilly &Parker, 2013; Higham et al., 2012). It is suggested that this facilitates engagement through helping family members to feel accepted and understood. The present analysis supports the usefulness of acknowledgement and validation in this regard. They are common features of the way Lydia relates to family members, and form part of the 'accepting' element of 'creating a safe space'. It is apparent that such responses are also important when alliances are strained. For instance, Lydia's acknowledgement and validation of Donna's expressed ambivalence about therapy plays a role in moving the family towards mutual engagement. O'Reilly & Parker (2013) propose that client disengagement from therapy may be a means of avoiding or managing criticism. This could be one factor contributing to Donna's withdrawal from therapy, as evidenced by her reluctance to engage in the conversation at times. These times often coincide with Mandy expressing dissatisfaction with Donna's behaviour, suggesting that Donna could be using disengagement as a way of managing criticism.

Researchers have adopted various methodological approaches in their study of family therapy process and it is apparent that the methodology employed shapes the nature of the findings. Task analysis studies of specific 'change events' (e.g. Friedlander et al., 1994; Higham et al., 2012) provide a better understanding of how certain issues, such as conversational impasse, are resolved in family therapy. Such studies improve our understanding of process, but are restricted to relatively circumscribed elements of therapy practice. Conversation analyses (e.g. Sutherland & Strong, 2011) enhance our knowledge of how certain therapeutic interventions are carried out in practice and the effects that these have. Again, the value of such investigations is in their ability to shed light on specific

changes taking place in therapy. I believe that grounded theory is especially valuable in this area as it offers benefits which these other approaches do not. For instance, as has been demonstrated here, it can allow an understanding of the *overall* therapy process to be developed, within which the relationships between different elements of the process can be elucidated. Moreover, it can adequately capture the relational nature of the process, representing the way in which change arises through the reciprocally influencing participation of therapists and family members. The iterative nature through which a grounded theory develops allows researchers to build on their findings and extend their conceptual understanding to a wider range of contexts and conditions.

Therapist feedback

Written feedback on the change process model was provided by the three therapist participants. All three therapists proposed that the model would generalise well to other cases of family therapy. They suggested other contextual factors which may influence the therapy process, such as the need to address safeguarding issues, family structure (e.g. the presence of dependent siblings other than the index client) and cultural background of the family and therapist. One therapist commented that some of the conversational practices identified in the analysis bore similarity to established ideas within the field of family therapy (e.g. 'reframing'). Two of the therapists commented that, whereas the model provided a very detailed description of the changes taking place in spoken dialogue, it was less able to capture concurrent changes which likely took place in areas not explicitly spoken about. For instance, changes in participants' perceptions of themselves or their relationships, which are likely to have altered through the experience of therapy, were thought to be important elements of the therapy process not fully represented in the present analysis.

Clinical implications

The present study was not aiming to establish the effectiveness of family therapy for self-harm. However, it is possible to comment on the way in which the therapy process of negotiating meanings and family relating impacted upon difficulties being experienced by the families. In both cases, changes can be seen in how the family understand their difficulties and relate to one another. Jess's family become better able to manage the anxiety

associated with self-harm and Donna and Mandy come to relate to one another in a more encouraging and supportive way. Although it is clearly inappropriate to make claims of effectiveness from just two cases, both families studied were clearly helped by family therapy to manage the difficulties they faced. Furthermore, it is unlikely that individual therapy for Donna or Jess would have been as effective, given the relational basis of the difficulties in each case. One-to-one therapy could have brought about changes in understanding and action for Donna and Jess, but without similar and contemporaneous changes in their family members, this would have been of limited benefit.

This study indicates that for helpful negotiation of meaning and family relating to take place it is essential to establish and maintain the mutual engagement of family members. The model of change developed from the current analysis suggests that this can be facilitated by introducing the family to the procedures and values of therapy, enacting a collaborative approach in contracting the foci and tasks of therapy, and maintaining a generous, accepting stance which encourages a feeling of safety. In addition, whereas the model of the change process provides a framework for creating a safe space, the analysis suggests that the creative employment of different strategies may be called for to achieve this end in different cases. For instance, when overt relational conflict is present this must be attended to and further work will be needed to enhance the safety of therapy and repair relations. Acknowledging and validating the perspectives being expressed by all parties can contribute towards achieving mutual engagement. When in-session conflict is severe and the emotional tone becomes elevated, however, more drastic action may be called for, such as separating family members for a period of time before attempting to bring them back together and reinstate dialogue. Therapists can also facilitate the repair of damaged relationships by interventions aiming at enhancing family members' empathy for one another. Modes of questioning which create opportunities for the discordant parties to better appreciate one another's experience or perspective, such as internalised other interviewing, can prove useful in this regard.

The findings of the present study support the allocation of resources for the provision of reflecting teams in family therapy. The reflecting team members were instrumental in facilitating changes in meaning and relating and their presence allowed great flexibility in meeting the specific therapeutic needs of the families. For instance, the management of in-

session conflict in Donna's case could not have been managed as effectively had there been a lone therapist.

Carrying out the present study has influenced my development as a clinician in a number of ways. Closely watching the videos of family therapy exposed me to other therapists' approaches and ways of being with clients. As well as giving me a greater appreciation of systemic practices in general, there were also specific interventions which I have incorporated into my routine practice. For instance, the first time I meet a client I will almost always ask, at the beginning of the appointment, "How does it feel to be here today?" This is perhaps indicative of a broader influence of carrying out this study, which is a deeper understanding of the fundamental importance of the therapeutic relationship for change. Through doing this research I am more attuned to the moment-to-moment experience of the people I work with and give much more effort towards 'creating and maintaining a safe space'. Also, the process of conducting a grounded theory analysis helped me to think about therapy as a form of recursive 'action research' in which frameworks of meaning are applied to information brought by the client. Conducting this research has made me much more aware of the influential role I have as a therapist in co-constructing what 'data' emerges in therapy. I have also become much more sensitive to the power I hold as a therapist and how, without careful reflection, it is possible to constrain or silence the narrative of the client in efforts to find information to fit with theoretically-derived hypotheses.

Strengths and limitations of the study

The appropriateness and utility of the methodology and methods employed in the present study represent its main strengths. Family therapy is a systemic approach that looks at people in their relational context and starts from a position of interaction. Because of its interactionist underpinnings, grounded theory is particularly well-suited to the study of the process of change in family therapy. The language of symbolic interactionism accurately describes the changes that were seen across the two cases. It was apparent that family members were using the new understandings gained in therapy about the meanings that actions or events had for others to modify the way they acted and interacted with one another.

Due to the in-depth, involved nature of the analysis, it was not possible to include more than two full family therapies. Consequently, there are limits to the generalisability and

theoretical reach of the change model developed. This is a characteristic feature of the initial stages of grounded theory research, in which further data collection is driven by theoretical sampling guided by the developing analysis. In order to further refine the model of the change process it would be necessary to test its applicability in a wider range of contexts. Further consideration is given to this below.

Video-tapes of family therapy represent rich material which, in comparison to interview transcripts, makes additional data available to analysts. As well as participants' words, their intonation, body language, facial expressions, etc. all become potential objects of analysis. This may help to illustrate, for example, the way in which body language can belie what individuals actually say. The availability of non-verbal communication facilitated the interpretation of the present therapy material. However, greater use could be made of these elements of participants' communication. For instance, Donna's body language was often a clear indicator that she did not feel safe or comfortable in therapy. She sometimes disengaged by playing on her mobile 'phone, and non-verbally expressed anxiety by such things as knee tapping and not removing her coat or bag. This information was not utilised to its' full extent as the analysis focussed on and coded verbal communication. The ability to include non-verbal information is limited, to an extent, by the written format of a research report. Perhaps technological advancement will soon make it possible for video extracts of therapy to be embedded in a Results section. Such video could be used to validate conceptual claims in the same way that narrative descriptions are currently used. Even without this technological development, however, efforts could be made to better capture the non-verbal elements of therapy participants' communication. Use of behavioural rating schemes such as the SOFTA (Friedlander et al., 2006) could be helpful in this regard.

It is important to acknowledge that therapists in the SHIFT trial administered family therapy according to a manual, which was written specifically for the trial and based on the Leeds Family Therapy Manual (Pote et al., 2000). Therapists received training on the use of this and carried out a test case of family therapy prior to working with SHIFT clients to ensure fidelity to the manual. Also, one of the research supervisors was a co-author of this manual and supervised SHIFT therapists in its use. Although it has not been possible to view the SHIFT manual I can comment on the way in which therapists being trained in and using a manualised approach may have influenced the present analysis from my knowledge of the Leeds Family Therapy Model (Pote et al., 2000). This manual outlines a model of therapeutic change in which therapists aim to enhance family members' understandings of

relevant beliefs, narratives and patterns of relating. The goal is then to develop different (and less problematic) beliefs, narratives and patterns of relating and work to amplify this change. This broad model of change bears similarities to that which arises from the present analysis, which is perhaps to be anticipated given therapists were administering this manualised treatment and the analysis was advanced through discussion with one of the authors of the manual. Whereas the manual provides guidelines for therapy it also gives therapists some "flexibility to express their own creativity" (Pote et al., 2000; p.6). I believe the value of the present analysis lies in the detailed explication of exactly *how* change takes place *in practice* and its consideration of the ways in which change is facilitated or constrained by particular contexts and conditions.

Reflections

The two supervisors of the current study were a sociologist, who conducts qualitative research in health and social care, and a family therapist, lecturer and family therapy trainer. It was extremely valuable to have supervisors from different professional backgrounds (i.e. academic and clinical) as their different ways of thinking about the data and the research process prompted productive discussion. The presence of a non-clinician was particularly helpful as they were more able to identify when my analytic thinking was being constrained by unspoken theoretical assumptions. For instance, my use of terms such as 'constructing', borrowed from the vernacular of the post-modern therapies, was challenged. I was encouraged to reflect on whether such terms accurately captured what was happening in the data or whether they in fact represented an inexact rendering of the therapy material.

I was new to grounded theory and found the initial stages of the analysis challenging. As I mention above, I was mistaken in thinking that analysis was a question of simply following prescribed techniques. I came to understand that these techniques were only helpful to the extent that they facilitated a dialogue with the data and stimulated conceptual thinking. When I realised that my therapeutic skills in interpretation and developing hypotheses were transferable to the analysis I began to feel much more comfortable. I was struck by the similarities between grounded theory analysis and the therapy process of ongoing collaborative formulation. Just as therapy requires the theoretical and experiential knowledge of the therapist to be in dialogue with the meanings and experience of the client(s), there is an analogous dialogue which occurs between the data and the prior knowledge of the researcher. In either case, if the therapist or researcher becomes too

preoccupied with their own ideas or assumptions, and fails to ensure their fit with the data or client, the endeavour is compromised. The result will be either unsatisfactory therapy or poor qualitative research.

Future research

Because only two cases were included in the present analysis, the conceptual model of the change process has been developed from a limited range of contexts and conditions. Further theoretical sampling is indicated by the analysis and would help to develop a deeper understanding of the process of change under a wider range of conditions. One area that has been insufficiently clarified by the first two cases concerns the risk of serious harm or injury. Neither Donna nor Jess were at great risk of serious harm and consequently the way in which the meaning of self-harm is negotiated under conditions of extant risk is not well understood. Further elaboration of the model with regard to the impact of ongoing risk of serious injury would require theoretical sampling of cases that demonstrate high risk of injury and low engagement as well as high risk and high engagement. In cases where there is significant risk of harm there would need to be greater consideration given to how this risk can be managed. Sampling of such cases would illustrate how this impacts upon the overall process of therapeutic change.

It would be interesting to investigate to what extent the present change process model might extend to other clinical problems or the practice of family therapists with different theoretical orientations. The model has been developed in the context of the particular clinical problem of self-harm and with family therapists that are broadly collaborative and dialogical in how they work. Selectively sampling across different types of presenting problems ('obsessive compulsive disorder', 'conduct' problems, etc.) and different types of therapy (e.g. structural or behavioural family therapy) and testing the fit of the current change process model would tell us about its theoretical reach. Through this further analysis, modifications could be made to extend the theoretical generalisability of the model across a wider range of contexts and conditions.

Other established approaches to family therapy research could be employed to augment further studies using the model developed in this investigation. For instance, since it is clear that engagement is a crucial element of the therapy process, the inclusion of self-report or observational tools which measure different aspects of the therapeutic alliance, such as the

SOFTA (Friedlander et al., 2006), would be an interesting addition. This would allow further insight into how different elements of the therapy process impact upon development and maintenance of various levels of the therapeutic alliance.

Another avenue for further research would entail using the change process model developed here in order to generate hypotheses about the process of family therapy which could then be tested experimentally. For instance, as the engagement of key family members was found to be critical to starting the process of joint exploration of meaning and relating, a study could be designed to test the impact of the presence or absence of mutual engagement on therapy outcomes.

REFERENCES

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family process*, 27(4), 371-393.

Avdi, E. (2005). Negotiating a pathological identity in the clinical dialogue: Discourse analysis of a family therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 78(4), 493-511.

Bacino, L. (2014, May 21). Shock figures show extent of self-harm in English teenagers. The Guardian. Retrieved from http://www.theguardian.com/uk on 11/12/2014

Barbe, R., Bridge, J., Birmaher, B., Kolko, D., & Brent, D. (2004). Suicidality and its relationship to treatment outcome in depressed adolescents. *Suicide and Life-Threatening Behavior*, 34, 44-55.

Bennewith, O., Stocks, N., Gunnel, D., Peters, T., Evans, M., Sharp, D. (2002). General practice based intervention to prevent repeat episodes of deliberate self-harm: cluster randomised controlled trial. *BMJ*, 324 (7348): 1254.

Beck, M., Friedlander, M., & Escudero, V. (2006). Three perspectives on clients' experiences of the therapeutic alliance: a discovery-oriented investigation. *Journal of marital and family therapy*, 32(3), 355.

Berger, P. L. & Luckmann, T. (1967). *The Social Construction of Reality*. Garden City, NY: Anchor.

Bhaskar, R. (1978). *A Realist Theory of Science*. Brighton: Harvester Press

Bhaskar, R. (1986). *Scientific Realism and Human Emancipation*. London: Verso.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkeley: University of California Press.

Blumer, H. (1986). *Symbolic interactionism: Perspective and method*. Berkeley: University of California Press.

Blumer, H. (1979). Comments on "George Herbert Mead and the Chicago tradition of sociology". *Symbolic Interaction*, 2(2), 21-22.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice*, 16(3), 252.

Boscolo, L., Cecchin, G., Hoffman, L. & Penn, P. (1987). *Milan Systemic Family Therapy: Conversations in Theory and Practice*. NY: Basic.

Bridge, J. A., Goldstein, T. R., & Brent, D. A. (2006). Adolescent suicide and suicidal behaviour. *Journal of Child Psychology and Psychiatry*, 47, 372 - 394.

Brophy, M. (2006). *'Truth Hurts'; Report of the National Inquiry into Self-harm among Young People*. London: Mental Health Foundation.

Burck, C., Frosh, S., Strickland-Clark, L., & Morgan, K. (1998). The process of enabling change: a study of therapist interventions in family therapy. *Journal of Family Therapy*, 20(3), 253-267.

Burck, C. (2005). Comparing qualitative research methodologies for systemic research: The use of grounded theory, discourse analysis and narrative analysis. *Journal of Family Therapy*, 27(3), 237-262.

Carter, G., Reith, D. M., Whyte, I. M., & McPherson, M. (2005). Repeated self-poisoning: increasing severity of self-harm as a predictor of subsequent suicide. *British Journal of Psychiatry*, 186, 253-257.

Charmaz, K. (2014). *Constructing grounded theory*. London: Sage.

Clarke, A. (2003). Situational analyses: Grounded theory mapping after the postmodern turn." *Symbolic Interaction,* 26(4), 553-576.

Comtois K., Russo J., Snowden M., Srebnik D., Ries R., & Roy-Byrne P. (2003) Factors associated with high use of public mental health services by persons with borderline personality disorder. *Psychiatric Services*, 54, 1149-1154.

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). Los Angles: Sage.

Cotgrove, A., Zirinsky, L., Black, D., & Weston, D. (1995). Secondary prevention of attempted suicide in adolescence. *Journal of Adolescence*, 18(5), 569-577.

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

Couture, S. J., & Strong, T. (2004). Turning differences into possibilities: Using discourse analysis to investigate change in therapy with adolescents and their families. *Counselling and Psychotheraphy Research*, 4(1), 90-101.

Crawford, M. J., Thomas, O., Khan, N., & Kulinskaya, E. (2007). Psychosocial interventions following self-harm Systematic review of their efficacy in preventing suicide. *The British Journal of Psychiatry*, 190(1), 11-17.

Diener, M. J., & Monroe, J. M. (2011). The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: a meta-analytic review. *Psychotherapy*, 48(3), 237.

Dey, I. (1993). *Qualitative data analysis: A user friendly guide for social scientists*. London: Routledge.

Elliott, R. (2010). Psychotherapy change process research: realizing the promise. *Psychotherapy Research*, 20 (2), 123-135.

Fergusson, D. M., Woodward, L., & Horwood, L. (2000). Risk factors and life processes associated with the onset of suicidal behaviour during adolescence and early adulthood. *Psychological Medicine*, 30, 23-39.

Fox, C. & Hawton, K. (2004). *Deliberate Self-harm in Adolescence*. London: Jessica Kingsley.

Frankel, Z. E., & Levitt, H. M. (2009). Clients' experiences of disengaged moments in psychotherapy: A grounded theory analysis. *Journal of Contemporary Psychotherapy*, 39(3), 171-186.

Friedlander, M. L., (1995). *Cognitive Constructions Coding System coding manual*. Unpublished manuscript, State University of New York at Albany.

Friedlander, M. L., Heatherington, L., Steveson, B., & Skowron, E. A. (1994). Sustaining engagement: A change event in family therapy. *Journal of Counselling Psychology*, 41(4), 438.

Friedlander, M. L., Heatherington, L., & Marrs, A. L. (2000). Responding to blame in family therapy: A constructionist/narrative perspective. *American Journal of Family Therapy*, 28(2), 133-146.

Friedlander, M. L., Escudero, V., Horvath, A. O., Heatherington, L., Cabero, A., & Martens, M. P. (2006). System for observing family therapy alliances: A tool for research and practice. *Journal of Counselling Psychology*, 53(2), 214.

Friedlander, M. L., Lambert, J. E., & de la Peña, C. M. (2008). A step toward disentangling the alliance/improvement cycle in family therapy. *Journal of Counselling Psychology*, 55(1), 118.

Frosh, S., Burck, C., Strickland-Clark, L. and Morgan, K. (1996). Engaging with change: a process study of family therapy. *Journal of Family Therapy*, 18: 141–162.

Gergen, K. (1985). The social constructionist movement in modern psychology. *American psychologist*. 40(3), 266.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory (Vol. 2)*. Mill Valley, CA: Sociology Press.

Glaser, B. G. & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing Company.

Green, H., McGinnity, A., Meltzer, H., Ford, T. & Goodman, R. (2005). *Mental Health of Children and Young People in Great Britain 2004*. London: Office for National Statistics.

Green, J., Wood., A., Kerfoot, M., Trainor, G., Roberts, C., Rothwell, J., Woodham, A., Avodeji, E., Barrett, B., Byford, S. & Harrington, R. (2011). Group therapy for adolescents with repeated self harm: randomised controlled trial with economic evaluation. *BMJ*, 342, 682.

Greenberg, L. S. (1984). A task analysis of intrapersonal conflict resolution. *Patterns of change*, 67-123.

Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology*, 54, 4-9.

Greenberg, L. S., & Foerster, F. S. (1996). Task analysis exemplified: The process of resolving unfinished business. *Journal of Consulting and Clinical Psychology*, 64(3), 439.

Gould, M., Greenberg, T. & Velting, D. (2003). Youth suicide risk and preventative interventions: a review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42: 386-405.

Hammersley, M. (1989). *The dilemma of qualitative method: Herbert Blumer and the Chicago tradition*. London: Routledge.

Harrington, R., Kerfoot, M., Dyer, E., McNiven, F., Gill, J., Harrington, V., ... & Byford, S. (1998). Randomized trial of a home-based family intervention for children who have deliberately poisoned themselves. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(5), 512-518.

Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology*, 64(6), 1326.

Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman., Goldney, R., Gunnell, D., Hazell, P., Van Heeringen, K., House, A., Owens, D., Sakinofsky, I., Traskman-Bendz, L. (1998). Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *BMJ*, 317(7156), 441–447.

Hawton, K., Fagg J., Simkin, S., Bale, E. & Bond A. (2000). Deliberate self-harm in adolescents in Oxford, 1985-1995. *Journal of Adolescence*, 23(1), 47-55.

Hawton, K., Rodham, K., Evans, E. & Weatherall, R. (2002). Deliberate self-harm in adolescents: Self report survey in schools in England. *BMJ*, 325, 1207-1211.

Hawton, K., Bergen, H., Casey, D., Simkin, S., Palmer, B., Cooper, J., Kapur, N., Horrocks, J., House, A., Lilley, R., Noble, R., & Owens, D. (2007). Self-harm in England: a tale of three cities. *Social Psychiatry and Psychiatric Epidemiology*, 42, 513 - 521.

Hazell, P. L., Martin, G., McGill, K., Kay, T., Wood, A., Trainor, G., & Harrington, R. (2009). Group therapy for repeated deliberate self-harm in adolescents: failure of replication of a randomized trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(6), 662-670.

Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, 83(1), 97-111.

Hepp, U., Wittman, L. & Schnyder, U. (2004). Psychological and psychosocial interventions after attempted suicide: an overview of treatment studies. *Crisis*, 25: 108-117.

Higham, JE, Friedlander, ML, Escudero, V. and Diamond, G. (2012), Engaging reluctant adolescents in family therapy: an exploratory study of in-session processes of change. *Journal of Family Therapy*, 34: 24–52.

Hoffman, L. (2007). The art of "withness": A new bright edge. In Anderson, H. & Gehart, D. (Eds.), *Collaborative therapy: Relationships and conversations that make a difference* (pp. 63-79). New York, NY: Taylor & Francis Group.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of counselling psychology*, 38(2), 139.

Kapur, N., Cooper, J. & Hiroeh, U. (2004). Emergency department management and outcome for self-poisoning: a cohort study. *General Hospital Psychiatry*, 26: 36-41.

Kindsvatter, A., & Lara, T. M. (2012). The Facilitation and Maintenance of the Therapeutic

Alliance in Family Therapy. *Journal of Contemporary Psychotherapy*, 42(4), 235-242.

Klonsky ED (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*. 2007;27:226–239.

Leitner, M., Barr, W., & Hobby, L. (2008). *Effectiveness of interventions to prevent suicide and suicidal behaviour: a systematic review*. Scottish Government.

Lyotard, J. (1988). *The Differend: Phrases in Dispute*. Trans. Van Den Abbeele, G. Minneapolis: University of Minnesota.

Macgowan, M. J. (2004). Psychosocial treatment of youth suicide: A systematic review of the research. *Research on Social Work Practice*, 14(3), 147-162.

McDougall, T., Armstrong, M., & Trainor, G. (2010). *Helping Children and Young People Who Self-Harm: An Introduction to Self-Harming and Suicidal Behaviours for Health Professionals*. London: Taylor & Francis.

McNamee, S., & Gergen, K. (1992). *Therapy as social construction*. Thousand Oaks: Sage.

Mead, G. H. (1934). *Mind, self and society*. Chicago: University of Chicago.

Meltzer, H., Harrington, R., Goodman, R., & Jenkins, R. (2001). *Children and adolescents who try to harm, hurt or kill themselves*. London: Office for National Statistics.

Merry, S., McDowell, H. & Hetrick, S (2004). *Psychological and/or Educational Interventions for the Prevention of Depression in Children and Adolescents*. Cochrane Database Systematic Review: Cochrane Database.

Minuchin, S. (1974). *Families and Family Therapy*. Harvard University Press.

Muniz de la Pena, C., Friedlander, M., & Escudero, V. (2009). Frequency, severity, and evolution of split family alliances: How observable are they? *Psychotherapy Research*, 19(2), 133-142.

NICE (2004). *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. Retrieved from http://www.nice.org.uk/guidance/cg16

Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current directions in psychological science*, 18(2), 78-83.

Oldershaw, A., Richards, C., Simic, M., & Schmidt, U. (2008). Parents' perspectives on adolescent self-harm: Qualitative study. *The British Journal of Psychiatry*, 193(2), 140-144.

Oliver, C. (2011). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work*; 42 (2): 371-387.

O'Reilly, M., & Parker, N. (2013). You can take a horse to water but you can't make it drink': Exploring children's engagement and resistance in family therapy. *Contemporary Family Therapy*, 35(3), 491-507.

Pinsof, W. M., & Catherall, D. R. (1986). The Integrative Psychotherapy Alliance: Family, Couple and Individual Therapy Scales. *Journal of Marital and Family Therapy*, 12(2), 137-51.

Ploeg, J., Ciliska, D. & Dobbins, M. (1996). A systematic overview of adolescent suicide prevention programs. *Canadian Journal of Public Health*, 87:319-324.

Pote, H., Stratton, P., Cottrell, D., Boston, P., Shapiro, D. and Hanks, H. (2000). *The Leeds Systemic Family Therapy Manual and Therapist Adherence Protocol*. Leeds: LFTRC.

Prochaska, J. O., & Norcross, J. C. (2002). Stages of change. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 303–314). Oxford: Oxford University Press.

QSR International. (2012). NVivo qualitative data analysis software; QSR International Pty Ltd. Version 10, 2012.

Rafuls, S. E., & Moon, S. E. (1996). Grounded theory methodology in family therapy research. In D. H. Sprenkle & S. M. Moon (eds.), *Research methods in family therapy* (pp. 64–80). New York: Guilford.

Robbins, M. S., Liddle, H. A., Turner, C. W., Dakof, G. A., Alexander, J. F., & Kogan, S. M. (2006). Adolescent and parent therapeutic alliances as predictors of dropout in multidimensional family therapy. *Journal of Family Psychology*, 20(1), 108.

Rossouw, T. I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(12), 1304-1313.

Sluzki, C. E. (1992). Transformations: a blueprint for narrative changes in therapy. *Family process*, 31(3), 217.

Strauss, A., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Sage Publications.

Strong, T., Busch, R., & Couture, S. (2008). Conversational evidence in therapeutic dialogue. *Journal of Marital and Family Therapy*, 34(3), 388-405.

Sutherland, O. and Strong, T. (2011). Therapeutic collaboration: a conversation analysis of constructionist therapy. *Journal of Family Therapy*, 33, 256–278.

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Hillsdale, NJ: Erlbaum.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. WW Norton & Company.

Wood, A., Trainor, G., Rothwell, J., Moore, A., & Harrington, R., (2001). A randomised controlled trial of group therapy for repeated deliberate self-harm in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40: 1246-1253.

World Health Organisation (2014) *Health Behaviour in School-Aged Children*. WHO

APPENDIX

Appendix 1: Participant information sheet

How do therapists negotiate the meaning of self-harm during family therapy?

Participant information sheet

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the project?

This project aims to investigate the meanings that are ascribed to self-harm in therapeutic conversations taking place during family therapy. The objective is to better understand how self-harm is constructed through the interactions of family members and therapists. There is a particular interest in the things which therapists do with language when negotiating the meaning of self-harm with the family. The project is being carried out as part of a Doctor of Clinical Psychology qualification.

Why have I been chosen?

You have been chosen because of your involvement as a therapist in the SHIFT trial. I aim to recruit four therapists.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form) and you can still withdraw at any time without having to give a reason. If you wish, you may can take up to a week to decide whether you want to participate

What do I have to do?

If you agree to take part, your involvement will include:
- Agreeing for videotapes of your therapy sessions (recorded as part of SHIFT) to be viewed by the principle researcher and used to conduct a qualitative analysis
- Taking part in one interview, which will last between one and two hours and will involve watching video clips of your therapy sessions and discussing them with the principle researcher. There may also be additional questions concerning the therapy which has been used for the analysis. The interviews will take place at the University of Leeds and I will reimburse travel expenses.

Will I be recorded, and how will the recorded media be used?

The project involves analysis of video-recordings of therapy sessions recorded as part of the SHIFT trial. The interviews will be tape recorded to allow for transcription and analysis. The audio and video recordings used during this research will be used only for analysis and no one outside the project will be allowed access to the original recordings. Both video-recordings of therapy sessions and audio-recordings of interviews may be sent to a third party for transcription; however this will take place under a confidentiality agreement with the transcription service.

What are the possible disadvantages and risks of taking part?

There are no foreseeable risks or disadvantages of taking part, other than that of being exposed once more to potentially distressing material contained in the therapy videotapes.

What are the possible benefits of taking part?

The opportunity to review and reflect on your therapy practice in greater depth.

Will my taking part in this project be kept confidential?

All the information you provide during the course of the research will be kept strictly confidential. You will not be able to be identified in any reports or publications. The research will be written up as a D.Clin.Psychol. thesis.

Contact for further information

Please contact Ben Green, Principle Researcher, using the below details if you would like further information about the project.

Address:	Programme in Clinical Psychology, Leeds Institute of Health Sciences, Charles Thackrah Building, Clarendon Road, Leeds, LS2 9LJ
Email:	psc1bjg@leeds.ac.uk
Telephone:	0774 7708415

Thank you for taking the time to read this information sheet. Should you wish to participate, you will be given a copy of this information sheet and a copy of your signed consent form to keep.

Participant Information Sheet. Version: V1/30.06.2013

125

Appendix 2: Consent Form

Consent to take part in the project:
How does the therapist negotiate the meaning of self-harm during family therapy?

	Add your initials next to the statements you agree with
I confirm that I have read and understand the information sheet dated 30/06/2013 explaining the above research project and I have had the opportunity to ask questions about the project	
I agree for the data collected from me to be used in relevant future research	
I agree for the interview that I participate in to be tape-recorded	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason	
I agree to take part in the above research project	

Name of participant	
Participant's signature	
Date	

Name of lead researcher	Ben Green
Signature	
Date	

Participant Consent Form V2:09/08/2013

Appendix 3: Transcriber Confidentiality Agreement

Transcription of SHIFT sub-study family therapy sessions: Confidentiality Agreement

This is an agreement between:

Ben Green, Psychologist in Clinical Training, University of Leeds

And

....

I, ..., confirm that all information I am exposed to whilst transcribing the family therapy sessions will remain confidential. I understand that the data has been provided by NHS patients and therapists as part of the SHIFT trial on the condition that any information about them will not be shared with anyone outside of the research team. I hereby agree not to disclose information regarding the participants to anybody.

Transcriber signature:

Signed   ....

Print name   ....

Date   ....

Researcher signature:

Signed   ....

Print name   ....

Date   ....

Transcriber confidentiality agreement. V1: 19/6/2014

NHS
Health Research Authority
NRES Committee North East - York

Room 002
TEDCO Business Centre
Viking Business Park
Rolling Mill Road
Jarrow, Tyne & Wear
NE32 3DT
Telephone: 0191 4283563

10 October 2013
Mr Benjamin J Green
Psychologist in Clinical Training
The Leeds Teaching Hospitals NHS Trust
G.O4 Charles Thackrah Building
University of Leeds
Leeds
LS2 9JT

Dear Mr Green

Study title:	**How does the therapist negotiate the meaning of self-harm during family therapy?**
REC reference:	**13/NE/0304**
IRAS project ID:	**132863**

The Proportionate Review Sub-committee of the NRES Committee North East - York reviewed the above application via correspondence.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager, Mrs Helen M Wilson, nrescommittee.northeast-york@nhs.net.

Ethical opinion

Members queried the issue of PPI with you and you confirmed that you would look at this. Members suggested finding a local organisation with an interest in what you are doing in the research, and you contact INVOLVE, for guidance in how to do the PPI with that organisation. You also confirmed you had taken on board in the research the written feedback you had received from your colleagues.

The Committee would strongly recommend that consideration is given to PPI.

On behalf of the Committee, the sub-committee gave a **favourable ethical opinion** of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

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 ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

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

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

<u>Registration of Clinical Trials</u>

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved were:

Document	*Version*	*Date*
Covering Letter		03 October 2013
Evidence of insurance or indemnity		19 September 2013
Interview Schedules/Topic Guides	V1	30 June 2013
Investigator CV	Ben Green	24 June 2013
Other: CV	Mary Godfrey	25 June 2013
Other: CV	Paula Boston	30 June 2013
Other: Confirmation of ethics review requirement		04 October 2013
Participant Consent Form	V2	09 August 2013
Participant Information Sheet	V1	30 June 2013
Protocol	V1	30 June 2013
REC application	Version 3.5	03 October 2013

Referees or other scientific critique report

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

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

After ethical review

Reporting requirements

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

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

Feedback

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.
information is available at National Research Ethics Service website > After Review

13/NE/0304   Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

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

Yours sincerely

Dr Sarah Bartlett
Chair

Email: nrescommittee.northeast-york@nhs.net

Enclosures:	• *List of names and professions of members who took part in the review* • *"After ethical review – guidance for researchers"*
Copy to:	Faculty Research Ethics and Governance Administrator Miss Rebecca Forster, Leeds Community Healthcare NHS Trust

Leeds Community Healthcare **NHS**
NHS Trust

Telephone enquiries, please contact Linda Dobrzanska
Phone: 0113 203 3473 / 07958066828
Email: lch.research@nhs.net

Stockdale House
Headingley Business Park
Victoria Road
LS6 1PF

24th October 2013

Mr Benjamin J Green
Psychologist in Clinical Training
The Leeds Teaching Hospitals NHS Trust
G.O4 Charles Thackrah Building
University of Leeds
Leeds
LS2 9JT

LCH Ref: NP/0140

Dear Mr Benjamin Green,

Re: Study titled: 'How does the therapist negotiate the meaning of self-harm during family therapy?'

Thank you for your recent submission to Leeds Community Healthcare NHS Trust requesting governance approval for the above study.

Following consideration of your submission I am pleased to confirm that research management and governance approval has been granted by Leeds Community Healthcare NHS Trust for the above research to take place as described in your application and accompanying documentation.

Conditions of approval

You should be aware that approval is granted subject to the conditions specified below:

- In undertaking this research you must comply with the requirements of the Research Governance Framework for Health and Social Care (2nd edition 2005) which is mandatory for all NHS employees.

- Consent for Leeds Community Healthcare NHS Trust to audit your project, which is implicit in your acceptance of approval.

- Where any amendments, substantial or non substantial are made throughout the course of the study these should be notified to Leeds Community Healthcare NHS Trust.

- A copy of the final study report should be forwarded to Leeds Community Healthcare NHS Trust.

Chair: Neil Franklin: Chief Executive: Rob Webster

- Should any serious adverse event(s) occur throughout the course of the study these should be notified to Leeds Community Healthcare NHS Trust using the contact details set out above.

- You comply with Leeds Community Healthcare NHS Trust Policies on the handling of data. These policies are available from the research manager.

Should you require any clarification regarding any of the points raised above, or have any further queries in relation to approvals and post approval study management process then please do not hesitate to contact me on 0113 2033473.

Finally, may I take this opportunity to wish you well with your study and look forward to hearing about your progress in due course.

Yours sincerely

Dr. Amanda Thomas
Executive Medical Director

Approved documents

The documents reviewed were:

| Document	Version	Date of Document
REC Form	3.5	03/10/2013
SSI	3.5	30/09/2013
Participant Information Sheet	1	30/06/2013
Consent Form	2	09/08/2013
CV of researcher Ben Green	1	30/06/2013
CV of academic researcher Paula Boston	1	25/06/2013
Mary Godfrey	1	30/06/2013
Sponsor identified: The University of Leeds (student project)		
Indemnity identified: The University of Leeds/Henderson		19/09/2013
Research Protocol	1.30	30/06/2013

Cc:

Mary Godfrey
Reader in Health and Social Care
Leeds Institute of Health Sciences
University of Leeds
Charles Thakrah Building
101 Clarendon Road
Leeds
LS2 9LJ

Paula Boston
Senior Lecturer
Director of Family Therapy Training
Leeds Institute of Health Sciences
University of Leeds
101 Clarendon Road
Leeds
LS2 9LJ

Appendix 6: Development of the change process model

The initial model (Figure 6.1, below), was drawn out to help me think about the different elements of the change process identified through the analysis and how they were related to one another. For instance, 'Creating favourable conditions' (which became 'Creating and maintaining a safe space' in the final model) was seen to be a process which was necessary for other elements of the change process to take place. Other models of the change process from the family therapy literature, in particular that of Sluzki (1992), helped me to think about the processes operating in the therapy sessions in this study.
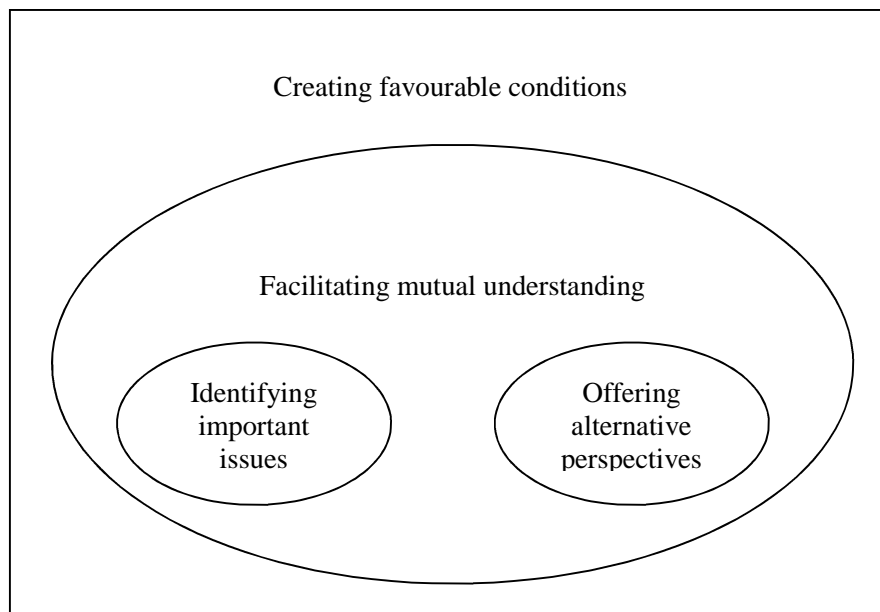

Fig. 6.1 – Model 1.

The initial model was a useful starting point but did not capture the dynamic nature of change seen in the data. Figure 2 (below) shows the third change process model, which better represented the process of change by showing when different sub-processes were taking place over the course of the therapy. Upon discussion with supervisors, the main problem with Model 3 was that it depicted change in linear terms, whereas it was becoming apparent from the analysis that change was much more of a circular, recursive process.
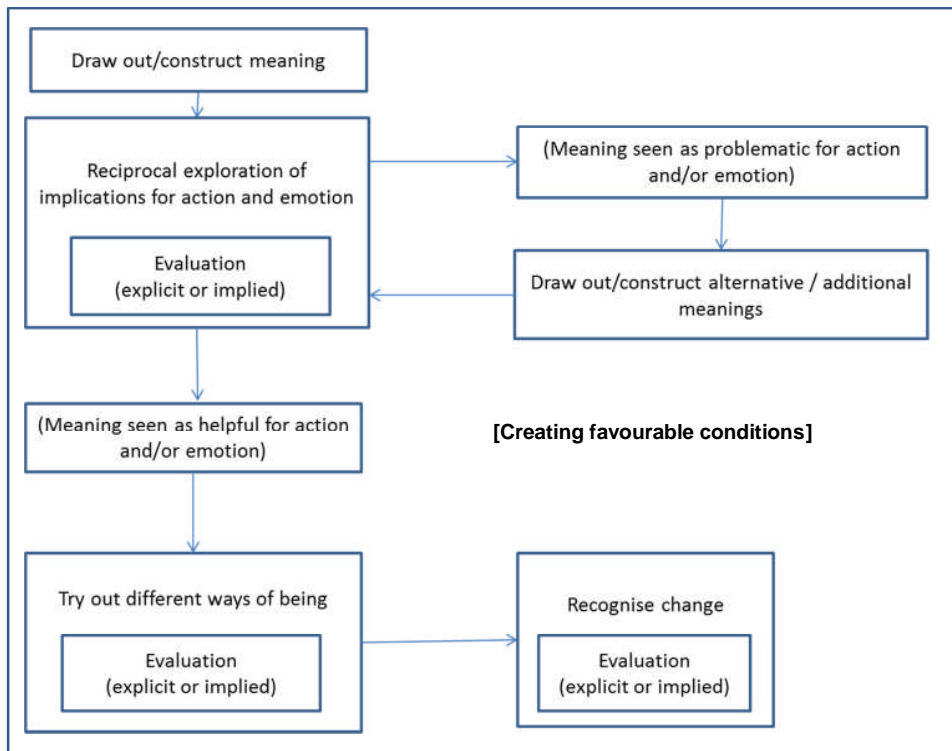
Fig. 6.2 – Model 3

The circular, recursive process of change is better depicted by the fourth version of the change process model (Figure 6.3, below), which more clearly shows how key processes of 'constructing meaning' and 'joint exploration of meaning and relating' recur throughout the therapy. It can be seen that this model is quite close to the final model (Figure 6.4, below).
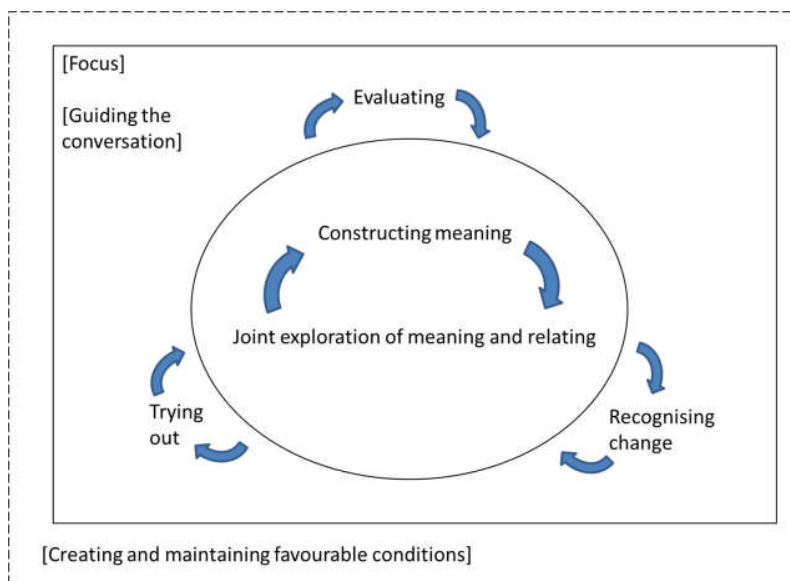
Figure 6.3 – Model 4

Following discussing Model 4 with supervisors, the analysis further developed in three important ways. Firstly, the process of 'putting things on the table' was named and explicated and came to be one of the three central processes of change. Second, 'creating and maintaining favourable conditions' was renamed 'creating and maintaining a safe space' as this better captured the quality of the therapeutic space that therapists worked to establish and maintain. Third, 'constructing meaning' was changed to 'co-constructing meaning'. This change was indicative of greater consideration being given to the role played by family members in the therapy process in general. Whereas the earlier revisions of the model had a focus on therapist interventions, as analysis progressed it became clearer that the family were playing an active, and critical, role in all levels of the change process through, for instance, the content they brought to therapy, how they responded to therapist interventions and how they engaged in processes of joint exploration of meaning and relating.
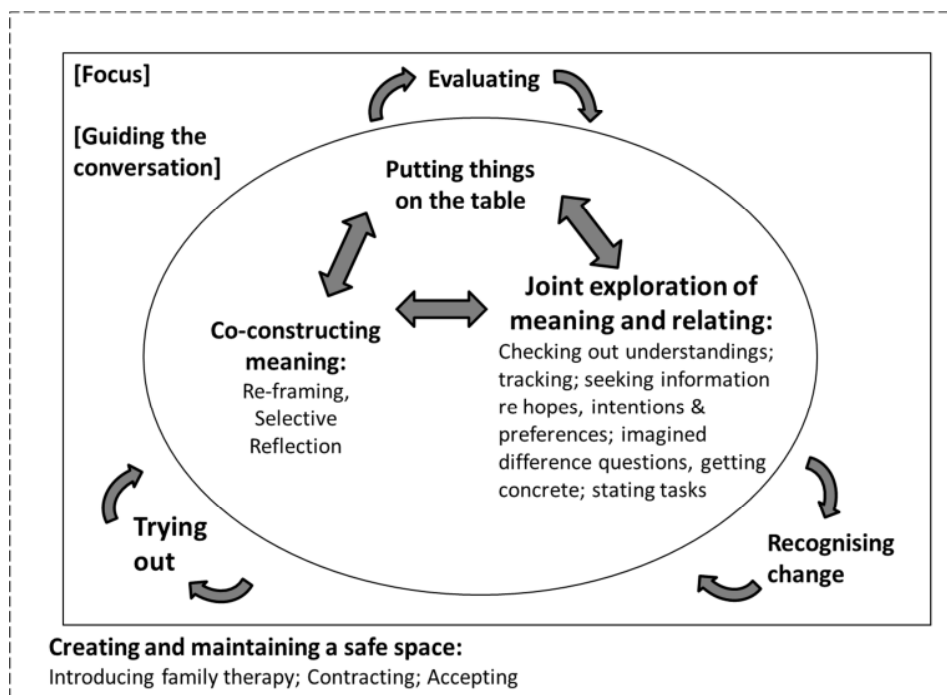
Figure 6.4 – Final Model for Jess's Therapy.