Exploring Fathers' Experience of Behavioural Family Therapy:

A Qualitative Investigation

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Acknowledgements

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Preface

The preface introduces four components of the Doctoral Thesis portfolio. These components are all related to the practice of counselling psychology. This portfolio begins with an exploratory piece of research focusing on fathers' experiences of Behavioural Family Therapy (BFT). Following on from this a reflective essay is presented that considers my professional journey in developing my identity as a counselling psychologist. A theoretical essay then evaluates two models of practice and how they can be applied in group therapy. Finally, a process report is presented describing a piece of therapeutic work with a client experiencing psychotic phenomenon. These four areas are now introduced in more detail. The reader will notice that each component emphasises the importance of attending to the individual subjective experience. Throughout my training I have increasingly appreciated the significance of understanding the client's world from their frame of reference. For me, attention to subjectivity provides the basis of building a strong and authentic therapeutic relationship.

Section A- Empirical Research

Exploring fathers' experiences of Behavioural Family Therapy: A Qualitative Investigation

Behavioural Family Therapy (BFT) is an evidence-based psychological intervention that has been applied in the context of psychosis, marital distress and parenting difficulties, as well as problems

relating to anxiety, phobias, dementia, and learning disabilities. It aims to explore how the family copes with day-to-day difficulties and involves a psycho-educational component to help families understand and manage psychological distress. BFT has been evaluated in the past with specific attention to its effectiveness in reducing relapse rates in psychosis (Fadden, 1998; 2009). Less research, however, has focused on the subjective experiences of having BFT and no known research has explored

fathers' experiences of BFT. More generally, limited research has explored fathers' experiences across other types of family therapy. This is interesting in light of theories suggesting fathers benefit from family approaches and are considered to play an important part in them (Martin, 1977). A gap in contemporary literature provided a solid rationale to explore this concept further. This research represents an original investigation into the subjective experiences of fathers who have participated in BFT.

Semi-structured interviews were carried out with five fathers to explore their experience of BFT. Interpretative Phenomenological Analysis (IPA) was the chosen methodology. IPA aims to explore an individual's lived experience in detail. Its founder, Jonathan Smith distinguishes IPA as "an attempt to unravel the meanings contained in […] accounts through a process of interpretative engagement with the texts and transcripts" (p.189). Verbatim transcripts were analysed with IPA generating the following three themes: Fathers' Reflections prior to BFT,

Fathers' Reluctance about BFT and Fathers' Positive views of BFT. The results were considered in relation to existing research in this field, with reference to counselling psychology philosophy. The findings highlighted specific reservations fathers have about the process of family therapy, and drew attention to the significance of engaging fathers in family interventions. This study contributes to knowledge by considering how the above themes inform counselling psychology, other clinical practice, service provision and training. The implications for future research are also discussed.

Section B - Reflective Essay

Finding a therapeutic approach to fit all...If only it were that simple

Maintaining a broad and open stance in the applicability of a collection of theoretical models can sometimes represent confusion and uncertainty. This essay considers this confusion, and its impact upon my professional journey in developing my philosophy of practice, which is aligned to the values of counselling psychology. It discusses how key factors (clinical supervision, personal therapy and self-reflection) and experiences (employment in the NHS and professional training) have influenced my theoretical orientation. Reference is made to both theoretical and empirical evidence, using case examples as I explain how I have integrated my personal philosophy into my practice. This piece of work demonstrates a focus on the subjective experience in referring to how pluralism informs my approach with clients. A pluralistic perspective includes the view that there is no one best therapeutic model

(Cooper and McLeod, 2011). Working within a pluralistic framework involves continuous collaboration with my clients allowing them to make informed choices from their subjective world.   It also explores my "use of self" within the therapeutic relationship and how this has impacts the process of therapy.

Section C – Theoretical Essay

With reference to two theoretical models, compare and contrast process and content interventions in working with a couple or a group.

This essay explores psychodynamic and Cognitive Behavioural Therapy (CBT) approaches to working with couples, covering issues of diversity, conflict and communication. From a reflective counselling psychology stance, it provides a descriptive overview of each model, whilst considering how each is applied in practice, drawing on their salient features. It provides a broad understanding of the philosophies underpinning both approaches and a brief history of how each framework has developed guidelines for working with couples. It then compares and contrasts some of the interventions used in each approach paying attention to process (e.g. relational dynamics) and content (e.g. therapeutic techniques). Consideration is given to the therapeutic relationship and evidence-based practice. It further examines how counselling psychology ethos fits with the notion of couples work. In reflecting as a counselling psychology trainee I note my professional and ethical desire to collaborate with the presenting frame of reference, whether a client, a couple or a group.

Section D – Process Report

How do we make sense of this? Understanding human complexity within an interpersonal framework.

This process report describes and analyses a piece of therapeutic work with a female client named Claire (pseudonym) who is treated under an early intervention in psychosis service. The report begins by providing an assessment and multi-theoretical formulation of Claire's difficulties whilst considering the research literature relating to complex cases. An overview of Cognitive Interpersonal Therapy (CTI) is provided, as the model chosen to work with Claire. This approach suggests that "psychosis is fundamentally a normal human experience, the form and content of which reflect core cognitive, interpersonal and development life...experiences" (Gumley & Schwannauer, 2006 p.xii). Drawing on attachment theory, CTI incorporates a focused, collaborative approach to help clients with complex needs establish more adaptive ways of coping.   Process and therapeutic interventions are evaluated from a transcript in relation to relevant theoretical constructs and counselling psychology philosophy. This case provided a key learning experience in contributing to the assessment and delivery of psychological therapy, for specialist clinical presentations within a multi-disciplinary team (MDT). Gumley & Schwannaur (2006) note the importance of integrating the therapist's work into a systemic context when providing multi-disciplinary care. This process report illustrates how considering Claire's subjective

experience throughout our work together was pivotal in developing a

respectful and empathic therapeutic alliance.

Section A - Empirical Research

Abstract

Behavioural Family Therapy (BFT) as a family intervention has previously been evaluated, with specific attention to its effectiveness in reducing relapse rates in psychosis. Less research, however, has focused on the subjective experiences of having BFT and no known research has explored fathers' experiences of BFT. More generally, limited research has explored fathers' experiences across other types of family therapy. This is interesting in the light of theories suggesting fathers benefit from family approaches and are considered to play an important part in them (Martin, 1977). A gap in contemporary literature provided a solid rationale to explore this concept further. This research represents an original investigation into the subjective experiences of fathers who have participated in BFT.

Semi-structured interviews were carried out with five fathers to explore their experience of BFT. Interpretative Phenomenological Analysis (IPA) was used to analyse verbatim transcripts which generated three themes: Fathers' Reflections prior to BFT, Fathers' Reluctance about BFT and Fathers' Positive views of BFT. The results were considered in relation to existing research in this field, with reference to counselling psychology philosophy. The findings highlighted specific reservations fathers have about the process of family therapy, and drew attention to the significance of engaging fathers in family interventions. This study

contributes to knowledge by considering how the above themes inform

counselling psychology, other clinical practice, service provision and

training. The implications for future research are also discussed.

Introduction

Setting the Scene

The National Health Service (NHS) is one of the largest suppliers of therapeutic interventions in the UK (Clark, 2011). Increasingly recognised as a fundamental part of recovery in secondary mental health care are family interventions. Family therapy is considered to minimise frustration for carers and reduce relapse rates in individuals with schizophrenia (Fadden, 1998; 2009). One type of family intervention currently offered in the NHS is Behavioural Family Therapy (BFT), yet little is known about how individuals experience it. In line with clinical governance and evidence-based practice, it is important for practitioners to consider how therapy is perceived by service users, and whether the therapy being offered matches the needs of the target population. A crude way of measuring this is through attendance numbers. It has been noted through clinical work that fathers are hesitant to participate in BFT. It is indeed a more complex process to understand the reasons why fathers are reluctant to engage in BFT. According to research the number of men engaging in therapeutic processes remains considerably less than women (Wexler, 2009). Research suggests this relates to the stigmatisation of therapy and men's preference to take care of their problems independently (Noyes, 2007). This study investigates this interesting area, with specific attention to fathers' engagement in BFT from a trainee counselling psychologist perspective, whereby understanding another's intersubjectivity and a

humanistic focus on facilitating growth is paramount (DCoP, 2005; Kasket, 2011).

Relevance to Counselling Psychology

The Division of Counselling Psychology (DCoP) stipulates "It is expected that there will be congruence between the model of research chosen and the values expressed in counselling psychology." (DCoP, 2005, p.6). Furthermore, it is a requirement of doctoral-level theses to generate knowledge relevant to the researcher's specific area of professional practice and to demonstrate applicability to their discipline (Kasket & Gil-Rodriguez, 2011). Counselling psychology research is concerned with becoming aware of the necessity to explore a certain topic "…through… direct experience" (Kasket, 2011, p5). The current study fulfils this objective of being practice-led as it was inspired from the researcher's clinical experience of delivering BFT. Moreover, understanding fathers' experiences of BFT promotes an important counselling psychology value, "…to engage with [fathers'] subjectivity…values and beliefs" (DCoP, 2005, p1).

Cooper (2009) refers to the humanistic value-base of counselling psychology, suggesting research is about expressing and responding to the voice of the client from genuine inquiry. This value is incorporated in a desire to understand fathers' perspective of BFT, within a phenomenological approach that allows them to voice their views openly. Cooper also refers to privileging the uniqueness of an individual over

psychological theories and assumptions. This principle is exemplified through a personal reflexive process, in which fathers' perceptions about BFT are considered at the forefront of the researcher assumptions. Furthermore, counselling psychology seeks "…to work always in ways that empower…" (DCoP, 2005 p.2). Understanding fathers' experiences to uncover and address their needs serves to empower fathers, in BFT and more generally, in family interventions.

Definition of Behavioural Family Therapy

BFT is an evidence-based psychological intervention that has been applied in the context of psychosis, marital distress, parenting difficulties, as well as problems relating to anxiety, phobias, dementia, and learning disabilities. Originally developed in 1984 by Falloon, Boyd and McGill, BFT is now an NHS initiative in the UK, and has been delivered by the West Midlands Meriden Family Programme since 1998. It aims to explore how the family copes with day-to-day difficulties and involves a psycho-educational component to help families understand and manage psychological distress. Attention is given to recognising the early signs of relapse and developing a clear relapse plan. Family members are encouraged to identify and work towards individual and family goals (Meriden Family Programme, 2013). It is often carried out in the home environment by two multi-disciplinary professionals across 10 to 14 sessions. Research demonstrates BFT's effectiveness in reducing stress and enhancing problem solving strategies within the family unit

(Campbell, 2004, Fadden, 1998; 2009). BFT differs from other family interventions in that it is not intended to explore relational dynamics as a primary focus of the approach. The researcher has experience of delivering BFT as part of a psychological role in an Early Intervention in Psychosis Service (EIS).

What is Psychosis?

Psychosis is generally understood as a mental state involving a loss of contact with reality. It is diagnosed by a cluster of symptoms including hallucinations (e.g. hearing voices) and delusions (e.g. holding distressing beliefs that are often untrue or irrational). Psychosis can also affect cognitive functioning, insight, motivation and communication often leading to social deficits (Fraser Health Authority, 2013). According to Fadden and Smith (2009), BFT is relevant with individuals and families experiencing psychosis, for a number of reasons. These include a focus on engagement with the family; a display of genuine concern in listening to the family's story and concerns; the therapist's relationship with the health system; provision of reassurance; lack of blame and normalising, and flexibility in working outside office hours to accommodate working or studying individuals.

BFT Application and Psychosis: The Evidence-Base

The evidence for using BFT with families in the context of psychosis relates to its psychoeducational, stress management, relapse prevention

and problem solving focus. Thus, family interventions incorporating these components result in positive outcomes (e.g. reduction in environmental stress) when applied to psychosis (Haddock & Lewis, 2005; White, 2002). This is unsurprising in respect of the confusion and anguish that can develop in the face of mental health difficulties especially when they are encountered for the first time. For example, Pearson, Burbach and Stanbridge (2007) highlight that families often need to make sense of how the mental health problem began; want to develop strategies for problem resolution; require information to aid the understanding of their experience; and often want to talk, be listened to and understood. Despite the efficacy of family interventions, engaging families can be a complex process. Families may decide not to accept the offer of BFT or may choose to withdraw after a few sessions (Smith, 1992; Barrowclough & Tarrier, 1992). There is no current research looking at individual or family non-adherence in BFT specific to psychosis. However, a small qualitative study conducted by James, Cushway and Fadden (2006) suggests that qualities important to engaging families in the context of psychosis include therapist authenticity and reflective practice.

Personal reflexivity

Incorporating a reflexive stance represents an important part of learning and understanding (Etherington, 2004). According to Etherington, researcher reflexivity is "the capacity of the researcher to acknowledge how their own experiences and contexts…inform the process and

outcomes of inquiry."(p.31). Sharing my prevailing thoughts about this study at the outset allows the reader to recognise how my potential biases and previous knowledge of fathers and BFT informs my work. Furthermore, being responsive to subjectivity is instilled in my counselling psychology identity, by remaining aware of how my beliefs can colour my perspective (Kasket, 2011). Kasket postulates that reflexivity in research equates with the counselling psychology principle of attending to subjectivity within a relational context.

Many theorists (for example Deveroux, 1967; Moustakas, 1994) have noted a connection between a researcher and their research topic. This is true of the current research whereby understanding fathers' experiences of BFT represents both a personal and professional interest. Professionally, it is significant to the research rationale that for the last six years I have worked in a specialist service for people experiencing a first episode of psychosis. As part of my development in this position I undertook training in BFT, before adopting a lead role in delivering family-based interventions and providing peer supervision within an MDT framework. Through these experiences I found that fathers were reluctant to engage in BFT either by choosing not to participate, or through more subtle resistance of missing scheduled sessions. This observation led me to further explore the topic area of fathers and family interventions.

My personal curiosity in this field is related to having a father who is sensitive to discussing emotional problems, whereby he is often

considered to "stick his head in the sand". Within my psychological experience I have reflected on this as a defensive coping strategy, when not knowing how to respond or resolve issues. During my childhood, my father adopted a problem-solving role in his eagerness to "fix" rather than "talk" about difficulties. I recognise how this experience potentially influenced my early professional practice when working with fathers. For example, I recall being reluctant to use exploration for fear of being dismissed by my authoritarian father. This led me to reflect on my personal stance, and consider how this impacted on building therapeutic relationships with fathers in my clinical work. Equally, I have worried about how fathers may perceive me as a therapist seeking to probe into their personal lives.

In recognising these connections with the research topic it was important to bracket my views and ideas emerging throughout the process (Smith & Osborne, 2008). Planning and providing a rationale of how to proceed in light of these influences (McAteer, 2010) was significant to the overall process. Therefore, I was vigilant to examine every procedure in a critical, yet honest and non-defensive way (Kasket & Gil-Rodriguez, 2011). Sometimes, being so close to the subject area, I felt unable to see the wood for the trees. Conscious of this difficulty, I regularly debriefed with my NHS supervisor as well as periodically stepping away from the writing process. This helped me to reflect on my thoughts and feelings towards the participants, the analysis, and the general composition of the

thesis. In maintaining a relative degree of self-awareness, I bracketed my thoughts using a reflexive journal. This was instrumental in identifying biases and beliefs throughout the research process (Etherington 2004; Kasket & Gil-Rodriguez).

I similarly utilised personal therapy and supervision to consider my personal experiences and their impact on my interviewing style and analysis. Extra care was taken with my interview questions and mid-interview prompting, designed not to lead or encourage participants towards areas that chimed with my views. The internal process of reflections was aided by writing notes following each interview, to consider my reactions to each participant. This helped to note *my* presence as the investigator and capture my developing understanding of different concepts; consider how interpretations in analysing the data were influenced by my subjective reactions to the participants; and importantly, reflect on how my everyday professional role with families impacted on the research process.

Moreover, the presence of reflexivity throughout the thesis increases validity of the study in illuminating my personal reflections and how they affected the procedural and theoretical aspects of the research. This aligns with Yardley's (2008) proposal about transparency in her guidelines for validity in qualitative research. As more recently argued by Kasket and Gil-Rodriguez (2011) it is critical that doctoral-level research demonstrates reflexivity in how the study was conducted. In following

their proposals, this thesis provides a coherent explanation of how participants were selected and recruited; the steps taken in the interview analysis and a description of how the themes hang together. It presents a critical discussion of the findings in relation to the subject matter and previous research.

Conducting a thorough review of the literature relevant to the overall topic area of men and therapy has vastly broadened my knowledge. More specifically, it has enabled me to develop a more critical stance of the narratives that stereotype men. This has been important both for the beginning of the thesis and the ending in terms of the existing literature in this area. As suggested by Kasket and Gil-Rodriguez (2011), I have endeavoured to provide an authentic and objective account of the strengths and limitations of my study and the thesis. My desire and training to be a counselling psychologist was instrumental in this process. I will return to how my personal and professional experiences have shaped my research in the subsequent sections of reflexivity. These sections are also written in the first person in order to remain close to the researcher's personal experiences.

Structure of Thesis

A broad introduction to the topic area of fathers and BFT has been provided. What follows is a critical review of the existing literature pertaining to men and therapy, gender roles, fathers' roles in the family

and fathers and family therapy whilst adopting a counselling psychology stance. There is then a focus on the research methodology explaining IPA and its applicability to this study, leading to the research aims and a further reflexivity section providing a personal rationale for using IPA. This is followed by a results section, covering the themes that have been identified within this process, before presenting the main findings in relation to the current literature. Limitations and strengths of the study are considered along with implications for practice and suggestions for future research prior to a final reflexive statement.

Literature Review

Overview

This review begins very broadly by analysing the research pertaining to men's experience of counselling and psychotherapy. This leads onto the more controversial topic of gender roles, which explores how cultural demands of a western society may serve to influence the notion of a male identity within the family setting. It then considers the father's role in the family system followed by a more specific topic of fathers and family therapy. Although men and marital therapy is not under a separate sub-heading, it is acknowledged as a related area. Many theories of men and their expectations of marital therapy are congruent with other related research and for this reason did not require a specific focus, but are referred to in other sections. As space does not permit attention to every study in the topic area, the review incorporates the most relevant literature, and what can be gleaned from the gaps within it. In synthesizing the literature from different perspectives, an argument develops for research in the field of fathers and BFT. The terms *family therapy*, *family work* and *family intervention* are frequently used within this review. Although distinctions can be made between these terms, they are used interchangeably unless otherwise stated. BFT is a specialist family intervention that comes under the broader term of family therapy.

Literature Review Method

A conventional literature search was undertaken using terms "men and therapy", "men and family therapy", "fathers' role in the family", "gender roles", "fathers and therapy/family therapy", "fathers' experiences of family therapy". Additional searches were undertaken to identify any literature pertaining to men and therapy, from a counselling psychology perspective – as recommended by Kasket and Gil-Rodriguez (2011) when conducting research. This included searching the *Counselling Psychology Review* (the Division of Counselling Psychology's quarterly peer-reviewed research publication). The snowballing technique was used to pursue references from articles amongst the initial reading material (Ridley, 2008).

Databases scanned for research and literature included PsycINFO, PsycArticles, MEDLINE, and Academic Search Complete with no date restrictions. Papers not available online were sourced via the British Library and Senate House Library, London. Conferences and training events were attended in order to network with clinicians and authors working in the field of fathers and family therapy. Contact was maintained with the Meriden Family Therapy Programme to stay abreast of any other material relating to fathers' participation in BFT. Searches were also undertaken through EThOS, (a British Library internet source providing access to online unpublished theses).

Men and Therapy

As little current research pertaining to fathers' experience of family therapy exists, the wider field of men and therapy was reviewed. This section adopts a relative account of the available literature. Therefore, areas including male engagement in domestic abuse programmes or specific general health matters are not incorporated.

Much of the literature investigating this topic is in reference to American populations. Thus, White (2009) argues that men's psychological distress in Britain is largely overlooked. He questions why this is, whilst drawing attention to wider indications across the UK of psychological difficulties in men. For example, compared to the figures for women, three times as many men committed suicide in 2008 (Office of National Statistics, 2010). Such indications remain evident today. For example, the Samaritans record almost the same number of contacts from men and women (Samaritans Information Resource Pack, 2012), revealing that many men seek emotional support, albeit over the telephone. Various reasons may account for the lack of psychological literature exploring men or fathers and their experience of therapy. It may be that little is known about men's feelings towards therapy as there are few men practising it; alternatively if they are having therapy, they choose not to become involved in research about it, or as mentioned above, they are using other therapeutic means. White argues that men's psychological vulnerability is denied by a historical patriarchal society.

Relatedly, it is argued that strength, independence and power are all characteristics associated with men that deter them from therapeutic services, for fear of being perceived as weak (Bergman, 1995; Pollack, 2005). Good et al. (2005) acknowledge the impact of masculine socialisation experiences in regard to men's reluctance to ask for help and suggest that alternative therapeutic modalities (e.g. online counselling) are possibly preferred. Similarly, Millar (2003) suggests British services offering psychotherapy could encourage males to seek therapeutic help by clarifying the role of therapy to reduce anxiety about the unknown. The importance of employing an assertive outreach approach when attempting to engage men in therapy has also been stressed by others (Addis & Mahalik, 2003; Good, Thomson, & Braithwaite 2005; Levant, 1998; Eisler & Blacock, 1991; 1995; Mahalik, Good & Englar-Carlson, 2003; Millar, 2003; Mooney, 1998; Pleck, 1995; Pollack, 1998).

In an opposing and feminist view, Garde (2003) argues that to adapt therapeutic approaches to fit in with masculine socialisation only serves to collude with a positivist male standpoint. She protests this is not helpful in promoting male healing and indirectly perpetuates the notion of masculine constructs. In more recent literature, Wester, Vogel, O'Neil, and Danforth (2012) concur that men are socialised to adopt a "stoic demeanour" (p.200). They argue that Western society "rewards adherence to this aspect of the male gender role–instrumentality and stoicism can often contribute to career advancement and success in athletic endeavours" (p.200).

However, Wester and colleagues conducted this study with an American sample, and the same conclusions cannot necessarily be inferred within British society. Indeed, there is a shortage of contemporary British research exploring masculine gender roles, or men and therapy, which is pertinent to this study. Cultural and societal factors could have an important bearing on how British men and/or fathers perceive themselves and the idea of therapy. From a counselling psychology perspective, this is of critical importance, as individual male psychological distress could relate to such factors as opposed to, or in addition to, gender socialisation (Wester, 2008). Wester emphasises how counselling psychologists are committed to working flexibly within cultural parameters, whilst paying attention to the role culture plays in clients' lives. In respect of the current study, this highlights the need to gain a better understanding of how fathers perceive BFT, in terms of their culture and societal context.

Other literature suggests an element of shame is present in men seeking psychotherapy. For example, Osherson and Krugman (1990) postulate that men's apprehension to engage in therapy represents a normal struggle. In arguing that shame stems from a fear of feeling exposed derived from early development issues relating to self-esteem, adequacy and attachment, they propose that therapy symbolises these early experiences through self-exploration, feeling inadequate in the face of women and feeling dependent on someone (as they were on their mother as a child). Whilst interesting, this theory arises from psychoanalytic

concepts, which represent a very distinctive perspective. From a counselling psychology view, it is important to consider how other psychological theories might contribute to understanding male views of therapy.

In thinking further about psychological concepts, it is worth noting a mixed method study by Kierska and Blazina (2009) who explored men's experiences fear of the feminine (FOF). FOF is related to a hypothesis developed by Freud (1937), who argued that when men confront fears of losing power, it results in castration anxiety, which is often triggered in relationships with women. Kiersak and Blazina found that FOF is likely to be activated in psychotherapy and may also be driving psychological defences in men, to distance themselves from thoughts and behaviours believed to be non-masculine. The qualitative section of the study incorporated focus groups, to gain male views on gender differences and how FOF manifests. Based on male interview responses they emphasised the significance of building a solid therapeutic relationship in psychological work with male clients. Importantly, this research acknowledges the need for further developments in understanding how the therapeutic alliance can be fostered in a male-sensitive manner.

In considering factors that inhibit male help-seeking Noyes (2007) conducted interviews with college students to examine male therapy decision-making processes and therapy experiences. He found men tend to experience difficulty in making the decision to attend therapy. Noyes

employed qualitative methodology interviewing participants on two different occasions, with the first interview being shortly after the initial appointment and the second interview being five weeks later. The findings suggested that participants experienced the highest levels of conflict when deciding whether to begin therapy, with conflict reducing as they engaged in the therapeutic process. This finding concurs with other theories regarding the importance of attention to the therapeutic relationship (in engaging men). The quality of the therapeutic relationship is significant amongst common factors across models of therapeutic approaches (e.g. Gilbert & Leahy, 2007; Green, 2010; Martin, Garske, & Davis, 2000,) and associated with better outcomes (Arnkoff, Glass, & Shapiro, 2002; Garfield, 1974; Hubble, Duncan, & Miller, 1999).

Other research postulates that therapists encounter problems engaging men partially because men have difficulty trusting therapists, which hinders the working alliance (Good & Robertson, 2010). They propose that therapy is most effective with men when therapists are knowledgeable, (e.g. drawing on cognitive and emotional issues they are likely to encounter with men) and prepared in building a repertoire to help men with real life issues. Good and Robertson therefore argue the importance of gaining the relevant training and supervision appropriate to male psychology. The authors provide an informative review from a male and client-centred perspective, drawing on clinical, practice-based and evidence-based practice experience.

It is noted from the research thus far that many inferences made about men and therapy reify gender concepts, especially as the same may not be true for gay men. Despite an emphasis on the therapeutic relationship, many studies pay little, if any, attention to tailoring therapy for individual needs. Cooper and McLeod (2011) highlight the importance of adapting therapeutic approaches on an individual basis: "If we want to know what is most likely to help clients, we should talk to them about it." (p.6). In adopting this stance, gender is not the key consideration when working with men, but rather to establish collaboratively what is helpful to them, whereby the therapist can adapt their therapeutic style and approach accordingly. This pluralistic view is closely aligned with counselling psychology philosophy, which is committed to developing how professionals relate to clients (Milton, 2010) and is dedicated to understanding human beings as complex individuals (Orlans, 2011). Theories that categorise in this way, or refer to global generalisations and constructs, do not privilege the importance of individual difference and diversity. Moreover, polarised assumptions based on gender, are not necessarily helpful because they suggest that all men are the same and want the same thing. The connotations that men are less inclined to seek therapeutic help due to masculine gender roles are now explored in more detail.

Masculinity and Gender Roles

Historically, literature has explored how the male experience of "achieving manhood" (Levant, 1995, p.243) might be influenced by tradition, culture and society (Levant, 1996; 2001). Chodorow (1989) asserts that gender and identity differ profoundly for boys and girls, impacting on the way male and female gender roles develop in the family unit. More recent literature concurs that Western culture creates a context in which men attempt to live up to expectations of their gender identities (Addis & Cohane, 2005; Good, Thomson & Braithwaite 2005; Schaub & Williams, 2007: Wester, 2008). Considerable research explores masculine gender roles (O'Neil, 1981,1982, 1990; O'Neil, Helms, Gable, David & Wrightsman; O'Neil, 1986; O'Neil & Lujan, 2009; Pederson & Vogel, 2007; Thompson, Pleck & Ferrera, 1992), whereby is argued that when men do not live up to masculine expectations it creates Gender Role Conflict (GRC). GRC is defined as a "psychological state in which socialised gender roles have negative consequences on the person or others" (O'Neil, Good, & Holmes 1995, p.166).

The primary measure of GRC is the Gender Role Conflict Scale (GRCS) developed by O'Neil, Helms, Gable and Wrightsman, (1986). It examines men's thoughts and feelings about masculine gender roles using a Likert scale incorporating four factors: Success, Power and Competition (SPC), Restrictive Emotionality (RE), Restrictive Affectionate Behaviour, Between Men (RABBM), and Conflict Between Work and Family

Relations (CBWFR). These factors were identified by interviewing 527 male students from two mid-western universities using an 85 item self-report instrument, where they were asked to agree or disagree about their personal role attitudes, behaviours and conflicts in particular gender-role situations. Analysis of the results identified the four patterns of GRC listed above. As noted by Wester, Vogel, O'Neil and Danforth (2012) the difficulty with expressing loving emotions is one example of how GRC can manifest in men. This is theorised to result from inner conflict relating to what boys are taught about being masculine and developmental demands of interpersonal and/or romantic relationships in which they are expected to be more emotionally expressive.

A number of conclusions about male attitudes towards therapy have been drawn in quantitative research using the GRCS. For example, it is proposed that men who align themselves in terms of their gender hold negative views of help-seeking (O'Neil et al., 1986; Mendoza and Cummings, 2001). Comparably, in exploring men's expectations of therapy using quantitative measures (including the GRCS) Schaub and Williams (2007) concluded that GRC can interfere with men's ability to meaningfully engage in therapy. They found that men who reported discomfort with disclosing feelings, expressing emotion to other men, and who emphasised the importance of competition and professional achievement had higher expectations of the therapist and assumed less personal responsibility during the therapeutic process.   In examining willingness to seek counselling, Pederson and Vogel (2007) suggest that

men experiencing greater GRC are more likely to self-stigmatise, less likely to disclose, and are less likely to have positive attitudes towards counselling. They provide empirical support for theoretical assertions that when men are uncomfortable with disclosing distress they are less willing to seek psychotherapy.

These findings are informative, especially if the same is true for fathers who are offered therapy which relates directly to the stress of having a child with psychosis. The fact that research suggests that GRC can be a barrier to men entering therapy is paradoxical in light of research demonstrating that greater GRC is linked with increased psychological distress (Blazina, Pisecco & O'Neil, 2005). Thus, GRC creates psychological difficulties for men, yet because of GRC they are reluctant to seek psychological help for these difficulties. If these theories are applied to fathers in family therapy, some of the suggestions outlined to engage men in therapy may prove fruitful. For example, more attention to the rationale for therapy and the manner in which it is introduced to male clients could have a bearing on whether they choose to participate in it.

The GRCS was developed from other masculine measures pertaining to conflict and has been proven reliable (Moradi, Tokar, Schaub, Jome & Serna, 2000). However, studies using the GRCS are also critiqued. For example, the samples used to test the scale are largely limited to students indicating the conclusions made are not representative of the general population (Good, Wallace & Borst, 1994; Good et al., 1995). Other literature has argued that there is insufficient information provided relating

to the development of the items and the extent to which they really

measure GRC, rather than social ideologies of GRC (Betz & Fitzgerald,

1993; Thompson & Pleck, 1995). The GRCS reportedly does not account

for cultural differences across men (Norfolk, Vandiver, White & Englar-

Carlson, 2011). The reliability of the CBWFR factor has also been

questioned and revisions have been recommended to include cross-cultural

perspectives (Norwalk, Vandiver, White & Englar-Carlson, 2011). More

generally, GRC scales can problematise factors such as power and success

viewing these as inhibitory or detrimental; however, in some contexts they

may prove useful. For example, Mahalik, Good and Englar-Carlson (2003)

argue therapists should become more acquainted with the literature

discussing masculine socialisation on the basis that it can work to enhance

the therapeutic relationship. They argue that asking questions identifying

issues such as stigma and the fear of emotional expression are important in

respecting the experiences of men.

In acknowledging the limitations of quantitative GRC research and a

lack of GRC research with younger men, and Irish populations,

O'Beaglaoich, Sarma, and Morrison, (2013) conducted a qualitative study.

They asked Irish adolescent males to evaluate GRC theory and GRCS

items with the intention to design a GRC measure that would be better

attuned to "lived experiences of adolescent boys" (p.31). The themes

identified in their findings reinforce a number of interesting drawbacks of

the GRCS, including contextual difficulties with items needing more

clarity; the wording of the items needed to be tailored to specific age

groups and cultural differences. These findings are pertinent for counselling psychology, specifically the responsiveness to human understanding of GRC and allowing participants to express their views on real life phenomenon. The attention to social, culture and context are also in line with counselling psychology philosophy in highlighting the need to understand individuals in a humanistic and holistic manner.

Other studies have suggested that self-esteem (Berko, 1995), self-disclosure (Pederson & Vogel, 2007; Vogel & Wester, 2003), public stigma (Vogel, Wade & Hackler, 2007) and self-stigma (Hammer and Vogel, 2010; Vogel, Heimerdinger-Edwards, Hammer & Hubbard, 2011; Vogel, Shechtman & Wade, 2010) influence men's decisions to participate in therapy. Hammer and Vogel draw attention to men's underuse of counselling services, in a quantitative study examining the efficacy of a male-sensitive brochure. The findings suggest that terminology deemed to be more compatible with traditional masculine roles improves attitudes towards help-seeking and decreases self-stigma. Vogel et al. (2011) subsequently suggest exploring how mediating factors such as self-disclosure, cultural variables and therapist trust affect male help-seeking. The latter factor could highlight valuable information about the emphasis men/fathers place on the therapeutic relationship which is potentially relevant to how fathers view family therapy. The importance of the therapeutic relationship is central to counselling psychology philosophy. However, it is striking that publications by Vogel and colleagues, in the

American Journal of Counselling Psychology, pay little attention to the relationship and more generally, how their studies inform the discipline.

An overall critique of the GRC studies is noted in the use of quantitative measures to determine male perceptions of therapy. The assumption that participants have the same fixed definition in mind when they score items on a scale is questionable (Potter & Wetherell, 1987). Other influential theorists argue that it is better to pay attention to establish the meaning participants give to their answers, which is often dependent on context (Gilbert & Mulkay, 1984). Moreover, collecting narrow datasets through quantitative measures, does not allow participants to provide a narrative pertaining to their experiences of being male or of therapy. Structured questionnaires rarely provide exploration of rich human experience (Langdridge, 2007), and do not embrace "a view that springs from a holistic conceptualisation of human beings" (Manafi, 2010 p.22). A more general but relevant critique of GRCS is noted in the absence of GRC research pertaining to fathers and their view of family therapy.

Nevertheless, the research above provides empirical evidence about men and how GRC may lead to reluctance to engage in therapy. This is a point for consideration in this study specifically, because the concept of GRC may shed light on how fathers view and experience family therapy. If men remain ambivalent and apprehensive about having therapy and more generally, about expressing their emotions, it is reasonable to suggest

that fathers are less likely to engage in family therapy. The GRC concept is further complicated by how men see their role as a father. For example, O'Neil and Lujan (2009) suggest that fathering, whether being a father, having a father or losing a father, shapes a man's gender role identity. They consequently argue that understanding the male client's view of fathering is important within the therapeutic process. From a pluralistic viewpoint, to know how a man positions himself in the context of fathering provides therapeutic commitment to prioritising the client's perspective (Cooper, 2007). O'Neil and Lujan also postulate that therapists help fathers to establish if any values they have about fathering impede their ability to parent effectively. This process requires the therapist and the father to explore the healthy aspects of their gender roles and identify what works well in the family context. This type of therapeutic intervention can empower fathers to improve their capacity to parent and function more effectively within the family (O'Neil & Lujan, 2009). With this in mind, the next section looks at research pertaining to the fathers' role in the family.

The Father's Role in the Family

An underlying question in this study when looking at fathers' experiences of BFT is to what extent the father's role within the family may or may not represent their involvement in family therapy. The father's role in the family is a long-standing object of study dating back in the UK to the 1980s. Professor of Family and Developmental Psychology,

Lewis (1986) compared the change in fathers' involvement in childcare in a longitudinal study over 20 years. He found that fathers played a bigger part in rearing children in the 1980s than they did in the 1960s. Furthermore, Lamb (1986) argues that the degree to which fathers play a part in family life relates to how prepared they are for the role of fatherhood, which varies considerably. Wexler (2009) argues that fathers differ in the way they provide parenting roles, and attributes this to a number of factors including the experience the father has had in their own upbringing and how they related as a child to their own fathers. Nevertheless, Wexler's work does not include fathers who grew up without a father and the effect of this on their parenting style.

Carr (1998) suggests that developing sensitivity to children's emotional needs is a complex process for fathers. It is comparably more difficult than carrying out domestic child-care duties (e.g. feeding, the school run and helping with homework). Carr further argues that fathers' involvement in their child's care "is determined by their appraisal of their own competence as parents" (p.373). On the basis of this theory, it would be interesting to establish if fathers who consider themselves to be more competent parents (and therefore more engaged in their child's care), would be more willing to participate in family interventions. Carr suggests that this self-appraisal is linked to the level of social support they receive. He proposes that the more social support the father has, the more competent they feel as a parent. Again, this is an important point to

consider in the remit of family therapy, specifically how fathers could benefit from BFT as a form of social support.

Similarly, Fonagy, Steele, Steele, Higgitt and Target (1994) argue that fathers can help their children to develop resilience in the face of stress. They suggest that children's interpersonal competence and self-esteem are positively related to increased father involvement in family life. Moreover, paternal attachment to the child offers security and safety which provides a role model in respect of the child forming later relationships. In contrast, Lamb (1986) argues that father's involvement is not always a positive factor in children's adjustment, especially if the mother views this involvement to undermine her maternal role. However, Lamb's point may represent the historical bias in which researchers have concentrated more heavily on mothers than fathers (Phares, 1992). Research from the US discovered that males prefer to share child-care duties equally with their female partners (Askari, Liss, Erchull, Staebell & Axelson, 2010). Moreover, Pleck (2010) postulates that fathers are now more present in US family homes and provide more child-care.

Mahalik and Morrison (2006) propose applying cognitive-behavioural techniques (developed by Beck, Rush, Shaw & Emery, 1979) to change male masculine schemas and subsequently enhance father involvement in family life. Mahalik and Morrison suggest therapists employ specific cognitive and behavioural interventions that encourage men to examine their own experiences as fathers and their own reactions to

their fathers. In recognising reactions to their own father's emotional distance, examining the personal evidence of restrictive masculine schemas, Mahalik and Morrison hypothesise that men will become more involved in fathering roles. With reference to a hypothetical case study, they illustrate cognitive-behavioural interventions potentially modified firmly-held beliefs about masculine roles. Whilst on a theoretical level these conclusions appear plausible, this study can be criticised for lacking a real-world dimension in the researchers' unexplained use of a hypothetical case study.

A father's role in the family invariably differs if they choose to stay at home. Rochlen, Suizzo, Mckelly and Scaringi (2008) conducted a qualitative study using Grounded Theory. They provide a rich account regarding the decision-making processes and lives of stay-at-home fathers living in America. The results showed that fathers recognised stigma toward their roles with perceived discomfort and awkwardness, mainly from mothers. The authors speculated that mothers felt threatened by non-traditional male roles. Fathers were apparently unaffected by these views, leading Rochlen et al. to summarise that fathers in their study were satisfied with their stay-at-home roles, despite perceived stigma attached to not conforming to gender-based norms. Furthermore, fathers felt that being at home allowed them to connect with and be more responsive to their child's needs. Therefore it could follow that fathers who are more involved in their child's upbringing would have more favourable views about

attending family therapy. Given the sample of this study was limited to American, heterosexual, middle-aged, married, Caucasian men, the authors postulate that further research is required in the topic area of stay-at-home fathers.

A later quantitative study by Fischer and Anderson (2012) compared the characteristics and gender role attitudes of US stay-at-home fathers with those of employed fathers. Fischer and Anderson remark that many contemporary men now consider themselves to have more involvement in child-care, yet the research in this is slight. Their findings suggest that stay-at-home fathers have significantly less traditional gender role attitudes than employed fathers. A strength of this paper is noted in the recommendation that public policies work to de-stigmatise beliefs and conceptions that men are not "real men", if they choose to be stay-at-home fathers (p.28). They further suggest that applied psychologists would benefit from thinking about the reasons why men become stay-at-home fathers and call for them to monitor and challenge their biases regarding stereotypical gender roles for men. This perspective marries with counselling psychology ethos, in terms of understanding fathers within a reflective-practitioner model and working towards anti-discriminatory practice (DCoP, 2005).

Fundamental changes in women and men's roles have been observed over the last 30 years (Bonney, Kelley & Levant, 1999; Haddock, Zimmerman, Lyness & Ziemb, 2006: Lewis & O'Brien, 1987). This

section has identified that fathers are now considered to be more involved

in family life (Pleck, 2010), and the importance of paternal involvement in

respect of a child's development (Carr, 1998). This increasing importance

underlines the need for fathers to be involved in family interventions. The

notion of fathers participating in family therapy is now considered in more

detail.

Fathers and Family Therapy

Research looking at fathers in family intervention goes back

decades. For example, Martin (1977) examined the importance of

including fathers in a brief family intervention, involving conflict

resolution and contingency management. He concluded that in respect of

its overall effectiveness, it did not seem to matter whether the father was

included in the intervention. In addition to the fact that this research is

outdated, it only accounted for a specific family intervention.

Littlejohn and Bruggen (1994) carried out a literature review

exploring father roles in family therapy and how this has changed. They

argued that although there is limited empirical data suggesting that fathers

are less likely to attend family therapy, there is a widely held view

amongst clinicians and researchers that this is the case (e.g. Heubeck,

Watson & Russell, 1986). Littlejohn and Bruggen concluded that

sufficient research supports the view that fathers are important when

implementing family therapy. Whilst outdated, this review is pertinent to

the current study, in suggesting a need to engage fathers in family work. It is interesting that later literature has not looked at this topic area.

Other research suggests that fathers are typically not present in family work because of their work commitments (Phares, 1992). NHS protocols in community mental health teams increasingly stipulate that practitioners provide interventions, such as BFT, flexibly to accommodate employed individuals (including working parents). Despite this, there is no known research exploring fathers' attendance or experience of BFT. However, this is also true of other family interventions, like systemic therapy which is considered to be an effective intervention (Campbell & Draper, 1985; Carr, 2000; Carr, 2009). Whilst acknowledging the importance of assessing clinical effectiveness, these studies do not offer insight into the lived experience of family therapy which seems a little disconcerting, when considering the promotion of client-centred care in the NHS through NICE guidance. It follows that if more is known about what fathers find helpful and unhelpful in BFT, it can be tailored to match their needs. Understanding more about fathers' needs could also aid the engagement process when introducing the idea of family work.

A study examining the effectiveness of Solution Focused Family Therapy, reports that fathers tend not to be as vocal as mothers and participate less in the therapeutic process (Graham et al., 2001). In a subsequent study designed to determine the process of therapist-client interactions in family therapy, Graham, Walsum and Conoley (2001)

found that both mothers and fathers responded when prompted by the therapist. However, it was also found that fathers took a less vocal role than mothers and therapists were consequently less likely to validate their contributions. Thus, mothers' participation was positively reinforced because they contributed more.   The results demonstrate a relationship between a low number of therapist responses and reduced father participation in family therapy.

In the light of these findings, and the lack of empirical research investigating fathers' participation in family therapy, it would be interesting to further explore father involvement. Similarly, it would be of interest to design a study that aimed to encourage fathers' participation in family therapy, for their involvement seems of equal importance to that of the mothers (Graham, Walsum & Conoley, 2001). The subject of fathers and therapy certainly needs further investigation, specifically to allow fathers to provide their perspective of family therapy. From a counselling psychology viewpoint, enabling fathers to express their views in this field would empower fathers. Moreover, research in this area could assist professionals on both a therapeutic and empathic level. Going beyond the consulting room in gaining "real life" opinions to benefit both professionals and clients is at the heart of counselling psychology research (Milton, 2010).

It would seem that the presence of fathers in family work is not considered as important as mothers' participation (Duhig, Phares &

Birkeland, 2002; Walters, Tasker & Bichard, 2001; Vetere; 2004). As

Vetere (2004) points out, the lack of attention to fathers in family therapy

is perplexing given the research showing an important relationship

between fathers and their children's development. Similarly, Walters et al.

found that attendance in family therapy sessions is more consistent if

fathers have a strong attachment with their own fathers, have a positive

relationship with their partners, and are more involved in parenting.

In investigating the role of fathers in developmental

psychopathology, Phares, Fields, Kamboukos, and Lopez (2005), argue

that fathers are being neglected in research. Interestingly, Phares and

colleagues note that when fathers are involved in family interventions,

inter-parental conflict decreases and family attendance is more consistent.

The finding that fathers' inclusion is a factor enhancing family

engagement supports the rationale for the current study. It would be

interesting to carry out similar studies across mental health services

delivering family interventions. There is a noticeable gap in the field of

research looking at fathers in family therapy.

A qualitative study that investigates families' experience of BFT

very generally (i.e. without specific attention to fathers' or mothers'

experiences), found that there is an overall positive effect of experiencing

BFT (Campbell, 2004). It is interesting that there were twice as many

mothers as fathers who took part in the interviews and the quotes used to

illustrate the positive experiences of BFT are provided by mothers. This

finding is consistent with previous research suggesting that mothers, traditionally participate in interventions that are concerned with the psychological well-being of their child (Graham, 1984). In terms of mental health issues, this view supports research exploring mothers' feelings of guilt and responsibility when their child becomes unwell and the subsequent urge of responsibility to resolve the problem or make it better (Phares, 1992). It would be of theoretical interest to carry out this study with the same number of mothers and fathers, to provide an equal overview of perspectives.

Noting the wealth of research focusing on clinical outcomes, Campbell (2004) carried out a phenomenological inquiry of the lived experience of BFT across family members and found an overall positive effect. Although Campbell's sample was open to any family member, it is interesting that there were double the number of mothers to fathers who participated (Campbell, 2004). A crude explanation for this observation could be that more mothers volunteered to participate in the research or were easier to recruit because of their availability, whilst another explanation could be that more mothers than fathers were taking part in BFT at the time of the study. Indeed, previous research suggests that females regardless of their role in the family are more likely to seek help in the form of psychotherapeutic interventions (Goode, Dell & Mintz,1989; Robertson, 1988). In thinking further about Campbell's study in connection with the present research, it would be interesting to consider if

and how fathers' perceptions of BFT were different to other family members.

More relevantly, Gregory (2009) writes as the father of a son experiencing schizophrenia in a chapter of a casebook describing family interventions for psychosis. Gregory describes how he and his family came to have BFT, interestingly depicting his initial ambivalence and uncertainty about family work. He then provides an overview of how BFT was effective in various ways, taking into account more positive communication, reduced stress levels by effective problem-solving, and regular support and psycho-education from professionals. Thus, it mainly remarks on the more practical benefits of BFT and omits a detailed exploration of Gregory's feelings about the process. Interestingly, there is a small section in this chapter entitled, "My feelings about BFT – Written by Mum", which describes an emotional account of what BFT was like from the mother's point of view. One needs to consider that males are being compared to females in this context and in their willingness to attend or discuss therapy. It may be men's reluctance towards therapy is being considered an issue because of this. In respect of counselling psychology principles, this argument is twofold. On one hand, to respect fathers' wishes in relation to their subjectivity of their experiences, but on the other, to embrace this shortcoming in understanding fathers' experiences, as a research opportunity that is practice-led (DCoP, 2005).

Review Summary

This review has identified that although more British men are opting for therapy, in general, men's utilisation of therapy is considered to be less than women's. From reviewing the research on men and gender roles, it is apparent that societal pressures and conforming to a male identity plays a part in men's attitudes to therapy. It is also apparent that women's use of therapy is used as a benchmark against which men are compared. Therefore, remaining abreast of the growing literature on male socialisation and the way in which gender roles are evolving is significant to developing a deeper understanding of men's needs, and expectations of therapy. From looking at the role of the father in the family environment it is noted that fathers' roles vary in respect of their involvement in family life. The varying nature of this role is an important consideration to keep in mind when working with fathers in family therapy. Thus, obtaining a deeper understanding about fathers' roles in the family can provide helpful information for clinicians, which could aid the engagement process. Finally, in regard to the literature on fathers and family therapy it seems that the research widely ranges in respect of focus and objectives. Historical research relates to fathers' importance in family therapy (Lamb, 1986; Littlejohn & Bruggen, 1994), however, minimal literature explores father engagement in family therapy or their experience of it. The following section outlines the limitations of the existing research, in relation to the rationale for this study.

Limitations of and Identified Gaps in the Existing Research

The preceding literature review has demonstrated that the research looking at men and therapy predominantly focuses on why men do not utilise therapy (Van Walsum 2001; White, 2009) with little exploration to male "real life" perspectives of this phenomenon. It has also shown that, whilst informative, much of the GRC research has employed quantitative methods, which again neglects male subjective experiences of therapy and tends to reify gender concepts. There is a noticeable gap in counselling psychology research exploring male subjective experiences of therapy and this is particularly true for fathers and family therapy. The most important finding in relation to the present study is that limited research investigates fathers and family therapy, and there is no evidence of research exploring fathers' experiences of BFT.

Study Rationale

Research suggests that fathers' involvement in family interventions is central to engaging the family and their presence can improve the probability of good outcomes (Walters, Tasker & Bichard, 2001). Despite this, the literature on family approaches has minimal references to fathers (Littlejohn & Bruggen, 1994). The existing material looking at family therapy appears to focus on measuring outcomes and the effectiveness of particular family interventions (e.g. Campbell & Draper, 1985; Fadden, 1998; 2009) but does not offer insight into the individual experiences of family therapy. The shortcomings in the current research alongside the

research outlining the significance of fathers in family approaches (Lamb, 1986) and observations made through clinical experience provided a strong incentive for pursuing this area of research.

From the researcher's clinical experience, fathers have been observed to be sceptical towards the idea of BFT, often adopting a tentative stance in the process. Limited empirical research exists in the more general field of fathers and family therapy and there is no evidence of research engaging with the specific topic area of fathers and BFT. The current research informs the counselling psychology profession by placing a strong emphasis on reflexivity attending to subjectivity and intersubjectivity in systemically contextualising fathers' experiences (DCoP,2005: Kasket, 2011). It also adds value to this evolving profession in adopting a research-informed approach that is responsive to clinical practice (Hanley, Cutts, Gordon, & Scott, 2011). Finally, a qualitative approach has been chosen to enhance the meaning of fathers' experience and help to develop a richer understanding about a phenomenon where little is known.

Research Questions and Aims

1). What are fathers' experiences of BFT in terms of their perceptions, thoughts, and feelings?

Further to the above, this study also aims to investigate how fathers understand their role (e.g. their input in the process) in BFT. This aim will be addressed by asking the following research question:

2). How do fathers understand their role in BFT?

In addition, the study aims to inform clinical practice in an evidence-based way when working with fathers within the BFT framework and more generally, in therapeutic work with fathers.

Methodology

This section provides a rationale for using a qualitative method and description of IPA whilst considering its relevance to this research within a counselling psychology framework. Participant recruitment and ethical considerations are detailed, before describing the more specific procedural and analytic details of conducting the research.

The Rationale for Qualitative Methodology

As discussed, much of the research exploring fathers in family therapy uses quantitative methods. Whilst quantitative methods are valuable in measuring the efficacy of family approaches or the quantity of father participation, they neglect the individual and potentially "unique" experience of fathers receiving family therapy. As pointed out by Rafalin (2010), counselling psychology is a profession that more readily seeks understanding over universal truths. This is not to say that quantitative research is not applicable to counselling psychology but rather that qualitative methodology was considered the most fitting within the objectives of this study. Furthermore, accessing the "truth" means using whichever approach is understood to be most helpful for the questions that are asked from the research proposal (Hanley et al., 2011). A qualitative framework is employed to explore the meaning of fathers' experience and develop a richer understanding about a phenomenon where little is known (Strass & Corbin, 1998).

Qualitative data collection involves an interpersonal approach whereby the researcher can become more immersed in the analytical process. Qualitative research involves heuristic inquiry which derives from phenomenology, and leads to discovery (Moustakas, 1990). Furthermore, qualitative methods allow "participants to challenge [and correct] the researcher's assumptions about the meaning…of concepts and categories" (Willig, 2008, p.16). Willig refers to how qualitative data generates comprehensive evidence of the participants' narrative. As stated, a fundamental objective of this research is to truly explore the depth and complexity of (fathers') human experience, regarding a particular phenomenon (i.e. BFT). Therefore, qualitative methodology was chosen as the *best fit* to represent that lived experience and to considerably reduce analytic steps away from the raw data. Another reason for choosing a qualitative method relates to the researcher's epistemological standpoint.

Methodological Reflexivity and Epistemological Standpoint

Epistemological reflexivity refers to the theoretical position of the researcher (Willig, 2008). Thus, researchers have developed methodologies, that are not only fitting to the purposes of their research but mirror their personal outlook on reality (Etherington, 2004). In carrying out this study it was important for me to think about *why* a qualitative and phenomenological approach was not only right for the study but also *how* it fits with me as a person. From an early age I have been intrigued by the meaning of concepts in my efforts to make sense of

the world. I recall never simply having a desire to know why events happened without understanding how the circumstances around those events arose. Moreover, my experience of having a mother who had complex psychological difficulties led me to question these difficulties and how they were experienced by her and others. I became increasingly concerned with the meaning of these experiences for my mother, myself and my sibling. Willig (2008) proposes that the process of understanding how people make sense of the world is significant to qualitative researchers. Indeed, the theoretical concepts I have adopted as a person, clinician and researcher have guided my decisions in conducting this research. Thus, a natural long-standing interest in lived experiences is what underpins my theoretical stance and this aligned me as a researcher with the IPA approach. As noted by Etherington, (2004), the researcher's role is often enriched through personal history and enables them to connect emotionally and empathically with others.

Introduction to IPA and Theoretical Underpinning

IPA aims to explore an individual's lived experience in detail. Its founder, Jonathan Smith (1997) distinguishes IPA as "an attempt to unravel the meanings contained in…accounts through a process of interpretative engagement with the texts and transcripts" (p.189). Thus, it is interpretative insofar as its attempts to construe the meanings of participants' words and actions – in relation to a particular event or phenomenon (Smith & Osborn, 2008). The phenomenological component

lies in the objective to discover the meaning(s) of a lived experience and its focus on the uniqueness of participants' thoughts and perceptions. IPA seeks to understand (analyse) the subjective meanings of experiences from the participant's perspective, rather than make objective descriptions (Smith, 1996; Smith, Jarman & Osborn, 1999; Smith & Osborn, 2008). Smith and Osborn (2008) point out that IPA also emphasises the role of the investigator as active and involved. The researcher's task is quite complex in respect of understanding the participants' personal world. This process is complicated by the researcher's view and perceptions of the world.

Smith and Osborn (2008) argue that these conceptions are required as a way of making "sense of the participants trying to make sense of their world" (p.53). This means that there are two stages of interpretation, or a double hermeneutic is involved. Thus, on a theoretical level, IPA is related to hermeneutic and interpretative philosophy (Palmer, 1969; Smith, 2007). More specifically, and as stated by Smith, Flowers and Larkin (2009) IPA has been drawn out of three main areas of philosophy: phenomenology (the study of experience), hermeneutics (theory of interpretation) and idiography (concerned with the particular, hence, grasping the meaning of an experience for a given person).

IPA was considered the most appropriate method for a number of reasons. As IPA is discovery-oriented, it allows for the detailed idiographic study of each case and captures a textured understanding of

individual perceptions (Willig, 2008). Moreover, new information about fathers' experiences of BFT can be gleaned through intense engagement with each individual interview transcript, through IPA. Other qualitative approaches were considered for this study, with Grounded Theory (GT) developed by Glaser and Strauss, (1967) being the main alternative as an approach that also explores lived experiences. GT is a longer-standing method than IPA and now exists in varying forms. Constructivist GT (Charmaz, 2008) is potentially the most popular approach as it offers greater flexibility (Smith, Flowers & Larkin, 2009). However, due to the nature of GT and the emphasis on reaching saturation, a larger sample size is usually expected (Strauss & Corbin, 1998). IPA is particularly relevant to studies where the sample size is small, allowing for a more detailed or micro analysis of the data, (Smith, et al., 2009). Furthermore, IPA was considered a favourable method because it attempts to treat each interview in the same way throughout the analytic process whereas GT uses each interview to guide the next. The following section discusses the relevance of IPA to counselling psychology.

IPA and Counselling Psychology

IPA has a theoretical obligation to understanding an individual in holistic terms. Moreover, it assumes a solid connection between a person's language, thoughts, feelings, and physical being (Smith & Eatough, 2007). The notion of holism inherent in this approach connects it with humanistic psychology (Graham, 1986). Thus, IPA proposes a "humanistically

informed holistic model of the person but is still oriented to research within academia and within psychology as a discipline" (Smith & Eatough, p. 37). To this end, emphasising the value and agency of human beings within a social and relational context is fundamental to IPA (Smith, et al., 2009) and is also consistent with counselling psychology philosophy (Milton, Craven, & Coyle, 2010). Milton and colleagues note how counselling psychology in practice, involves hearing *how* an event is experienced in a way that is sensitive to the client's psychosocial framework. Thus, IPA and counselling psychology are connected by a theoretical underpinning in which participants (in research) and clients (in clinical practice) are experts of their own experiences.

Validity

Considerable debate surrounds the concept of validity in qualitative and phenomenological research (Smith et al., 2009). Although guidelines have been formulated to aid the evaluation of these research methods, different theoretical and academic perspectives have evolved according to varying researcher views. In considering a pluralistic stance Yardley (2008) proposes that validity is demonstrated through a number of principles including the degree of fit between the research questions and methodology employed. As above, IPA was considered as the most appropriate method to explore fathers' lived experience of BFT. This decision was substantiated via consultation in supervision and through seeking guidance at regional IPA meetings.

Yardley (2008) also proposes that validity is exemplified with sensitivity to the context of existing theory and research which was achieved with a thorough literature review, and attendance at workshops and conferences relevant to the general subject area of carers and BFT. Yardley further postulates that validity is demonstrated through commitment (shown with the level of attentiveness to each participant) and rigour (exhibited in the detailed application of IPA as per guidance of Smith, Flowers & Larkin, 2009). In addition, the researcher's supervisor examined the quality of the interviews and completeness of the analysis (see appendix 8). Finally, Yardley refers to the importance of coherence and transparency in validating research. As mentioned, this was achieved in coherently describing the procedural element of the study alongside keeping a reflexive journal. Transparency was further demonstrated by providing marked-up transcripts (see appendix 8), an exemplar consent form (see appendix 2) and interview schedule (see appendix 3) amongst other appendix documents pertaining to accountability.

Participants

Recruitment

Participants were identified via NHS community mental health practitioners delivering BFT to families where fathers had taken part. The researcher sent out the recruitment and information sheet (see appendix 1) via the organisational emailing system and attended MDT meetings to inform practitioners about the research. The recruitment letter was then

posted to fathers who met the inclusion criteria. Although letters were sent

to fathers who had experienced BFT in relation to other difficulties than

psychosis, only fathers who were connected to Early Intervention Services

(i.e. due to their child experiencing a first episode of psychosis)

responded to volunteer for the study Fathers made contact with the

researcher via phone or email. Any questions regarding the nature of the

study were answered at this point. A meeting was subsequently arranged

at an NHS site - conducive for interviewing and convenient for the

participant.

Sampling

Five fathers were recruited who were all white British, with

ages ranging from 48 to 64 years. A brief introduction to the participants is

at the forefront of the results section. Pseudonyms have been used to

protect confidentiality. A homogeneous sample of fathers were recruited

who had experienced six or more sessions of BFT within the last 15

months, as part of a Secondary Care approach, provided by staff members

in an NHS Mental Health and Social Care Partnership Trust.

Inclusion and Exclusion Criteria

Participants were fathers who had experienced at least six

sessions of BFT. Six sessions was deemed to be sufficient exposure to the

BFT model. The number of sessions in BFT can range (depending on the

family's needs and engagement in the process) but it generally takes 10 to

14 sessions (the frequency of sessions can also vary) to deliver the whole programme. In order not to interfere with the therapeutic process of BFT, it was important that the participants were no longer involved in therapy and there had been at least an eight-week gap since therapy ended. A maximum period of 15 months post-therapy was considered to provide participants adequate time to reflect on the therapeutic approach whilst not leaving it too long for them to have difficulty recalling their experience. Fathers who had experienced BFT delivered by the researcher were excluded from the sample. Fathers were also excluded if they had taken part in BFT as the client under mental health services.

Ethics

Ethical Approval

Initial ethical approval was obtained from the Research Student Progress Group at London Metropolitan University. NHS ethical approval was sought from a National Research Ethics Committee, via the online Integrated Research Application System (IRAS), to recruit participants from the Trust for which the researcher works. Following review of the IRAS application, an invitation was received to attend the Committee meeting for a formal discussion of the research proposal. This meeting provided an opportunity for the committee members to review the proposal subsequent to a telephone conference with the researcher. The committee requested amendments were made to the participant

information sheet and consent form whereby revised versions were submitted to the Research Ethics Committee. After approval was received (see appendix 6), additional authorisation was required from the concerned NHS Trust's Research and Development department in order to proceed with the research. Any written information sent to participants included the NHS logo so that participants were aware that the research was connected to the Trust.

Ethical Considerations

As argued by Olsen (2010), "ethics lies at the very heart of counselling psychology practice and is central to relational understandings" (p. 89). Furthermore, an overarching ethical consideration when carrying out research involving human participation is the need to respect each person's views, thoughts and feelings. Using qualitative methodology and enabling every father to make sense of their experience of BFT was part of this process. As part of the present study, participants were given the opportunity to ask any questions regarding the research from the outset (e.g. on receiving the recruitment and information letter) to ensure that they were fully informed about the study. An emphasis was placed on the research being voluntary, and informed consent (see appendix 2) was gained from all participants before they took part.

Participants were informed that the data would remain anonymous and confidential throughout the research process. Participants were also provided with a list of services available for support following the

interview as part of the debriefing process (see appendix 4). As per NHS

research protocol, they were also advised that they could withdraw from

the study at any time without giving a reason and with no consequence to

themselves or their children's treatment. Given the purpose of the research

interview where talking about BFT may have been an emotional process

for fathers, a three-step distress protocol (see appendix 5) was designed.

Provisions for confidentiality (see appendices 1 and 2) were made clear in

the information sheet provided to participants before their interviews.

Interviews were audio-recorded with a digital device and remained

anonymous. Any written or printed material (i.e. consent forms,

transcripts) was kept in a locked cabinet on NHS property and shredded

once no longer required. All recordings were transferred and stored

securely onto an NHS password protected lap-top following each

interview. The recordings on the audio-recorder were destroyed.

Transcripts that were printed for the analysis procedure were locked in a

secure cabinet.

Procedure

    Pilot Interview

        A pilot study was carried out with a father in advance of the

formal data collection. The purpose of the pilot interview was to assess

the feasibility of collecting data and to improve the interview schedule (see

appendix 3) if necessary. The pilot interviewee was made aware that his

interview might not be used. Reflecting with supervisors at this stage was

invaluable in lending more curiosity and openness to the researcher's interviewing style. Although the interview schedule was not adapted, the data from the pilot interview was not included in the findings due to practice in developing the interview style. Five fathers who met the criteria were subsequently invited to participate in the study. The following sections provide additional details of the interviews and data analyses using IPA.

Semi-Structured Interviews

The aim of semi-structured interviews fit with the objectives of the present research in facilitating a dialogue that encourages the participant to tell a story using their own words (Smith et al., 2009). Indeed, semi-structured interviewing allowed for the participant and researcher to engage in a free-flowing discourse in which template questions were adapted to participant responses (Smith, 2007). The way and the order in which the questions were asked varied, in order to enable the researcher to follow up unexpected lines of discussion, and to probe gently as interesting and important areas arose in conversation. The interview questions (see appendix 3) used were constructed carefully in a way to elicit answers corresponding to the research aims. Participants were interviewed separately at various NHS sites across south-east England. The interviews lasted approximately one hour for each participant and were audio-recorded. The interviews were transcribed via an independent and confidential transcription service (see appendix 7). Participants were

made aware that an external agency was being utilised in the information sheet provided prior to taking part in the research (see appendix 1).

Analysis of Interview Scripts

This section provides a detailed description of how the interviews were analysed, which according to Smith et al. (2009) is non-prescriptive. The first step of the analytic method from the point of interview transcription involved organising the transcripts with line numbers for ease of referencing. In order for the researcher to pay attention to each idiographic case the transcripts were individually analysed before moving to the next case. This involved reading and rereading each interview line-by-line, whilst listening to the respective audio-recording to help recall the voice of the participant, noting changes in tone, amplifications and contradictions. Text was underlined with a written rationale explaining why it was relevant or significant. Initial notes were made using a free-associating technique to capture thoughts arising from the process of reading the transcripts. By engaging with the text in detail, the analyses moved from an exploratory level to an interpretative level as different meanings were reflected upon.

On completing this stage, emerging themes were developed in a left-hand column on the transcript. These themes emerged from focusing on the initial notes while considering what was learned from the first stage of notation. As pointed out by Smith and colleagues (2009), this process denotes one part of the hermeneutic circle, in moving the researcher away

from the participant in the analytic stages of interpreting the interview dialogue. Therefore, the emergent themes reflect both the participants' original words and the researcher's interpretation of those words. These themes were individually cut out and clustered under superordinate themes by searching for connections across them. Within this process, some of the emergent themes acquired a superordinate status to bring together a series of related themes, whilst others were grouped together under new superordinate titles. The higher level superordinate themes and lower level emergent themes were then listed into a table for each participant. Once this process had been repeated across all five interviews, it was possible to look for patterns across cases.

As suggested by Smith et al. (2009), this involved laying each table of themes out on a large surface to explore connections across the cases, slowly reducing the total number of themes as some were collapsed into one. This stage helped the analysis move to a more theoretical level, as superordinate themes particular to individual cases represented higher order concepts relevant to all cases. These higher order concepts represent four core themes that were shaped by the research aims. The themes were then combined to produce a master table (see results section) of three superordinate themes and nine subordinate themes. To verify the analysis, the findings were shared with supervisors and counselling psychologist colleagues. Discussing the results with other professionals was an important reflecting process helping to enhance the credibility of themes.

Results

Overview

As described, a number of potent themes were identified in the analysis - displayed in the table below. This section expands on the themes using quotes from participants to illustrate their potency.

Master Table of Superordinate and Subordinate Themes

Themes	Quotes from Interviews (with pseudonyms and line numbers)
Fathers' Reflections Prior to BFT	
Trauma of Psychosis	It was very traumatic for us (Ted,31)
Needing Help	Um…I was open, um to anything that could be helpful, because I knew that's what I needed (Frank, 278-279)
Entering the Unknown	I hadn't, neither of us had done it before so it was a totally new experience, we'd never had therapy for anything (James, 252-253)
Fathers' Reluctance about BFT	
Ambivalence About Therapy	We all shared the initial sense of awkwardness about talking (Paul, 131)
Confusion of Role	I am used to wearing the suit and the tie (Jack, 90)
Fear of Self–Exposure	I think we should do this but I am going to be on my guard (Jack, 251)
Fathers' Positive Views of BFT	
BFT Having A Positive Impact	The counselling brought us out in different ways; we were able to express ourselves better. I think it really helped (Ted, 237-239)
Facilitating Openness and Honesty	It's the very first time that the five of us, you know actually sit in the room and talk (Jack, 646-647)
Building a Therapeutic Relationship	They were the right people for me to work with (Frank, 914)

The superordinate themes and under-arching subordinate themes are discussed in more depth, incorporating analytical interpretations of participant interviews. Quotes are included to evidence what has been learned about fathers' thoughts, feelings and perceptions of BFT. In some instances quotes are used where participants have said something of relevance interspersed with an unrelated comment. Here the unrelated comment is removed and indicated with "…".

Introduction to Participants

Before presenting the findings, a brief description of the cases used in the final sample is presented providing some basic background to each participant and the circumstances in which they experienced BFT.

Jack

Jack was a 62-year-old white male. He worked in a City environment as a Business Advisor. His son (aged in his early twenties) developed psychosis and had been under EIS for three years at the time of the research interview. Jack lived with his wife and son in a rural area.

Paul

Paul was a 56-year-old white male. He worked as a Business Manager in educational services. Paul's son experienced an episode of psychosis in his early teenage years approximately 18 months prior to his research interview. Paul lived with his wife, his son and a second child in an urban area.

Ted

Ted was a 48-year-old white male who worked in a City position as a Bank Manager. Ted's teenage daughter had developed psychosis whilst attending secondary school and had been under EIS for three years when he participated in this research. Ted lived with his wife and three daughters in an urban area. Ted had experience of counselling and reportedly found this useful.

Frank

Frank was a 64-year-old white male who was retired as a roofer. Frank's son had experienced psychosis in his early 20's and had been under EIS for over two years at the time of his research interview. Frank and his wife were separated and his son had spent some time living with him in an urban area. Frank received individual support from EIS after having BFT which he reported to be helpful.

James

James was a 57-year-old white female who worked as a Grounds-man in a school James' teenage daughter (attending college) had experienced psychosis approximately three years prior to participating in this research. James lived with his wife and two daughters in an urban area.

Fathers' Reflections Prior to BFT

This theme conveys fathers' thoughts and feelings prior to having BFT. Fathers expressed varying degrees of difficulty in understanding and coming to terms with psychosis. They described confusion and desperation entwined in a sense of powerlessness. A general willingness to try anything to help was conveyed amongst reasons for partaking in BFT. However, retrospective reflections when considering the idea of therapy were mixed. Whilst some fathers expressed openness to a family intervention, others recalled much apprehension.

Trauma of Psychosis

As stated, interviewees experienced BFT as part of a care approach from an Early Intervention in Psychosis Service. At the outset of their interviews fathers described the fear and bedlam generated by the experience of psychosis. For example, Ted recounts how his daughter becoming unwell affected the whole family:

"...it was very traumatic for us, um, and obviously my, um, other daughter and my son, um, because the whole experience has left them with, they're both obviously younger and they sort of grew up though..." (Lines, 31-34)

It is interpreted through Ted's phrase "obviously" that he seeks a shared understanding of his story. While hesitating, he conveys his perspective rather quickly as if disclosing the trauma of what happened to

him and his family is significant and needs to be heard. It could be

intimated that Ted has not had much opportunity to talk about the distress

caused by this situation and he finds talking helpful. This interpretation is

supported later in his interview, as he considers the usefulness of one-to-

one support. It is noted that his sentences are unfinished and fragmented,

potentially because he is unsure where to begin or end his narrative. A

systemic view is portrayed in his apparent need to explain how this crisis

affected the whole family. He conveys a caring and thoughtful attitude

when reflecting on the impact his daughter's illness had on his other

children, further supporting the interpretation that the experience of

psychosis was traumatic for all those involved. Ted's opening comment

appears to convey his frustration regarding the trauma of psychosis. This

theme of trauma is present in Jack's narrative:

"You know you just don't know what life is going to bowl you…and,

erm, my memory has shot away, having used the counsellor as negotiation,

a negotiator between I and [son's name] *because I couldn't not look in his*

room, you know I could leave his door shut for an hour but after a while I

just wanted to make sure he wasn't doing something stupid." (Lines, 20-

25)

Jack's use of language "you don't know what life is going to bowl at

you" seems to represent the inner turmoil he felt when faced with this

situation. His reference to losing his memory is interpreted to enhance the

cognitive impact of his son developing psychosis. It could also be argued

that he felt relief when the counsellor (i.e. BFT therapist) played a part in their situation, acting as a negotiator. His response indicates the confusion he encountered when caring for his son; part of him wanted to maintain his son's independence in keeping the door closed, whilst another part of him yearned to open the door in a protective manner to check his son was safe. His word "stupid" is considered to minimise something very threatening, which could be interpreted to provide a self-protective function in what was an all-consuming crisis for Jack. Thus, similar to Ted, the experience of psychosis is understood to be very frightening for Jack. This response is considered to represent the confusion, frustration, and helplessness experienced during Jack's struggle to understand his son's illness. Jack refers to the counsellor adopting a negotiating role, providing a sense that he used BFT to resolve points of difference between him and his son. Moreover, his language seems to represent a business stance, in which the counsellor was the "negotiator" in BFT, functioning as a consulting tool to help him deal with his son's worrying behaviour. Comparably, Frank also voices a strong impression of distress, when recalling his son's behaviour:

"He would have just stayed in the woods and peculiar things. Thought he was going to kill himself a couple of times you know…" (Lines 153-154)

Frank's use of the expression "you know" could imply that the researcher would understand his perspective without further explaining himself. There appears to be an assumption on Frank's part that his

experience of having a child with psychosis is understood. There is an apparent wanting for someone to see things from his perspective. Frank appears to stress the concept of suicide to reinforce the seriousness of events. This interpretation is supported in later points during Frank's interview, when he states the lack of support he received until BFT started. Similar to Jack's extract above, Frank's response is reminiscent of the desperation, confusion and fear he felt at this time. He leads on to reiterate the difficulties experienced in coping with this trauma:

"...at the times he was bad especially when he was in the hospital, going to visit him in hospital, things worked out badly and I had to leave because he'd start getting aggressive or whatever. Um, but it was very difficult really." (Lines 848-851)

Frank accentuates his use of the word "bad" through his tone of voice to emphasise the severity of his son's psychotic symptoms. The description of "bad" in relation to his son being in hospital also suggests that at times, this was not something he could cope with. Therefore, it could be inferred that even when his son was in hospital the level of trauma that Frank experienced was not any less but different. Frank also uses the expression "badly" to depict the level of conflict experienced with his son, in a potential attempt to illuminate the distress that arose from this situation. This phrase could also be an acknowledgment of Frank's own role in his relationship with his son, suggesting that he could have handled

things differently. James similarly recalls a difficult time with his

daughter**:**

"*...when our daughter came home* [from hospital], *she wanted to

jump out her window because she wanted to get away so, and* [name of

therapist] *held the fort basically phoned the amb…cause I wasn't there,

phoned the ambulance and er, all we all had to look at each and we'd

think if it's good for* [daughter's name] *well we're go for it..* " (Lines 117-

121)

A theme of desperation gleams through James' response as he

remembers the turmoil created by psychosis. His recollection of his

daughter's frightening behaviour mirrors other participant responses,

particularly the emphasis on the gravity of her actions. It is interesting that

the family home is referred to as "the fort" arguably symbolising a place of

protection, that James felt was compromised when his daughter tried to

escape. It is also noted that James connects his other daughter telephoning

the ambulance with him not being there. It could be surmised that James

would usually be at home or was the main carer during this time.

Consequently, it is possible James felt accountable for his daughter's

attempt to flee the house. It is further interpreted James and his wife were

distraught at this juncture of their daughter's illness and were therefore

willing to try anything that could help. Thus in the midst of a despairing

situation the family were willing to try BFT. It is intimated that the

hesitancy and fragmentation of this response is symptomatic of the chaos

felt by James about what happened but also of the ambivalence he felt towards having family therapy.

Perplexity and bewilderment regarding psychotic phenomena appeared prevalent across the cases as fathers referred to the disturbing impact of psychosis. Although fathers were not asked to talk about psychosis, most participants appeared keen to stress its acute impact. For some, describing the effects of psychosis and how it manifested in their child appeared to be a cathartic process. Most fathers talked of psychosis as an unknown entity evoking a range of emotions from panic to helplessness.

Needing Help

In discussing their thoughts and feelings in advance of BFT, participant responses varied. Some fathers expressed nonchalant attitudes towards therapy, whilst voicing a willingness to participate and others voiced more obvious reservations. However, most fathers communicated a struggle in coping with their child's psychosis and there was an overall theme that help was needed during this difficult time. For some, this need represented a compelling reason for participating in BFT, as depicted by Frank:

"Um, I was open, um to anything that could be helpful because I knew that's what I needed…Um, I could only have so many questions to

ask and, um, I wouldn't know how to go about them being answered."
(Lines 278-282).

Frank assertively refers to needing therapy as a platform to ask
questions. It could be intimated that he anticipated BFT to have a psycho-
educational component to allow him this opportunity and provide answers.
In contrast to James, Frank talks lucidly about BFT being a favourable
idea on a personal level, rather than taking part for the sake of his child.
Frank's reference to having so many unanswered questions could be
interpreted as a sense of feeling excluded, alone and isolated prior to BFT.
It is intimated that Frank was desperate to make sense of what was
happening to his son. Similar to Jack and James, it is interpreted that Frank
hoped the process of family therapy would provide a link for this traumatic
experience to be understood. Frank later alludes to being afraid of saying
certain things to his son prior to BFT, where it could be implied that he
hoped therapy would offer him a voice. It could also be interpreted that
BFT allowed Frank to have a conversation with his son in a safe,
containing environment. Frank's accounts support the earlier
interpretations that he wanted help and support. He later refers to needing
help on an individual basis, when recalling a session where his son refused
to take part:

"And I said well, we'll keep the appointment, me and [name],
because it can help us. Bearing in mind, we had no help, there was nobody

before and we had nothing. We didn't know what we could do with him…"
(Lines 544-546)

Frank stresses the point that they had nothing before BFT. In a despairing tone, he conveys a sense of powerlessness as he reflects back on the situation. It is intimated that Frank experienced a complete sense of loss regarding how to react to or cope with his son's illness. Reflecting across participant accounts, the significance of needing external support is very apparent. James explains his family's reasons for having BFT:

"...we had to look and discuss it, and we thought, well if it's gonna help [daughter's name] *to get better cause she was, at the time, already back at school on a part time basis aiming towards, she missed a year, so we wanted the best, anything we could do to help to get her to achieve what she wants and she went on to get two A's and a B."* (Lines 97-102)

James's response is fragmented in recalling the decision to have BFT. The regular use of "we" suggests that having BFT was not James's independent choice, from which it could be inferred that it was something he went along with. James links the family's rationale with a need to help his daughter. More specifically, BFT was necessary in supporting his daughter to achieve academically, whereby an emphasis is placed on BFT fixing things for "the best" to be accomplished. It is interesting that he then switches from wanting the best to a willingness to do anything to help. The extreme use of James's words illustrates the absolutes of the situation and the lengths he and his family were willing to go to, to get help. It is also

suggested that James and his wife hoped that participating in BFT would get their daughter back on track with her studies. Ted communicates the importance of talking:

"...if you don't let people in who are there to help, you can't move forward… Cause, basically I mean if we didn't, have had that counselling…you need somebody to offload onto to talk about your emotions..." (Lines 111-114)

Like other fathers, it is interpreted that Ted perceived family therapy as a vehicle for moving forward. Moreover, for him BFT was the better alternative to withholding his feelings. He advocates the process of talking, aligning it with a necessity where it could be interpreted that Ted found talking and sharing his emotions within the BFT framework a needed intervention. Jack also alludes to needing therapy:

"I think it came because, oh we hadn't done it and I was asking, you know… we need some sort of format to deal with some of the issues we had at the time..." (Lines 600-607)

Jack demonstrates an ability to take charge as he recalls asking for help. His use of the word "format" is an interesting one that might imply that Jack was seeking a guide, or a plan that would advise him on how to cope at the time. Similar to Frank's earlier extract, it could be interpreted that Jack also desired a psycho-educational aspect of BFT to help him understand more. Jack's assertiveness in asking for help differs from other

participants' recollection of having BFT, as a recommendation from professionals. Given Jack's work identity and observed business stance it could be interpreted that requesting help was his way of governing a situation, where he felt he had lost control. It is further interpreted that Jack was eager to resolve the difficulties he and his family were having at home, and on this basis wanted a family intervention.

Participants all communicated a willingness to try BFT as a result of the systemic difficulties of living with psychosis. Nevertheless, fathers also expressed apprehension regarding the unfamiliarity and strangeness of therapy.

Entering the Unknown

Participants acknowledged a sense of hesitation about being in therapy. BFT represented a new experience for most fathers. This was particularly evident in James's and Paul's interviews who reported knowing little about BFT or what it would involve, prior to taking part. James talks about BFT being a novel process:

"...it was suggested by the early intervention team to go through the process of the therapy, so we could sit around and discuss what had happened and where we go next...I'd never heard of it before obviously, so it was a new experience for both of, well all of us, all of us." (Lines,10-14)

James states that BFT was suggested by professionals, thus supporting the earlier interpretation that for James, his participation was

imposed rather than chosen. An informal association of therapy is inferred as he reports BFT to involve "sitting around". It is intimated that James perceived therapy as a casual intervention and perhaps did not perceive it to be a meaningful process. His reference to BFT as a new experience suggests that he did not know what to expect from the process. James's emphasis of the word "obviously" could indicate that he assumes the researcher would know that the process of BFT was unknown to him. This interpretation is supported in later points of James' interview, where he reiterates that the idea of therapy was a completely new concept for him and his family. James' reiteration of this fact might suggest that he felt shameful about having therapy. He later emphasised that BFT was an unknown entity:

"I hadn't, neither of us had done it before so it was a totally [laughing] *new experience, we'd never had therapy for anything."* (Lines 252-253)

There is a sense of togetherness as James refers to himself and another collectively learning. It is intimated that the decision to partake in BFT was a collaborative process for James. It is interesting that James laughs during this extract, which is interpreted to convey a sense of bewilderment about the family having the sort of difficulties that warranted therapy. His laughter could also be seen as a way of mitigating the circumstances. Thus, James stresses therapy had never been needed before, from which it could be intimated that therapy was an embarrassing

or shameful concept for James. Consequently, it is surmised that BFT was

an unknown entity and a process that James never anticipated either

himself or his family to experience. Paul similarly recalls being unsure

what BFT would involve:

"I don't think I really had any idea what it involved, er [short pause],

we were given some information beforehand, but the basic idea was we

have two professionals who are prepared to come in and help with a

problem that our son is having, or has had, whatever and he's, you know

he's still having to some degree, erm, if they think it's a good thing, then

whatever we think of it, we've got to do it." (Lines 90-95)

Paul appears to talk quite flippantly with his use of "whatever" and

"good thing", which may indicate that a lack of seriousness was attributed

to BFT. Whilst a sense of gratitude flickers through Paul's comment in

acknowledging the professionals willingness to help, his response also

suggests that he only took part on the basis of expert opinion. Perhaps for

Paul, the professionals were perceived as experts whose advice needed to

be followed. Therefore, similar to James, Paul distances himself from the

decision to participate in BFT. The phrase "we've got to do it" is

indicative of necessity, not choice. It may be that Paul felt there was no

other option. It is possible that Paul felt some shame about having therapy

and therefore it was easier to consider it as a necessary rather than optional

task. It could also be intimated that Paul felt persuaded to take part for the

sake of his son and his problem. It is interesting that Paul seems undecided

about his son's difficulties, not knowing whether they represent a past or present problem. Psychosis often has an unpredictable course and Paul's indecisiveness represents the mystification caused by it. It is suggested that like other fathers, Paul perceived BFT as opportunity to receive education and advice about psychosis, to help make sense of it.

To summarise this theme, fathers appeared to have little knowledge of what BFT would involve and, as a consequence, were hesitant about engaging in the process. It was also apparent that some fathers participated in BFT not fully understanding what it involved on the premise of advice from EIS practitioners. The hesitancy noted above leads onto the next them of reluctance conveyed by fathers both prior to and during BFT.

Fathers' Reluctance about BFT

It is interpreted that fathers communicated varying degrees of reluctance when describing their views and experience of BFT. Participants described a mix of emotions including ambivalence, fear of self-exposure and an element of confusion regarding their role in BFT. These feelings appeared to relate to a wider cultural context of shame, guilt and stigma associated with mental health difficulties and being in therapy.

Ambivalence about Therapy

Whilst communicating it in different ways, fathers alluded to feeling ambivalent about BFT before and during it. This was expressed

through concerns of what therapy might entail, hesitation about therapists coming into the family home, and uncertainty about the process being effective. Having a son or daughter with psychosis appeared to represent abnormality for fathers. The following accounts also illustrate fathers engaging in a process of normalising their scepticism about therapy. It also seems that BFT taking place at home was difficult for some fathers. Paul refers to BFT being awkward:

"Well, just a bit erm, it was awkward having these conversations, er as a family, erm in front of two strangers, erm, and I suppose we just had to, I don't think we worried about, at least I didn't worry about speaking in front of them. " (Lines, 23-26)

A sense of unfamiliarity is implied in Paul's phrase, "strangers" when speaking about the therapists. It could be interpreted that Paul had difficulty relaxing in BFT sessions for fear of being observed or assessed. Paul is hesitant throughout his interview, which supports the notion of feeling uncomfortable with new people (i.e. the researcher). This uneasiness is also noted in the length of his interview - the shortest amongst fathers. It is interesting that he denies worrying about talking in front of the therapists, which may represent cautiousness of revealing his true feelings about BFT. His comment: "we just had to" implies he felt compelled to be involved in BFT, supporting the interpretation that there was an element of persuasion to participate. Comparably, Ted alludes to feeling sceptical about therapists entering his home and providing advice:

"I think it's about somebody obviously coming into your home where that's, that's sort of your castle isn't it? Um, and perhaps telling you what you need to do, no-one quite ever quite likes hearing, 'oh, you're doing this wrong', well not necessarily wrong but giving advice out and how to take things forward."(Lines 117-120)

Ted's use of a question is interpreted as a way of seeking reassurance that he is not alone in his thinking. His use of language when referring to his home as his "castle" could indicate that he considered therapists coming into his home as invasive. Akin to Paul, it is inferred that Ted may have feared being judged in BFT. Equally, it is intimated in his use of the third person in this comment that the idea of getting things wrong was difficult for him. It could be argued that being advised of the best way to interact with his son felt challenging for Ted. His attempt to rephrase his sentence is suggestive of apprehension or uncertainty about how honest to be with the researcher. Other participants similarly expressed ambivalence towards therapy, with some seemingly equating it with a foreign experience. For example, James recalls questioning the idea of therapy:

"...who is it that needs therapy is the first thing and most people's idea of therapy is when something's not quite right." (Lines 95-96)

It could be said that James is attempting to normalise his perception of therapy being unusual or uncommon for the average family. It is also interpreted that for James having a daughter with psychosis was "not quite

right". Perhaps James struggled with the associated stigma of having a daughter experiencing mental health difficulties and having therapy as a consequence of those difficulties. James continued to engage in a process of normalising his initial reluctance towards therapy:

"I know quite a few people who would have said no, I'm not going to therapy, why do I need that? You, what's the word, you go down any, go down any avenue to find out what's going on and how to help her, that was the idea from our side." (Lines 123-126)

James is heard to use a question in this extract to strengthen his point that having therapy is undesirable or off-limits to others. This comment could indicate that help-seeking was out of the ordinary for him. He then seemingly attributes his attendance, being for the benefit of his daughter. A projected need to help her could be indicative of how powerless James felt, and so BFT was agreed to in an act of desperation to help. In using "our" he apparently reiterates that BFT was a joint decision. Whilst it could be suggested that shared choices are part of family life for James, it could also be inferred that he was encouraged to take part. Consequently, it might be suggested that James is attempting to distance himself from his decision to participate in BFT to offset the perceived stigma attached to having therapy. However, he also seems to be saying that he was prepared to do whatever it took to establish what was wrong and how to help. A similar pattern of normalising ambivalent feelings towards BFT is mirrored by Ted:

"Cause I know some people can be, I'm sure you have come across 'em, who'll say no, I don't want you near, we'll deal with it ourselves cause they're sort of too proud, but I think sometimes you need to let the barriers down."(Lines 122-124)

It is intimated that Ted originally felt uncomfortable with the idea of BFT. In stating that he knew others who would have declined therapy is considered a way of normalising this discomfort. Similar to other fathers, Ted's expression "too proud" could represent a sense of shame or embarrassment about having therapy. Frank also recalled having reservations about the potential effectiveness of BFT:

"Um, because I thought to myself, how can you change him? How can you stop this?" (Lines 487-488)

Frank's comment suggests he felt hopeless about his son's behaviour changing, or chances of recovery, whereby it could be interpreted that Frank was sceptical about how BFT would improve anything. Ambivalence about BFT prior to taking part was similarly conveyed by Jack:

"I am just cautious but positive if you like, positively cautious, if there is such a word, you know let's see where we can take this and see what happens about it."(Lines 261-263)

Jack carefully chooses his words in disclosing a degree of uncertainty he felt towards BFT. It is interpreted that similar to other

fathers, Jack wondered about the potential effectiveness of having therapy. Jack's phrase "let's see where we can take this" could indicate that he perceived BFT as a challenge. Furthermore, it is intimated that Jack's use of the word "positive" in the context of being "cautious" illuminates his ambivalence about having BFT.

In reflecting across accounts, it is surmised that fathers did not subscribe to BFT for any personal life-enhancing qualities, but rather because it was something they felt inclined to do. Yet, BFT was also perceived as a rescuing hand or a lifeline accepted at a time of crisis, desperation, and uncertainty. Fathers' narratives indicated that they were ambivalent about participating in BFT. On one level fathers felt they had something to gain in terms of needing support, whilst on another level they felt cautious about the process.

Confusion of Role

This theme relates to the second research aim pertaining to fathers' role in BFT. Two fathers perceived their role as undistinguished from any other family member's, whilst three fathers expressed a sense of confusion about how they should be in therapy. This confusion was illustrated through comments of not knowing how much they should lead the sessions, or to what extent they should show their emotional side. It is intimated that some fathers attempted to make sense of their role in BFT according to their perceived identity or work role:

"I am used to wearing the suit and the tie, you know I interview people. I am in charge of the interview it goes where I want it to. So this is role play, this is asking questions saying how you really feel and I'm not a good actor, I wear my heart on my sleeve, so this is dangerous play for me." (Lines 90-94)

Jack denotes a stance of being in charge, from which it is inferred that the BFT process may have felt incompatible with his identity. It is speculated that family therapy was a threatening experience for Jack, in which he felt out of his comfort zone or emasculated. It is interesting that he equates his experience of BFT with an "interview". Being on the receiving end of questions instead of asking them was potentially hard for him. Reflecting on this further, it could be interpreted that Jack is conveying an unconscious message of feeling challenged in the research interview, where he is again being asked to answer questions. A later comment indicates a degree of resentment about participating in BFT:

"So you want to get your own way, you want to be in control. So, not being in control being in your own house, that's difficult that's actually, this is not how it's meant to be, I haven't put all my effort into having this environment and then finding I'm not in control." (Lines 393-396)

Here Jack seems to be suggesting that his identity is associated with a clearly defined authoritative role, and consequently he experienced resentment about his lack of "control" in BFT. Thus, Jack's expression "this is not how it's meant to be" could also convey significant ideas about

how he imagines things should be. It is further interpreted that he attempted to cover this resentment with a jovial manner and cheerful tone as he joked and laughed through parts of his interview. Jack's point about finding himself not in command is a pertinent one. It is interpreted that he may have felt irritated in some sessions of BFT from experiencing a lack of control. This extract also bears a theme of bewilderment from being in a situation where he did not have all of the power, supporting the earlier interpretation that Jack is accustomed to a managerial role. Consequently, it could be argued that Jack struggled in adjusting to a position where he was not the leader. Paul also demonstrated feeling uncertain about his role in BFT:

"I think in the whole process of the treatment, my wife has been more involved… and I think probably she was perhaps more active in some sessions than I was but that's partly because I was trying not to, well obviously didn't want to dominate any sessions." (Lines 156-160)

It is interesting that Paul acknowledged his wife as being more active in the sessions. It may be that Paul perceived BFT as an intervention that was more related to his wife's caring role in their son's illness. Paul's use of "obviously" could indicate that he assumed a back seat in therapy because that was what was expected from him. However, the concept of "trying not to" could also suggest that this was difficult for him and he feared that he would dominate the sessions. Perhaps Paul like Jack is accustomed to a managerial position and therefore found the concept of

holding back challenging. Paul's response could signify a dominant presence in the family environment, and therefore the BFT process opposed this position. This interpretation is supported in a later comment from Paul:

"We would ask them [the children] *to lead and make notes or whatever, erm, if you're not careful it would be very easy to take over the session completely."* (Lines 166-168)

Paul's quote could indicate that he has a tendency to take the lead in situations at home. By using the expression "make notes or whatever", Paul might have considered these to be menial tasks. He emphasises his difficulty in not taking over, intimating that Paul often felt inclined to direct the sessions. Perhaps his familiar role of managing situations was compromised in BFT. Taking this interpretation further, it could have been disconcerting for Paul to take a back seat where his children are concerned. Ted similarly alluded to holding back in therapy:

"I mean obviously you can't open up everything as a father but you, you just need to be a bit more open at times, especially with this situation, I think now we talk about things more." (Lines 219-221)

This extract suggests that Ted finds expressing his feelings difficult. Reflecting on this further, it could be argued that Ted assumes it is not fitting for him to show an emotional side. It is inferred that restricting his feelings is associated with being a father. The phrase "obviously" is

considered to be Ted's way of creating a shared understanding of his view. It is interpreted that he assumes an unspoken rule that he as a father, does not show his vulnerable self. However, in the same sentence he appears to contradict this opinion by stating a need to be open, and "especially with this situation", reiterating the impact of psychosis. It could be that Ted is reflecting back on how he was and how he is now, realising that there are times when being more open is necessary. Thus, he would have typically held back his emotions before BFT, but has since discovered that it's better to be open. It is suggested that Ted identified benefits from talking in BFT, and as a result has started to open up more.

The extracts in this section strengthen previous interpretations that the experience of BFT for fathers was a new and strange process. It is argued that unfamiliarity led to confusion for some fathers, articulated in a sense of losing control or vulnerability in respect of revealing emotions. Finally, there seemed to be an association between being a father, head of the family, and restricting emotion. For each of them having the experience of BFT was destabilising and was perceived to challenge or weaken their identity as a father.

Fear of Self-Exposure

This sub-theme captures fathers' fear of expressing emotions and genuine distress in front of their families. Some fathers exhibited thoughts and attitudes indicative of self-preservation (e.g. protection from harm). There is an underlying sense or expectation that through exposing

their vulnerable selves, they will be found wanting and this is an

undesirable place to be, as a man or a father. This theme filtered heavily

through Jack's interview:

"Hmmm, right we are going to do this role play, how much of how I

really feel am I prepared to let out, you know and it's a negotiation..."

(Lines 69-71)

As mentioned, BFT places emphasis on communication where

families are asked to express a range of feelings towards each other in a

number of role-play exercises. It could be interpreted that Jack found these

exercises intimidating. There is an element of cautiousness expressed as he

recalls contemplating how honest he wanted to be about his feelings. He

seemingly reverts back to business language when referring to the role

play process as "a negotiation". It could be interpreted that Jack

participated in role play as a necessary compromise. A later response

supports the perception of Jack's need to be cautious in situations that

involve revealing feelings:

"I would rather be measured and walking into a situation where I

have got to reveal myself because everything in my life would lead me to

make sure I never put myself in that position, you know." (Lines 87-90)

This extract suggests that Jack's customary stance is one of

emotional control. It is intimated that self-disclosure represents unsafe

territory. The expression, "I never put myself in that position" is indicative

of a strong and purposeful resistance to reveal the true self. Jack asserts himself with the phrase "you know", which suggests an unspoken understanding of his frame of mind. His language also represents absoluteness about "never" revealing his vulnerable side, which might suggest that Jack felt uncomfortable with his emotions being exposed. One of Ted's comments was also interpreted as feeling confused about his role in BFT, whilst alluding to a need to protect himself:

"Um, I think the man's always, because he's the head of the household again tend to put the barriers up a little bit." (Lines 192-193)

Again, Ted refers to the man's role in the family as "head of the household" in which there is an associated need to restrict emotion – and could be interpreted as a defence mechanism. Ted's use of the word "barriers" could indicate a need to restrict his emotional self or a fear of revealing his vulnerable self. It is interesting that Ted speaks in general terms referring to the "man's" position as opposed to "my" position which is very suggestive of a social norm of fathering. This interpretation is supported later when Ted later links his guarded position to societal male role models:

"You don't expect a man to cry out, it's not the done thing in society is it?" (Line 209)

It could be intimated that for Ted, expressing emotions is associated with a perceived failure which is in conflict with his internalised ideas of

masculinity. Consequently, the situational demand of revealing emotions did not lie comfortably with him. His use of questioning could be his way of checking out with the researcher, if emotional inexpressiveness is considered to be socially normal for the male gender.   However, it is difficult to interpret whether he is seeking affirmation or disagreement in his comment. An underlying fear of feeling exposed is comparably conveyed by James who discovered that BFT was not what he expected:

"You're expecting trick questions and things like that and what's the word, trying to catch you out and things but it's not." (Lines 389-380)

It seems striking that James uses the phrase "trick questions" which could imply that he thought BFT involved some ploy to trap him. Parents can often feel responsible when their child develops mental health difficulties. Therefore, it could be interpreted that James anticipated the process of BFT to target blame for their daughter's problems. It is interesting that he subsequently indicates that it did not apportion blame, suggesting a discrepancy between what he expected from BFT and what he experienced. In other parts of his interview James mentions a concern that he and his wife may have been too strict with their daughter. Perhaps James perceived his daughter's difficulties as a negative reflection of his parenting, and therefore feared reprisal in therapy.

A common thread runs through fathers' presuppositions about the process of therapy exposing difficult emotions. There appeared to be an underlying anxiety exhibited by fathers that therapy would be emotionally

challenging or involve something unpleasant. An overarching message

pervading through the accounts is one in which therapy represents a threat

to self. On another level, fathers seemingly question their gender identity

and masculinity at the prospect of therapy. An element of surprise was

also apparent in discovering that BFT did not turn out to be what was

expected. It might be argued that this revelation led fathers to form

positive views of BFT.

Fathers' Positive Views of BFT

As fathers became involved in the process of family therapy, they

observed various benefits from taking part. It seems that once fathers

became acquainted with the process of BFT they considered it a helpful

and valuable intervention. Positive views across the participant accounts

created three sub-themes entitled: BFT having a positive impact,

facilitating openness and honesty, and building a therapeutic relationship.

What is striking across these themes is how participants' views of therapy

changed as a consequence of having BFT. It appears that these fathers

learned that there are benefits or rewards from taking part in this process.

BFT having a Positive Impact

Towards the end of their interviews fathers disclosed an array

of positive opinions relating to BFT. For some fathers, this related to

understanding their child and families better, and learning more about psychosis. Whilst for others, advantages of BFT related to a warm, welcoming therapist style and learning better ways to communicate. Frank expressed the surprise he felt in acknowledging the benefits of BFT:

"Indebted to them really for receiving that therapy because um, you, it's kind of, it seems a bit crazy in the beginning. They leave you with pieces of paper and once you start to actually work on them you find they actually work, which is you know quite surprising." (Lines 41-44)

Frank's use of phrase "indebted" is notable as he emphasises his gratitude for having therapy. This expression conjures up an image of an anxious father who is deeply grateful for the help received at a time of chaos and confusion. It is interesting that Frank reports surprise as he reflects on the effectiveness of the skills he learned in BFT. It could be inferred that Frank was doubtful BFT would make a difference. This is consistent with one of his previous comments when wondering if there was any hope for his son and supports the notion of fathers' sense of helplessness reported earlier. Frank alludes that his initial experience of BFT was "crazy", implying that he perceived the exercises to be peculiar and was unconvinced about their effectiveness. Perhaps Frank was initially unimpressed with the tasks which could be a reflection of the hopelessness Frank felt in regard to his son's illness. Ted also describes BFT as "good" whilst considering the stigma attached to therapy:

"I think it's good but as I say there's this stigma attached to it and I think if a lot of people can get over that stigma and just, um, you know, they could be helped rather than not receive the help that perhaps they need." (Lines 346-349)

It is interpreted that Ted felt a sense of shame associated with therapy. Although he projects this shame onto others, it could be intimated that Ted was embarrassed by the notion of family therapy. Alternatively, it might be argued that Ted was initially unaccepting of therapy which he overcame, and now feels that others should too. It is suggested that the positive effects of BFT and having the opportunity to vent his thoughts overpowered Ted's early apprehensions of therapy. Consequently, it is interpreted that Ted appreciated BFT, which he has since reflected on as a purposeful intervention. This interpretation is supported in another extract as Ted refers to how BFT improved communication in the family:

"...the counselling really brought us out in different ways, we were able to express ourselves better. I think it really helped." (Lines 237-239)

The use of "really" conveys a truthful and authentic opinion, that for Ted BFT allowed the family to communicate more effectively. It is inferred from the notion of being "brought…out in different ways" that BFT facilitated a new way of communicating or relating for Ted and his family. It is also suggested that Ted felt BFT enabled the family to express their feelings in an open and honest way. Given Ted's earlier comments about needing help, it is conjectured that BFT provided the type of support

he wanted, and he was grateful for the experience. Similarly, Jack refers to noticing the benefit of BFT once he began to relax:

"I can see the benefit of it and, you know as it's gone on and I've relaxed a bit and decided okay, it's not going quite as deep as I thought and it's moved off into an area where I am actually relatively comfortable as to those dark recesses that we all have where you don't want to go, you know, that we've done it and we had fun." (Lines 131-135)

It is conjectured that Jack anticipated BFT to be an uncomfortable process. Despite his apprehension of therapy he describes feeling comforted by the reality of it. It is interpreted that Jack began to relax in the sessions once he was reassured that he was not going to be analysed in psychological depth. It could be argued that Jack was fearful of BFT exposing his vulnerable self, and a sense of relief came with realisation that it did not delve that "deep". A similar discrepancy detected in James's transcript is also noted between Jack's preconceptions of what BFT involved, and his experience of it. Jack's fear of self-exposure is considered to link in with feelings of guilt depicted later in his narrative. In terms of BFT's positive impact it is further inferred that Jack experienced a sense of achievement for taking part. Thus, Jack enjoyed the process and was pleased with the outcome, partly because he was not required to show unwanted parts of himself.

The quotations and interpretations above indicate that once in therapy, fathers acknowledged benefits of it. It would seem that having

their views heard within a containing environment, where they could ask questions and express frustrations, was an aspect of BFT that was particularly useful. In a similar vein, fathers seemed pleased that having BFT facilitated openness and honesty between family members enabling them to speak out. The commonalities between fathers' views of therapy aiding open and honest discussions are now illustrated.

Facilitating Openness and Honesty

As fathers talked about their experience and perceptions of BFT they appeared to recognise how the structure of family work brought families together, encouraging them to talk lucidly and sincerely. There was an overall appreciation of BFT, in that it encompassed an open forum to vent thoughts and feelings that they might not have communicated otherwise. For example, Jack states how it was good that family work involved everybody:

"I think it was very good, I think it is a useful tool because it's the very first time we all get involved. It's the very first time that the five of us, you know actually sit in a room and talk." (Lines 645-647)

It is interesting that Jack refers to BFT as "a useful tool" implying that BFT was perceived to fix their problems. It is interpreted that like a tool, family work could make life easier. Jack's reiteration that BFT provided the first opportunity for the family to be together implies that he felt this was monumental and a positive step forwards. It could be inferred

that the family found it difficult to talk together before they were given a platform to do so. Jack appears to acknowledge this as a significant benefit of BFT. Thus, it is intimated that Jack experienced a sense of acceptance from the therapists in which he was able to be congruent and sincere about his thoughts and feelings. Ted also comments on how BFT was useful for the family to communicate feelings. He refers to how BFT was good in facilitating honest conversations:

"...they would talk through strategies...ways to deal with things and, you know, say that you're not happy with this, and how to do that which was very useful...um, yeah so it was good." (Lines 78-81)

Ted notes how BFT provided him and his family with coping mechanisms, allowing them to express positive and negative feelings. It is inferred that for Ted, the format of BFT provided an opportunity for him, and his family to convey their thoughts and experiences in a helpful manner. Moreover, the fact that he draws attention to the usefulness of being able to express difficult feelings could indicate that Ted found this aspect of BFT refreshing. Consequently, it is interpreted that BFT may have helped Ted and his family to cope with confrontational situations in the home. In reflecting further, Ted describes how it was advantageous for other family members to hear him open up:

"Yeah, I think for me as being the dad, or the head of the house it was probably quite, it was good for the others to see me on probably a

different side and perhaps opening up, whereas perhaps I wouldn't

normally have done that."(Lines 255-258)

Ted reiterates the benefit of expressing himself in the presence of his family, whilst recognising this was not the norm for him. Ted draws a comparison between dad and "head of the house" as he implies that the family are not used to seeing him opening up. The phrase, "head of house" could be interpreted as setting an example of leadership for the family to follow. Consequently, it could be suggested that Ted was unacquainted with showing his feelings because it was not a manly or fatherly thing to do, but has since learned benefits of doing so. This interpretation ties in with an earlier comment Ted made about taking himself upstairs, away from the family to cry. Perhaps BFT enabled Ted to normalise his emotions with his family and show that he too has a vulnerable side. Furthermore, it could be inferred that Ted was accustomed to hiding his true feelings for fear of looking weak, but within the process of BFT was able to embrace a new way of being. Comparably, Paul refers to BFT helping his son to talk more openly about his experience of psychosis, making it more real:

"It made it more real in a sense, erm, because he was able to talk

about things perhaps more, well he did talk about things more in the

sessions than he would have done otherwise." (Lines 147-149)

Paul describes the sessions being useful in allowing his son to express what it was like to have psychosis. It would appear that Paul's son

had not been able to do this with his parents previously. It is interesting that his son's openness made it "more real". Perhaps Paul had not really acknowledged the reality of his son's difficulties until BFT began. Therefore, it could be argued that BFT brought the family together and Paul became more involved in his son's care. It could also be interpreted that Paul felt he got to know his son better through the process of BFT. It is conceivable that Paul had lost sight of who his son was behind the mask of psychosis, and he was therefore grateful to discover more about him.

The quotations above suggest that after the initial discomfort of being in therapy, fathers found BFT helpful. Many fathers' accounts indicate that they were somehow permitted to show their emotional side in BFT. This theme also highlights that some fathers assume a gender identity that purports the man of the family to be the leader, or the strong one that conceals emotional disarray. What is most evident from this section is that fathers found the process of talking more freely in a transparent manner valuable.

Building a Therapeutic Relationship

Building a therapeutic relationship is significant to most if not all modes of therapy. It is considered the means in which the therapist builds rapport and forms a collaborative bond with their client (Gilbert & Leahy, 2007). A strong therapeutic relationship enables the client(s) to feel safe with the therapist. In the current study fathers made reference to a number of these features being present in their experience of BFT. Within

this frame of reference warm qualities of the therapist(s), feeling comfortable or relaxed in the sessions and a non-judgemental attitude were identified. For example, Frank comments on the match of therapists:

"...they were the right people for me to work with and definitely for [name of son] *as well."* (Lines 914-915)

It could be gleaned from Frank's expression here that the therapists facilitated an empathic connection enabling him to feel comfortable in BFT. His reference to the "right people" portrays a strong therapeutic relationship, providing comfort for Frank to disclose his thoughts and feelings during a traumatic time. He emphasises his point with the use of "definitely" indicating that his view is not questionable. It could be intimated that for Frank there was a distinguishing safeness felt with the therapists, which may have helped to dispel his initial hopelessness regarding what BFT could achieve.

Comparably, Jack comments on the non-judgemental attitudes of the therapists:

"...they are not critical, they are not judgemental. Anything you say they will only encourage you to discuss it more and not at all judgemental in anything you might say." (Lines 331-333)

It is interpreted that Jack anticipated the therapists would be critical of him, or would assess him in some way. It is also intimated from Jack's emphasis regarding the therapists' ability to remain non-judgemental that

he was given supportive warm encouragement to describe his internal turmoil at this time. Furthermore, he indicates that he was given an opportunity to elaborate on his perspective of things, which may not have been what he had envisaged in therapy. It could be interpreted that Jack had a specific view of what therapy might feel like and he was proven wrong in his experience of BFT. He appears to demonstrate feeling accepted and trusted by the therapists, which empowered him to talk openly. Similarly, Ted reflects on the significance of feeling at ease with the therapists:

"I just think the friendliness and you felt comfortable with them really. That was what was good." (Lines 151-153)

Ted felt comforted by the therapists' sense of approachability which may have authorised him to talk openly in BFT. Consequently, it could be suggested that Ted was reassured by the therapists' style of working, and their sensitivity to his distress. It would appear that for Ted, the therapist style was important to him, contributing to a strong therapeutic alliance and a positive experience of BFT. Perhaps he felt a closeness or affiliation with the therapists, which was pivotal at a time of confusion. The therapists' approach was encapsulated as respectful by James:

"I just believe that the people who are doing it, do a very good job and are respectful of people's concerns and they take things on board." (Lines 411-412).

James is perceived to communicate an authentic appreciation for the therapist's work in BFT. Similar to Ted, it would seem that James experienced a trusting and respectful bond in which he and his family could explore difficult issues. Furthermore, this extract suggests that James felt the therapists expressed empathic understanding and were willing to be guided by the family's needs.

The extracts in this section suggest that feeling comfortable with the therapists helped fathers to open up. Furthermore, this theme illustrates that fathers found BFT to be a warm and friendly experience, in which the therapists were accommodating. It is interpreted that fathers felt listened to, and felt they could talk openly with their BFT workers.

Discussion

Analysis of the data found three main themes and nine subordinate themes, extending from fathers' ambivalence through to positive interpretations of being involved in family therapy. Although all themes provide information in relation to understanding fathers' experience of BFT, it is apparent that there are varying degrees of relevance to the research aims. This is not necessarily surprising when considering the philosophy and objectives of IPA. Allowing participants to converse freely about their experiences in a non-influencing manner resulted in some fathers straying from the subject area in their interviews. This finding highlights how fathers were able to discuss issues that the researcher may not have anticipated, emphasising the explorative nature of IPA. In addition, some fathers talked more freely and for longer than others, potentially reflecting their personality or how at ease they felt during the interview. This section discusses the themes in relation to the objectives of the research and existing literature, before examining the implications for general clinical practice and more specifically for counselling psychology. Limitations of this study and suggestions for future research are considered before a final reflexive statement, depicting the researcher's reflections on carrying out this research.

Summary of Findings in Relation to Existing Research

Exploration of fathers' experiences of BFT revealed underlying patterns and commonalities in how fathers perceived BFT. The findings revealed that all fathers participated in BFT as a result of their child experiencing an episode of psychosis. Fathers' quotations demonstrate that fathers needed support during this experience and the help offered via BFT was generally beneficial. They described feeling uncertain about what BFT involved, with the majority being willing to try it, following recommendations from EIS professionals. An underlying ambivalence was portrayed by most fathers representing a range of emotions where fathers felt positive and negative about the prospect of BFT. Perceptions about BFT represented a theme of confusion regarding their role, and a fear of their feelings being exposed in BFT. Later themes suggested that BFT had positive impact. Most fathers recalled that BFT produced helpful and useful ways of thinking about communication. The following sections discuss the identified themes in relation to existing research, whilst paying attention to counselling psychology philosophy.

Fathers' Reflections Prior to BFT

Fathers conveyed a range of reflections concerning how they came to have BFT, and this theme captures how fathers felt about the prospect of taking part. In the early stages of the interviews, fathers recalled the anguish felt when their son or daughter became unwell, portraying a theme of trauma. The development of mental health difficulties in a family

member is often traumatic for all those involved. Families can often feel isolated, worried and helpless, not knowing where to turn, or how to begin talking about it (Fadden & Smith, 2009; Gregory, 2009). Reflections relating to fear, confusion and hopelessness were evident for most fathers. The trauma of psychosis was prevalent across cases, and was one factor associated with fathers' choice to participate in BFT. The distress caused by psychosis for fathers in this study is consistent with research by Martens and Addington (2001) who found having a family member with schizophrenia has a significant detrimental impact on other family members.

The anguish conveyed by fathers in the current study corroborates the main rationale for delivering BFT, to support families in distress (Fadden, 1998; 2009; Fadden and Smith, 2009). Researchers have noted how distress is higher amongst newer carers (Gibbons, Horn, Powell & Gibbons,1984) as is the case with fathers in this study. Fadden and Smith denote the importance of family support in the early stages of psychosis, especially when many young people are still living at home during the age of onset for psychosis. All but one father lived with their child in the current study. It is apparent from fathers' quotations that the systemic experience of psychosis was upsetting, and their abilities to cope were compromised. Previous carer distress has been associated with impaired interpersonal functioning, social withdrawal, and challenging behaviour (Tennakoon et al., 2000) as identified by fathers in the current research.

Ginkell and Conway, (2010) note that a person's psychotic behaviour is often considered unpredictable to others. This theory is interesting in light of fathers referring to the changeable nature of their child's illness. Moreover, for some fathers, psychosis was experienced as a grave and potentially dangerous mental health difficulty. Fathers revealed personal difficulties in understanding and coping with their child's symptoms. It is evident from this research that it is difficult for carers to stay calm, when living with someone who is experiencing acute mental health difficulties (Benzies, Butcher & Linton, 2009). Fathers' struggle with coming to terms with psychosis supports much previous research, advocating a need to assist families in early psychosis (Fadden & Smith, 2009: Lobban & Barrowclough, 2009).

The subordinate theme of needing help was encompassed in fathers' explanations for participating in BFT. For example, some fathers expressed how they needed somebody to talk to, whilst others referred to their willingness to do anything to help. These findings convey a transparent message about fathers' need for support in the face of mental health problems. The notion of needing help is depicted by Gregory (2009) writing as a father about the significance of his BFT experience. Gregory details how he had very little support as a parent prior to BFT. Similar findings were found in the current study, as the majority of fathers conveyed their need for support and validation in terms of finding the truth in what they thought and felt in relation to their child being unwell. The

idea that parents feel alone and isolated when caring for a child with

mental health difficulties is certainly not a new finding. Research

exploring the impact of caring has identified that living with someone who

has mental health difficulties can feel like a very lonely journey (Benzies,

Butcher & Linton, 2009). Ideally, this is where carer assessments, group

interventions, carer buddy systems and carer support agencies (e.g.

Rethink) come into play. However, as identified in fathers' accounts, there

is often an associated stigma with accepting these type of interventions.

The interpretation of fathers needing help also relates to research

acknowledging the therapeutic benefits of validation and emotional

support (e.g. Gilbert & Leahy, 2007). Thus, many fathers appeared to seek

emotional understanding regarding their distress, which was particularly

important for those who felt isolated and excluded prior to the process of

BFT. For example, both Jack and Frank's narratives demonstrated how

they had felt very alone prior to receiving family work. Whilst not

specifically focusing on fathers, Fadden and Smith (2009) stress the

necessity of family work in the wake of a family member developing

psychosis. Correspondingly, fathers' accounts of needing support were

expressed in the context of understanding psychosis, the unpredictable

nature of it, and not knowing how to manage the symptoms.

These factors correlate with the necessity for families to receive

psycho-education as argued in previous research (Bustilla, Lauriello,

Horan & Keith, 2001; Pilling et al., 2002) and stipulated in NICE guidance

for schizophrenia (NICE, 2009). Fathers needing help is significant from two perspectives: firstly, in terms of existing provisions to support families in the early stages of psychosis, and secondly the benefits of offering support to fathers on an individual basis, enabling them to explore their unique experiences of having a child with psychosis. For example, three fathers acknowledged the value of having one-to-one support, which appeared important in facilitating exploration of their subjective experiences. This finding resonates with research suggesting that brief, targeted, individualised interventions are equally as important, if not more effective, as family therapy when supporting carers in the early onset of psychosis (White, 2002). More generally, the finding that fathers who needed help participated in BFT can tentatively be aligned with previous research showing that family members are more likely to engage in family interventions if they perceive themselves to be in crisis (McCreadie et al., 1991).

The third sub-theme of entering the unknown was drawn out of fathers' uncertainty about what BFT involved in advance of participating. Many fathers referred to BFT as a novel process. Others referred to therapy as an intervention that had never been anticipated in individual or family life. Most fathers had never heard of BFT, and were unaware of the process. Two fathers in the current study admitted to not knowing what to expect from BFT, whilst the remaining fathers described anticipation about beginning therapy. This finding is interesting in the light of previous

research looking at men who had experienced counselling (Millar, 2003).

Millar identified a theme regarding men's perceived lack of knowledge of

counselling protocols. The prospect of BFT being an unknown entity could

be associated with fathers' reluctance to engage in it.

Participants in Millar's (2003) study reported that having more

knowledge about therapy, prior to the first session would have been

helpful in alleviating their anxieties about it. Millar concedes that a fear of

not knowing can be associated with a lack of control for men. Although

ambivalence was not overtly connected with a lack of control in the

present study, the apprehension associated with entering the unknown is an

important finding worth considering with fathers in BFT. By having a

greater awareness of the challenges fathers face, practitioners may begin to

understand fathers' reluctance to take part. Furthermore, recommendations

from Millar's research including publicity of the availability of therapy for

men could be transferable to BFT work with fathers. Transparency in

terms of the BFT process could be a helpful way to engage fathers.

Fathers' Reluctance about BFT

This theme is particularly relevant to the rationale for undertaking

this study, that is, from delivering BFT over several years the researcher

identified a pattern of fathers' reluctance to engage in the process. Most

participants communicated their initial hesitancy about BFT and conveyed

anxieties about being in therapy. This finding is consistent with previous

literature that men are ambivalent about seeking psychological help (Addis

& Mahalik, 2003; Hammer & Vogel, 2010; Millar, 2003; Rochlen, Whilde, & Hoyer, 2005). Thus, in considering the theme of ambivalence, it was interpreted that some fathers associated the need for therapy with an undesirable weakness. This finding is consistent with research exploring men's engagement with therapy (Noyes, 2007; Scher 1990; Wexler, 2009), and male help-seeking (Hammer & Vogel, 2010; O'Neil et al., 1986) where the idea of therapy evokes confusion and anxiety.

Men's discomfort with the notion of therapy has been debated (e.g. Addis & Mahalik, 2003; Kierski & Blazina, 2009). Moreover, fathers' ambivalence towards BFT is salient to existing research that men feel uneasy about having therapy (Pederson & Vogel, 2007). Fathers' indications that the decision to attend BFT involved encouragement from others, was also related to the theme of ambivalence. This finding corresponds with existing literature postulating that men enter therapy because they are persuaded to do so (Noyes, 2007: Wexler, 2009), yet it was also noted that fathers felt at ease once in therapy and acquainted with the process. This was most evident in Jack's account, especially when he acknowledged that BFT was not as bad as he imagined it to be. Wexler postulates that men feel more comfortable with the actual experience of therapy than anticipation of it, because their preconceived ideas of therapy are often challenged and reframed within the process of the therapeutic alliance. Therefore, it may follow that if there is more transparency about what to expect in BFT, fathers' anxieties about it could be reduced.

Consequently, the process of engaging fathers could be enhanced if they are encouraged to voice their fears.

Ambivalence about BFT was also connected to the stigma of having therapy. This finding echoes the work of Vogel, Wade and Hackler, (2007) who argue that stigma is often internalised by men in relation to mental health difficulties, and help-seeking. However it seems the impact of stigma can be considered on varying levels. On one level fathers may feel stigmatised by the recognition that their child has experienced mental health difficulties. On another level the notion of being in therapy can also lead fathers to feel stigmatised. Vogel et al. consider the ways in which men internalise negative views of society in what they refer to as "self-stigma". Vogel and colleagues (2011) argue that paying attention to self-stigma may be an effective way to develop male attitudes in their use of psychological services. They further highlight the importance of therapists being flexible to acknowledge that different people have different needs. Working with fathers' ambivalence in BFT is one way of attending to subjectivity as rooted in counselling psychology theory (DCoP, 2005).

A theme of confusion concerning what role to adopt in BFT was interpreted from fathers' accounts, which is directly related to the second research question. Traditionally, males have been discouraged from expressing intimate and sensitive emotions, yet in modern Western society there is an expectation that men are more prepared to show their vulnerable side (Levant, 1995). According to Levant, this creates "an

unnerving sense of uncertainty about what it means to be a man" (p.230),

which is interesting in light of the present findings, where fathers

described a sense of uncertainty of how to be in BFT. This was particularly

evident in three of the fathers' narratives, in achieving the right balance

between being a father figure, and a carer with personal needs in BFT.

This finding loosely aligns with the work of Roy, Gourde and Couto

(2011) who suggest that traditional norms can negatively influence male

engagement in therapy. Moreover, the confusion felt by fathers in respect

of how much to reveal of their emotional self, may have inhibited their

ability to meaningfully engage in BFT. Thus, despite the time span

between Levant's work and recent literature (inclusive of this study),

research continues to demonstrate a theme of men's undesirability to show

emotions in therapeutic processes.

Furthermore, some fathers assumed their position as the "bread-

winner" or "head of the family", which is relevant to what Chodorow

(1989) considered to be ingrained in British culture. In considering their

role in BFT, most fathers found it challenging not to adopt their customary

positions in BFT (e.g. a desire to take the lead as they would in their

professional roles). Similarly, some fathers conceded that their wives

generally deal with the majority of child-care issues. This raises a fruitful

opportunity for clinicians to consider fathers' everyday roles and how they

may affect their engagement in the BFT process, and therapy more

generally. Thus, it presents issues around potential transferences that may

arise in the therapeutic work and how they may use the therapist.

Comparably, the premise that some fathers felt alone in their distress, yet unsure how to express their isolation, is a point for consideration. Furthermore, in the light of the findings from this study, BFT workers could give more thought to talking with fathers about how family work may be challenging.

Although no known research explicitly explores how fathers' everyday responsibilities emulate their roles in family work, various literature considers the relevance of understanding clients in their systemic or relational context (e.g. Alilovic & Yassine, 2010; Bor, Legg ,& Scher, 2003). This focus has bearing on an approach discussed by Kagan, Tindall and Robinson (2010) as "community counselling psychology". Kagan et al. stress "the social justice agenda characteristic" (p. 484) which is considered relevant to the findings of the research and working with fathers in community settings. They contemplate the significance of working with those, who are relegated as a victim of their social circumstances, which is arguably connected to the stigma fathers in the current study associated with having BFT. Community psychology highlights the limitations of individual work (Thatcher & Manktelow, 2007) and anticipates system change as a factor that can be zealously applied within the practice of counselling psychologists. Moreover, Lee (2007) refers to promoting parity to clients who are socially excluded through mental health difficulties and numerous other factors. The underpinning of this theory could be applied to working in the community with fathers (e.g. in EIS). With regard to BFT, if therapists develop a

greater understanding of fathers' social context, it could enhance the therapeutic alliance before, and during therapy. Ways in which this recommendation could be implemented are discussed in the application of findings section.

The fear of self-exposure primarily related to fathers' concerns about being emotional in front of others, and trepidation was exhibited in fathers' expressions of "being on guard" and "putting up barriers". This theme resembles the GRC construct of restrictive emotionality detailing fears of expressing feelings (O'Neil, 1981: O'Neil et al., 1986). Similarly, Levant (1997) refers to a "crisis of masculinity" in which men are previously expected to avoid showing an emotional side, also known as the fear of femininity (O'Neil et al., 1986). Levant alludes to this being a consequence of generation differences, in which men in western society are raised to be like their fathers who set a precedence to be a provider, and emotionally strong. Levant notes how upholding a stoical stance can lead to unresolved inner conflict and anxiety. Internal conflict was common across participant accounts in an identified need to be helped, with concurrent ambivalence towards BFT.

Fathers' fear of feeling exposed in BFT was also associated with some fathers' tendency to assume therapy was for people in crisis, which is paradoxical in the light of the interpretation that having a child with psychosis was traumatic. Nevertheless, this finding highlights the need to raise awareness amongst fathers that BFT is a very applicable intervention

to stable and functioning people. In terms of engaging fathers, the concept

of working with resistance is considered here, which aligns with the

principles of motivational interviewing (MI), (Miller & Rollnick, 2002).

This approach assumes that most clients seeking psychological help are

ambivalent about change, and motivation fluctuates through the course of

therapy (Arkowitz & Miller, 2008). MI is a directive method with a client-

centred underpinning that has been strongly influenced by the work of Carl

Rogers (1951;1959). Its attention to the internal world of a client, in

collaboratively working towards growth and change mirror the values of

counselling psychology (DCoP, 2005). The idea of applying MI with

fathers is later considered amid the recommendations for clinical practice.

Fathers Positive Views of BFT

There was general consensus amongst fathers that BFT was useful in

covering the impact of psychosis on relations and family life. It was also

considered valuable in respect of facilitating honest and reflective

discussions. Fathers appeared appreciative of building a therapeutic

relationship in the process of BFT. Many fathers reported positive aspects

of BFT including the friendly manner it was delivered in; warmth

conveyed by the therapists; the effectiveness of the communication tasks

and systemic openness generated through the process. Fathers'

impressions that BFT facilitated open communication within the family

are consistent with a fundamental purpose of BFT (Fadden & Smith,

2009).

Additionally, it was interpreted that fathers felt there was a valuable

containing capacity of BFT, which enabled them to express difficult

feelings. This was particularly true for Frank and Jack both of whom

declared the detrimental bearing their son's experience of psychosis, had

on their relationships with them. Within this superordinate theme, fathers

alluded to their appreciation of the therapeutic alliance in BFT. For some,

this was the only containing relationship they had experienced to vent their

despair and helplessness, about having a son or daughter with psychosis.

Fathers' perception of a strong therapeutic relationship is indisputably a

central finding to disseminate within the wider system of those delivering

BFT. The significance of building therapeutic relationships with men

resonates with the work of Good, Thomson and Brathwaite, (2005) who

note that particular attention is needed when forming therapeutic alliances

with men. They argue that a key aspect of this involves understanding men

in the context of traditional masculinity, and accepting how different this

context is to the underlying philosophy of therapy. They further postulate

that if acceptance is achieved, therapists can learn to be more empathic

towards the struggle men encounter in the idea of entering therapy.

Application of Findings in Relation to BFT

The theme of "needing help" is central to the way NHS practitioners can support fathers in caring for a child experiencing psychosis for the first time. According to the Early Psychosis Declaration (WHO & IEPA, 2004), promoting recovery in early psychosis involves listening and learning from families. This declaration states that prompt and effective interventions should include work with families which in turn represent "an element of respect of individuals' rights to citizenship and social inclusion" (p.1). Furthermore, it is specified that families have access to psycho-education, alongside emotional and practical interventions to promote recovery in psychosis. The principles of BFT and the findings from this research are congruent with these stipulations. Thus, participants' accounts unquestionably verify the need to support family members to help them feel valued in caring for their children.

In further considering carer support, the current findings demonstrate that many fathers were grateful for having the one-to-one interview experience of this research. Moreover, one father stated that it was the first time anybody had given him a platform to talk. It would be beneficial for practitioners to focus more readily on their initial BFT interviews with fathers, and to proactively offer them carer assessments. Both interventions could offer fathers dedicated time to talk, and provide an opportunity for fathers to receive psycho-education regarding mental health difficulties. MDT development meetings could facilitate discussion

where clinicians might think about strategies to engage fathers in these
interventions.

In light of fathers' reluctance prior to BFT being related to entering
an unknown phenomenon, consideration could be given to an orientation
session with families prior to BFT beginning. Whilst it could be argued
that this is one purpose of individual interviews that take place in advance
of BFT, it was apparent from participant accounts that many fathers
seemed unsure about what to expect from BFT, creating some
ambivalence about the process. Consequently, a single orientation session
with families prior to these interviews would allow fathers (and other
family members) to gain partial experience of what being in BFT feels like
and hopefully offer them the opportunity to ask questions about BFT
without committing to the process. Similarly, as it is difficult to ascertain
the exact manner in which BFT was introduced to fathers before they took
part, it could be suggested that a protocol is developed to provide unity in
the way practitioners explain the rationale for BFT. It is impossible to
know how much time is spent with families doing this, and to what extent
practitioners address reluctance.

The discovery that fathers collaborated with other family members
and/or professionals in their decision to partake in family work, is
pertinent to the premise of BFT to provide support to the whole family and
not simply the client. In light of this, perhaps additional knowledge could
be provided to families and fathers in particular, to provide more clarity

regarding the rationale for BFT. This could be achieved by revising the literature given to families about BFT, to further emphasise that BFT is aimed towards the entire family regardless of their role in the family. Additionally, community teams delivering BFT could encourage fathers who have been involved in BFT, to provide written or oral testimonials about their experience of it, as an educational and normalising process.

A further implication for BFT work is associated with fathers' apprehension for entering BFT as an unknown entity, yet reporting a sense of ease once in therapy. This finding is consistent with existing research noting that this is often the case when working with male clients (Wexler, 2009). Indeed when men are engaged in therapy it becomes easier to work collaboratively with them to ascertain what would be helpful in the therapeutic work (Good, Thomson, & Braithwaite, 2005). Therefore, a single orientation intervention offered to fathers prior to BFT, would expose them to the feeling of being in therapy, where more detailed knowledge of the process could be provided so any sense of entering the unknown is reduced. On the other hand, there will always be an element of unknown in therapy and perhaps this can be a valuable experience to fathers. Thus, enabling or empowering fathers to tolerate uncertainty in BFT may ease pressures on them to always feel like they need to be in control. In addition, this form of intervention ties in with current NHS policy, to support carers in providing holistic mental health care packages.

Another clinical implication from this study relates to the stigma interpreted in fathers' accounts of BFT. In considering Hammer and Vogel's (2010) implementation of a male-sensitive brochure it could prove efficacious to design a similar leaflet for BFT. More generally, challenging the misconception of mental health difficulties and psychotherapy could be a small step towards engaging individuals who would like to seek help, but are hesitant due to public perception. In accordance with the client-centred underpinning of counselling psychology and EIS ethos, collaboration with fathers in designing this leaflet is recommended. It was encouraging that some fathers proposed that hearing from other fathers who had experienced BFT would be helpful. This suggestion could be endorsed by proactively working with fathers who have participated in BFT in disseminating information about it.

Difficulties encountered in engaging families have been previously considered (e.g. James, Cushway & Fadden, 2006). However, a profitable addition to this area could involve sharing the principles of community psychology in BFT training programmes. Social inclusion is instrumental to this approach and equally recognised as an important factor in the Early Psychosis Declaration (WHO & IEPA, 2004). Nevertheless, working with families can be a daunting step for practitioners, especially if minimal training in this area has been undertaken (Friedlander et al., 2006). Indeed, barriers exist in clinicians offering family interventions due to the anxiety created by the prospect of working with a dynamic system (Fadden, 2009).

Relevance of Findings to Counselling Psychology

Most fathers reported that they did not initially participate in BFT for their own personal gain. Yet despite ambivalence about entering BFT, the results indicate that BFT was perceived by fathers as a purposeful intervention. This finding somewhat aligns with a counselling psychology perspective, that an essential purpose of therapy is to enrich an individual's potential, irrespective of the problem they are in therapy for (Strawbridge & Woolfe, 2010). The overall findings from this study could help counselling psychologists to consider the beneficial nature of family interventions for fathers. This is particularly important given the challenges and opportunities for counselling psychologists to work with more than one member of a family (Friedlander et al., 2006). Whilst counselling psychology emphasises the importance of working with individuals from a relational stance, training courses differ in the depth of teaching provided in models of family therapy as well as the expectations for practical application of these approaches (Alilovic & Yassine, 2010). For example, it is not a mandatory course requirement for trainees to undertake a placement that specifically involves working with families. This is interesting given that NHS policies increasingly recommend family interventions, and at least half of the counselling psychology profession work in the NHS (James & Bellamy, 2010). Counselling psychology training programmes could incorporate a module in family interventions as

well as, encourage trainees to seek placements that would provide experience in delivering family work.

This latter point seems particularly important in respect of the research advocating that family work reduces both stress in the family home and relapse rates in people with psychosis (Fadden, 1998; 2009). Moreover, supporting carers (e.g. fathers) is firmly recommended within NICE guidance in relation to a number of mental health difficulties. Awareness of and responsiveness to NICE guidance is relevant for counselling psychologists in respect of adhering to evidence-based practice (Walsh & Frankland, 2009) and a scientist-practitioner model (Lane & Corrie, 2006). From another angle, it can also be argued that from exploring men's subjective experience within a phenomenological framework, it became apparent that they naturally face challenges about how their role is socially perceived. Counselling psychology can have a very valuable role in deconstructing societal pressures or social norms in therapy such that individuals are given more agency in choosing and constructing their own identity. The underpinning pluralistic stance of counselling psychology could pay attention to these aspects, in both understanding the individual's perceived societal expectations and how the individual experiences them. Part of the therapeutic process could incorporate how these facets can be negotiated fruitfully by the individual in developing their sense of self.

Limitations and Methodological Considerations

It was reported to the researcher during the recruitment stage that fathers who were perceived to lack interest in BFT, chose not to participate in this study. This is considered a limitation in that the sample population may have been biased in only providing views of fathers who on the whole found BFT helpful. Whilst speculative this is an interesting point to ponder, in respect of the variables (e.g. interpersonal style of the BFT therapist) that may have affected fathers' experiences of family work and subsequently influenced their decision to participate in this research. Thus, it is possible that fathers who found BFT to be a useful intervention were willing to talk about their experience of it, and fathers that found BFT unhelpful were not. Therefore, it would be of interest to investigate the experience of fathers who had been dissatisfied with their experience of BFT for comparison. Offering incentives (e.g. vouchers) might entice fathers to participate in such research.

It is also possible that participating fathers tempered their interview responses knowing the researcher was an EIS practitioner for fear of sounding critical towards the service. This point is particularly relevant to fathers whose children were still under the care of EIS during their interview, especially if they thought their feedback would affect their child's care in some way. Linked to the above, it is possible that participants may have felt uncomfortable talking about their BFT experience on NHS premises. An implication of this could be that fathers

were more reticent than they would have been, had the interviews taken

place with an independent researcher and in a venue distinct to the NHS.

On this note, it is also important to consider how the researcher's

experience of working with fathers in providing carer support and

delivering BFT could have influenced how the data was interpreted.

Despite the comprehensive reflexivity component to the study, the

experience of the researcher as an EIS practitioner will have shaped the

way participants' experiences were understood. In addition, the researcher

being female may have influenced the way fathers talked about their

experience of BFT particularly, if they felt uncomfortable airing their

views to a female. This point relates to GRC literature where fathers may

have felt embarrassed to voice their true feelings for fear of seemingly

being weak in doing so. Nevertheless, most fathers talked lucidly about

their thoughts, feelings, and perceptions towards BFT. In fact many

seemed to be grateful of the opportunity to talk and vent their views in an

open and uninterrupted way. This observation supports the proposal that

additional attention could be given to providing fathers with time and

space to talk about the impact of having a child with psychosis.

A final consideration relates to the method of analysis. As Willig

(2008) recommends, it is important to question how the research question

could have been investigated differently and how this could have produced

different understandings of the data. For example, a discursive approach,

with its concentration on the functional use of language, could have

provided extra information about power and the social actions performed by the participants within the interview. However, such approaches primarily focus on the dialogue between participant and researcher which may have negated the phenomenological experience of the individual as was important to the objectives of this study.

Suggestions for Future Research

The rationale for conducting this study was practice-led in investigating fathers' experience of BFT. This research provides qualitative information concerning fathers' perceptions of BFT, which in turn reveals that fathers felt ambivalent about participating. However, understanding fathers' experiences of BFT, does not offer insights into why fathers rebuff the concept of BFT. Accordingly, it would be of theoretical and clinical interest to gain views from fathers who decline BFT to consider their explanations for not partaking. However, careful consideration would need to be given to the way fathers are invited into this type of study as fathers who decline BFT may also eschew involvement in related research.

The opening question in the interview schedule asked fathers to reflect on how they came to have BFT, which resulted in them expressing their own needs for support. Fathers' identified need for help in early onset psychosis warrants further research, especially in light of the research specifying the importance of supporting families in order to promote recovery. To this end, and given the lack of research exploring fathers'

experiences of family interventions, it would be interesting to carry out a

mixed study to examine fathers' levels of distress in a parenting capacity.

Levels of distress could be measured through a quantitative measure,

subsequent to focus groups allowing for rich qualitative data to consider

fathers' lived experience. Research of this kind could be an empowering,

and validating process especially in terms of fathers sharing experiences.

In considering the literature promoting early intervention in

psychosis (Birchwood, Todd, & Jackson, 1998; McGorry & Jackson,

1999) it would be beneficial to talk with fathers in the early stages of their

child's difficulties to compare with the current findings and gather more

information about fathers' experience of this phenomenon. Thus, it is

possible that a study like this could pave the way for setting up a support

system for fathers who have already been acquainted through focus

groups. If fathers find the interview process positive in itself (as identified

in the current study), they may be open to engage in therapeutic

interventions. Testimonials advocating the helpfulness of talking could

encourage other fathers to participate in BFT as well as other therapeutic

interventions.

Reflexive Statement

This section considers how my views about the research topic area

have evolved through the process of carrying out this study, demonstrating

self-awareness, and acknowledging my reflective contributions (Willig,

2008). Monitoring how my presuppositions have influenced the process

has been invaluable. Keeping a reflexive journal alongside three years of personal therapy has helped me to reflect more objectively about the topic area. Etherington (2004) argues that when researchers apply a method that suits the objective of their research a "heuristic process of discovery [can occur, which] becomes a vehicle for growth and development" (p.110). I can relate to Etheringtons' theory in respect of my personal views towards fathers prior to, during and following my research journey. I refer the reader back to my first section of reflexivity, in which I discussed my experience of growing up with a father who at times appeared unapproachable because of an authoritarian manner. I further reflected on my father's difficulties in facing challenging aspects of emotional distress. This was particularly evident during my adolescent years when I experienced a sustained period of my own emotional anguish. Hearing the struggles encountered from other fathers in my research, has been a validating experience in respect of sympathising with my own father's tussle to understand my difficulties back then. Whilst I did not experience psychotic difficulties, I have grown increasingly aware and accepting (from talking with fathers), that my father found my emotional turmoil hard to comprehend. Subsequently, I feel more attuned to the sense of helplessness fathers conveyed in their desire to understand and help their children.

In thinking about the early stages of this thesis, I also recognise that my experience of being a daughter to a father who upheld traditional

masculinity concepts explained in GRC theory influenced my aptitude to critique this field of work. Much of the literature aligned with the male characteristics I grew up with, and I initially found myself acquiescing with theories of masculinity, which from an objective stance are deemed unhelpful in reifying male experiences of therapy. Reading the work of Lee (2008) during revisions of my literature review enabled me to develop a more critical outlook. Lee points out the theoretical gains of employing a shortlist of questions (e.g. why am I reading this?) when surveying the existing research in the topic area. Applying this shortlist helped me to consider the relevance of previous research to the objectives of my study.

With regard to the analytic process, gaining the appropriate balance between staying close to the narrative and delivering a high level interpretation for each account took many attempts. As a novel IPA researcher this was both frustrating because of time limitations, and rewarding in truly comprehending fathers' lived perspectives, regarding a phenomenon that is linked to my everyday practice in EIS. Thus, I am excited by the prospect of disseminating my findings, which I initially intend to present to my EIS colleagues, before cascading my study to the wider system of those practising BFT and subsequently through publications. It has been both an educational and emotional journey to complete this piece of work.

Finally, understanding fathers who are of a similar generation to my own father has helped me to grasp the difficulties fathers, and arguably

men more generally, have in sharing their vulnerable side especially with those whom they want to nurture and protect. On that note, and to end this section I have selected a quotation from the end of Jack's interview, which for me, was a powerful message that I will take away from this study:

Jack: *"I would like to put my hands up for fathers in need and say...we really do need some help"* (Lines, 619-620)

Conclusion

This study has achieved an important objective of counselling psychology research as considered by Cooper (2009) in providing a voice for participants who have experienced a particular phenomenon. Whilst based on a small sample, this research provides the lived experience of participants in accordance with IPA philosophy (Smith et al., 2009) and counselling psychology principles in paying attention to subjectivity and intersubjectivity (DCoP, 2005). The findings from this study represent new information about how fathers perceive and experience BFT. Broadening the knowledge in this field will hopefully assist NHS professionals in tailoring BFT interventions with fathers, and more generally when working with men. Interpretations of fathers' ambivalence towards BFT are enlightening in view of the observation that fathers exhibit a hesitant stance towards this type of family therapy. From a counselling psychology perspective, this study has incorporated a reflective practitioner stance in exploring personal assumptions to the area of fathers and family therapy. It has also discussed how the therapeutic relationship could aid the challenges faced by practitioners when attempting to engage with fathers' reticence to participate in BFT.

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Appendices

Appendix 1 – Recruitment Letter and Information Sheet

Recruitment Letter and Participant Information Sheet

<u>**Title of research**</u>: Exploring Fathers' Experiences of Behavioural Family Therapy.

<u>**Name of researcher**</u>: Kerri Lees

Date: 12th June 2012

To whom it may concern,

I am a trainee Counselling Psychologist at London Metropolitan University and am currently carrying out (Doctoral) research to discover some information about fathers' experiences of receiving Behavioural Family Therapy (BFT). This research is being supervised by Dr Anna Butcher at London Metropolitan University (please see below for contact details should you have any questions pertaining to the validity of the study).

Before you decide whether you would like to take part, I would like you to understand why the research is being done and what it will involve. I (the researcher) will go through this information sheet with you whilst answering any questions you have. This will probably take about 10-20 minutes to go through. Part 1 of this sheet tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study. Please do ask me if anything is unclear.

Part 1

1.1 What is the purpose of the study?

The aim of this study is to gain a better understanding about fathers' experiences of BFT. In researching this field of work I have found out that very little is known about fathers' perceptions, thoughts and feelings on this type of family therapy and there is currently no known research that has looked specifically at fathers' experiences of having BFT. Although this research is part of a Doctoral project, the idea has

been stimulated by clinical work and carrying out BFT across a number of families, as part of my long-standing role in (name of service)

1.2 Why have I been invited?

As an NHS employee I am aware from your family workers that you have taken part in BFT and would really like to hear about your experience. You are being invited to take part in this research as a father who has experienced at least six sessions BFT within the last 15 months. There will be five other participants (i.e. fathers) in this study but each of you will be interviewed individually and in confidence.

1.3 Do I have to take part?

Participation is entirely voluntary. If you choose to participate you will be asked to sign a consent form. You will be free to withdraw at any point in the study without having to give any reason.

1.4 What will I have to do if I take part?

As mentioned above, this research involves participating in an interview, where you would be asked to share your experience of receiving BFT. The interview would last approximately one hour and will be voice recorded. Your participation in the study is then complete.

1.5. What are the possible disadvantages of taking part?

There may be points in the interview when you could feel emotional or possibly experience some distress. However, if you chose to participate, you will be free to refuse to answer any questions and to terminate the interview at any point should you wish to. You will also have the opportunity to discuss any feelings evoked post interview with the researcher and information on sources of support are provided below:

- **Rethink** is a registered mental health charity that provides advice, information and support for clients and carers see www.rethink.org. for details of how to contact your nearest office. Telephone: **0845 456 0455** for Rethink general enquiries or email:info@rethink.org. Telephone: **0207 840 3188** or **0845 456 0455** (open 10am to 2pm Monday-Friday) for Rethink advice and information or e-mail: advice@rethink.org

- **The Princess Royal Trust for carers** is an organisation that **works to reach carers and develop services for carers across the country** through a unique network of 144 independently-managed Carers' Centres and interactive websites. Please see www.carers.org for details of how to

contact your nearest centre. Your local Carers' Centre will be able to assist you on a range of issues that may concern you as carer.

- **MIND** is the leading mental health charity for England and Wales. Mind provides information and support to help promote understanding of mental health. See www.mind.org.uk or telephone **0845 766 0163** for details about finding your local or nearest service.

- **The British Psychological Society** which provides details regarding qualified psychologists trained in a variety of psychological interventions across the UK.
  Telephone **0116 254 9568** or see www.bps.org.uk for further details.

- **The British Association for Counselling And Psychotherapy** which provides details of how to access a range of different therapies (e.g. CBT, counselling, and psychotherapy) through counsellors and psychotherapists across the country. Telephone **01455 883300** or see www.bacp.co.uk for further details.

1.6 What are the possible benefits of taking part?

There is no intended clinical benefit from taking part in this research. You are invited to share your experience of BFT for research purposes only. However, your views are considered very important and this study may help to inform and improve the way BFT is delivered in the future. Although it is difficult to determine at this stage what improvements could be made, it is recognised both locally and nationally within NHS policies that clients and carer feedback is pivotal to service development.

1.7 What if there is a problem?

Any complaint about the way you are dealt with during the study or any possible harm you may suffer will be addressed. The detailed information on this part is given in Part 2. Please see below.

1.8 Will my taking part in the study be kept confidential?

Yes. All ethical and legal practice guidelines will be followed and all information about you will be handled in confidence.

This completes part 1

<u>**Part 2**</u>

2.1 What will happen to the data if I don't want to carry on with the interview/study?

If you decide to discontinue with the interview, the data will not be used in the study and will be destroyed.

2.2. What if there is a problem?

Should you have any concerns about this research, please contact me either by phone: (work mobile) or email: ███████████████████ Alternatively or in addition, you can contact my research supervisor at **anna.butcher@londonmet.ac.uk** or by phone on (phone number). Any complaints will be taken seriously and dealt with sensitively.

Complaints

If you have a concern about any aspect of this study, please contact me either by phone: (work mobile) or email: ███████████████████ Alternatively or in addition, you can contact my research supervisor at **anna.butcher@londonmet.ac.uk** or by phone on (phone number). If you remain unhappy and wish to complain formally, you can do this via the Kent and Medway Partnership Trust complaints procedure. Details can be obtained from **http://www.kmpt.nhs.uk/Complaints-procedure.htm.** You can also contact one of the Trust's Complaints Co-ordinators below. All complaints will be carefully listened to and thoroughly investigated.

Detail for Complaints Co-ordinator

2.3. Will my taking part in this study be kept confidential?

Interviews will be voice recorded (using a digital audio-recorder) and strictly confidential. Ethical and legal protocols for the National Health Service and the British Psychological Society will be adhered to. All interview material will be anonymous from the outset of the research. You will not be asked to provide your name or any personal details during the recordable interview. The voice content of this interview will be used solely for analysis by the researcher. The interviews will not be heard by any person other than the researcher or an employee of 'Just Delegate' typing and transcription service - for the purpose of transcription only. This service is bound by a confidentiality agreement in accordance to the Data Protection Act. Following the transcribing process all interview content will be transferred onto an NHS password protected lap top and destroyed from the voice recorder. This lap top is secured by a data encryption system that can only be accessed by the

researcher. Only authorised persons will have access to the interview data. These include the researcher, the researcher's supervisor, NHS regulatory authorities and the Research and Development Department within XXXX Trust (for auditing/monitoring the quality of the research). Confidentiality would only be breeched if the information disclosed is likely to cause harm to yourself, or others and you would be advised of this process.

How long will your interview material be retained for?

The interview data will be kept for a period of five years in case of publication and will then be destroyed securely. However, if you chose to opt out the study the interview material will be destroyed with immediate effect.

2.4 What will happen to the results of the study?

The interview material (data) will be analysed as part of my Doctoral research project and written up into a thesis. Excerpts from interviews (omitting any identifying information) may be used in the writing up or publication of the study. These excerpts will be kept for a period of five years in case of publication and then will be destroyed. Your name would not be used in connection with the results in any way and all information that may otherwise identify you (e.g. names of family members or friends) will be changed with a pseudonym prior to transcription. All recordings will remain anonymous and stored securely onto a password protected lap top that only I can access. If you would like any feedback or formal results from the study this can be arranged. Please do let me know at the time of your interview, if you would like results from the study so that I can organise for this to take place. I will happily arrange a time at your convenience to allow you this opportunity.

2.5 Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Committee (name of committee).

2.6 Further information and contact details

If you require any further information about this study you can obtain information from the following resources. For anything that relates to:

1. Specific Information about this research project – please contact me either by telephone on (work mobile) or email at (work email address). Alternatively, you can contact my research supervisor, Dr Anna Butcher **anna.butcher@londonmet.ac.uk** or by phone on (phone number).
2. Advice as to whether you should participate in this study – please speak with myself and/or my supervisor (details as above) Or you may want to contact your GP and/or one of the organisations listed above.
3. Who you should approach if you are unhappy with the study – please refer to section 2.2 of this form.

Thank you for your time, it is much appreciated. If you chose to participate you will be given a copy of this information sheet in addition to your signed consent form.

Yours Sincerely,

Kerri Lees

Counselling Psychologist in Training

Appendix 2 – Informed Consent Form

Informed consent form

<u>Title of research</u>: Exploring Fathers' Experiences of Behavioural Family Therapy.

<u>Name of researcher</u>: Kerri Lees

Date: 12th June 2012

Description of procedure: In this research you will be asked questions regarding your experience of receiving Behavioural Family Therapy, within a voice recorded interview. Before you give your consent for your sessions to be recorded, it is important that you understand and agree to each of the points below. **Please initial the boxes on the right hand side in agreement for each statement.**

1. I confirm that I have read and understand the information sheet dated 12th June 2012 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

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

3. I understand that data collected during the study, may be looked at by individuals from the   xxxxx Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I agree for the interview to be audio-recorded and understand that it will only be used for analysis by Kerri Lees, or an employee of Just Delegate typing and transcription Service. This organisation is bound to a confidentiality agreement.

5. I agree to take part in the above study.

Name of participant…………….. .. .. Date…………………
Signature………………………

Name of person

taking consent……………………….. Date………………….
Signature……………………….

When completed: 1 for participant; 1 for researcher site file.

Appendix 3 – Interview Schedule

Date: 27th September 2011

Interview Questions

1.   **Can you tell me how you came to have family therapy?**

2.   **Can you tell me a bit about your experience of having Behavioural Family Therapy (BFT); what was it like?**

   Prompts:

- How would you describe it?

- Can you tell me about any thoughts or feelings you had in advance of having Behavioural Family Therapy?

- What were your thoughts about what it would involve?

- Were there things about the approach that you particularly liked?

- Were there things about the approach that you particularly didn't like?

3. What was it like being a father in family therapy?

   Prompt:

- How do you think your experience was compared to other people?

4.   **What part do you think you played in the therapy?**

   Prompts:

- How did you find it… getting involved in the sessions?

- How would you compare this to your other family members?

5. Is there anything that I have not asked about your experience of BFT that you think is important to this topic?

6. How has it been participating in this interview/study?

Appendix 4 – Debriefing Form

Debriefing Form

Title of research: **Exploring Fathers' Experiences of Behavioural Family Therapy.**

Name of researcher: **Kerri Lees**

Date: 12th June 2012

Dear

Thank you for taking part in this research. As you have already been informed, this is part of a Counselling Psychology Doctorate project that the researcher is conducting. If you are interested in the results of the study, or if you have any questions about this study, or if you wish to withdraw, please contact the researcher on (work number) or the following email address: xxxx My emails are checked regularly. You may also contact my research supervisor, Dr Anna Butcher at anna.butcher@londonmet.ac.uk regarding any aspect of the study including any complaints you may have.

It would be helpful if you do not discuss the interview content with anyone who may later take part in this study as this could affect the validity of the research conclusions.

If you have any questions you are more than welcome to address them now. Equally, if participation in this study has raised any concerns or issues that you wish to discuss further, a number of agencies can provide advice and support in confidence:-

- **Rethink** is a registered mental health charity that provides advice, information and support for clients and carers see www.rethink.org. for details of how to contact your nearest office. Telephone: **0845 456 0455** for Rethink general enquiries or email:info@rethink.org. Telephone: **0207 840 3188** or **0845 456 0455** (open 10am to 2pm Monday -Friday) for Rethink advice and information or e-mail: advice@rethink.org

- **The Princess Royal Trust for carers** is an organisation that **works to reach carers and develop services for carers across the country** through a unique network of 144 independently-managed Carers' Centres and interactive websites. Please see www.carers.org for details of how to contact your nearest centre. Your local Carers' Centre will be able to assist you on a range of issues that may concern you as carer.

- **MIND** is the leading mental health charity for England and Wales. Mind provides information and support to help promote understanding of mental

health. See www.mind.org.uk or telephone **0845 766 0163** for details about finding your local or nearest service.

- **The British Psychological Society** which provides details regarding qualified psychologists trained in a variety of psychological interventions across the UK.
Telephone **0116 254 9568** or see www.bps.org.uk for further details.

- **The British Association for Counselling And Psychotherapy** which provides details of how to access a range of different therapies (e.g. CBT, counselling, and psychotherapy) through counsellors and psychotherapists across the country. Telephone **01455 883300** or see www.bacp.co.uk for further details.

You can also speak with your GP in order to access free local counselling and psychological support.

Yours Sincerely,

Kerri Lees (Counselling Psychologist in Training)

Appendix 5 – Distress Protocol

Protocol to follow if participants become distressed during participation

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in this research whilst discussing their experience of BFT. The researcher is an Assistant Psychologist in the NHS with eight years experience of working with carers and within this capacity frequently works in highly emotional situations. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. This is because participants will be fully informed (via face to face contact or telephone), about the nature of the interviews in advance of taking part and will be given the opportunity to withdraw from the interview at any point. However, a three step protocol will be followed in the event of any participant becoming unduly distressed. This protocol is below and details signs of distress that the researcher will look out for, as well as action to take at each stage.

Mild distress:

Signs to look out for:

1) Tearfulness
2) Voice becomes choked with emotion/ difficulty speaking
3) Participant becomes distracted/ restless

Action to take:

1) Ask participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

1) Uncontrolled crying, inability to talk coherently
2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
3) Intrusive thoughts of the traumatic event- e.g. flashbacks

Action to take:

1) The researcher will intervene to terminate the interview/experiment.
2) The debrief will begin immediately
3) Relaxation techniques will be suggested to regulate breathing/reduce agitation
4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to abnormal events and that most people recover from PTSD
5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
6) Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:

1) Severe agitation and possible verbal or physical aggression
2) In very extreme cases - possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

Action to take:

1) Maintain safety of participant and researcher
2) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
3) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

© Adapted from the Distress Protocol written by Chris Cocking, London Metropolitan University Nov 2008

Appendix 6 – Letter of Ethical Approval

NHS
Health Research Authority

2 - FEB 2012

Date: 9ᵗʰ January 2012 (*Corrected 26ᵗʰ January 2012*)

Miss Kerri T Lees.

Dear Miss Lees

Study title:	**Exploring Fathers'Experiences of Behavioural Family Therapy: A Qualitative Investigation**
REC reference:	**11/LO/0982**

Thank you for your letter of the 24ᵗʰ November 2011, responding to the Committee's request for further information on the above research and for submitting revised documentation.

The further information was considered by a sub-committee of the REC at a meeting held on the 14ᵗʰ December 2011. A list of the sub-committee members is attached.

Confirmation of ethical opinion

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

The members were content with the overall response for further information provided by you but have requested that the Committee name be amended to 'NRES Committee London-Surrey Borders' on page 4 of the Patient Information Sheet.

Ethical review of research sites

NHS 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).

Non-NHS sites

Conditions of the favourable opinion

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

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.

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

11/LO/0982	Please quote this number on all correspondence

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

Yours sincerely

Enclosures:	List of names and professions of members who were present at the meeting and those who submitted written comments
	"After ethical review – guidance for researchers"
Copy to:	Dr Anna Butcher, London Metropolitan University Calcutta House Old Castle Street London, E1 7NT

Appendix 7 – Just Delegate Privacy Statement

JUST DELEGATE LTD
Transcription and Proofreading Specialists

JUST DELEGATE LTD
PRIVACY STATEMENT

Your privacy is important to Just Delegate Ltd.

Just Delegate Ltd is committed to ensuring the security of your information. To prevent unauthorised access or disclosure, maintain data accuracy, and ensure the appropriate use of information, we have put in place, as required of us under the Data Protection Act 1988, appropriate physical, electronic, and managerial procedures and policies to safeguard and secure and protect the information we may collect or be given by you.

This privacy statement provides information about the personal information that Just Delegate collects, and the ways in which Just Delegate Ltd uses that personal information.

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Just Delegate Ltd may collect and use the following kinds of personal information:

- information about your use of this website;
- information that you provide for the purpose of registering with the website;
- information about transactions carried out over this website;
- information that you provide for the purpose of subscribing to the website services; and
- any other information that you send to Just Delegate Ltd.

Using personal information
Just Delegate Ltd may use your personal information to:

- administer this website;
- personalise the website for you;
- enable your access to and use of the website services;
- send to you products that you purchase;
- supply to you services that you purchase;
- send you statements and invoices;
- collect payments from you; and
- send you marketing communications.

Where Just Delegate Ltd discloses your personal information to its agents or sub-contractors for these purposes, the agent or sub-contractor in question will be obligated to use that personal information in accordance with the terms of this privacy statement.

In addition to the disclosures reasonably necessary for the purposes identified elsewhere above, Just Delegate Ltd may disclose your personal information to the extent that it is required to do so by law, in connection with any legal proceedings or prospective legal proceedings, and in order to establish, exercise or defend its legal rights.

Securing your data
Just Delegate Ltd will take all reasonable technical and organisational precautions to prevent the loss, misuse or alteration of your personal information.

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Just Delegate Ltd will maintain all the personal information you provide securely.

Updating this statement

Just Delegate Ltd may update this privacy policy by posting a new version on this website.

You should check this page occasionally to ensure you are familiar with any changes.

Other websites

Our website may contain links to other websites.

Just Delegate Ltd is not responsible for the privacy policies or practices of any third party.

Contact Just Delegate Ltd

If you have any questions about this privacy policy or Just Delegate Ltd's treatment of your personal information, please contact us in the first instance by emailing us at support@just-delegate.co.uk containing the title **PRIVACY POLICY** in your subject heading.

Appendix 8 – Annotated Participant Transcript

File: Participant 2 - Jack

Length: 1:10 mins

Emergent Themes	Original Transcript	Exploratory Comments
	Researcher: So we are recording now, can you tell me how you came to have family therapy?	
	Participant 2: How I came to have family therapy?	
	Researcher: Yeah.	
Needing help	Participant 2: Well that's the end result of when we took [name] to A&E full of Paracetamol, I said we need some help and they arranged for us to see people that are on-site and they said that they would get in touch with this magical mystery place called the [name] of which I had never heard of and had absolutely no knowledge of. So that's where it stemmed from and then the counsellors have come in over the period of time and then at the end of session when [name] is significantly better…erm, when I say significantly better I mean he was in the manic…you see he was in the depressive stage when we first got things in, we'd thought we'd got through everything that life could bowl at us when suddenly we then experienced the manic side of his depression, which we hadn't experienced before, so having come out of that again, then at the end of that when we're getting to the time that you've been under the [name], for however long it is, it seems like a lifetime, but it might be three years, I don't know….certainly quite a long period of time. They're wanting to move on to [laughs] other people who have	Emphasis of 'end result' of treatment. Providing the background story. He makes a stand and admits that the family unit "we" need help. He articulates himself with an air of confidence, no hesitation. Is this an opportunity for him to tell *his* story? Counsellors coming in over a time period. It happened when John was significantly better. Mania stage being better than the depressive stage There are different stages of the illness. Seems like a lifetime. Emphasis on long time
BFT happening over a time period		
Trauma of Psychosis		

Therapeutic Relationship	managed to jump onto this list and I suppose we're a bit clingy, you know you just don't know what life is going to bowl you and having at last found a friend and, erm, my memory has shot away, I could looked up a name to remember but having used the counsellor as a negotiation…a negotiator between I and [name] because I couldn't not look in his room, you know I could leave his door shut for an hour but after a while I just wanted to make sure he wasn't doing something stupid, you know it would be easier to have the door open, you know it would have… ones mind had gone through, let's get him committed. Not that you want to put your son in a straightjacket, but at least whilst this stage passes and the drugs start to take effect he can just not do something everybody would regret. So anyway having got through that and finding out that we've now got to let go, and these wonderful people that have turned [name] back to a balanced human being suddenly want to depart, we just didn't feel ready, you know, it suddenly felt, that, you know, and the umbilical cord that you had grabbed hold of was going to be removed, so it was then [sighs], my words would be time to face the demons really. You know so the counselling sessions are about opening up…they are about behaviour and how you deal with issues and how you deal with things and bottling them up is not good and not discussing them is not good. So it's a stepped programme.	Jumping onto the BFT list, feeling clingy
		Having a found a friend at last, he seems to be saying he found this hard
		Forgetting the name of the worker
Trauma of Psychosis		Counsellor as negotiator between him and his son
		Helping at a frightening and difficult time, vulnerable period
		The worry caused by psychosis, impact of the illness
		Having got through it – the experience of psychosis
Positive views of therapists		Letting go of wonderful people that have turned John back to a balanced human being
		The umbilical cord being removed, feeling vulnerable like a helpless baby. Sigh as he reflects back, or perhaps sighing as he struggles finding the right words
Revealing the true-self		Counselling sessions being about opening up
Facilitating Openness		Comment to describe BFT – being about behaviour and how to deal with issues. Bottling up is not good. Stepped programme.
	Researcher: Okay, so from what you are saying there then it was sort of towards the end of the [EIP] support programme?	I attempt to clarify his point
	Participant 2: That's right, so the last sort of session was the	

Section B - Reflexive essay

Finding a therapeutic approach to fit all...If only it were that simple

Finding one's identity within a field that embraces a range of theoretical perspectives has both advantages and disadvantages. On the one hand I feel fortunate through my chosen profession, to have an awareness of varying positions from which I can practice flexibly and comfortably, with the client at the forefront of what I do. On the other hand, there are times when it feels like I 'can't see the woods for the trees'. Indeed, maintaining a broad and open stance, in the applicability of a collection of theoretical models can sometimes represent confusion and uncertainty. The following essay considers this confusion, and its impact upon my professional journey in developing my philosophy of practice, which is aligned to the values of Counselling Psychology (CoP).

In discussing my personal philosophy, I consider the key factors (e.g. clinical supervision, personal therapy and self reflection) and experiences (e.g. employment in the NHS and professional training) that have influenced my theoretical orientation. Reference will be made to both theoretical and empirical evidence, using case examples as I explain how I have integrated my personal philosophy into my practice. I will further explore my 'use of self' within the therapeutic relationship and how this has impacts on the process of therapy. In providing an honest reflection of my practice I also hope to illustrate my strengths and limitations both as a therapist and professional working in the current and evolving National Health Service (NHS). In providing a context for the reader, the essay begins by providing a brief outline of my clinical experience to date. It leads on to discuss how Cognitive Behavioural Therapy (CBT) originating from the work of Beck (1976), is an influential model guiding my practice, both as the primary approach taught in my training, and as the approach that underpins recent government initiatives such as IAPT (Improving Access to Psychological Therapies). This is followed by a section that explores themes of doubt and

uncertainty felt as a therapist. Exploration is then given to my personal traits and characteristics, how I have adopted a professional identity that are congruent with these and why I believe this is important for my practice. Finally, I provide a synopsis of my chosen theoretical orientation and how this fits with the points raised and reflected upon in this piece of work.

Setting the Scene...

In the first instance, I think it is significant to mention the clinical settings that have contributed to my knowledge, understanding and practice of both psychotherapy and research within a CoP framework. My client experience began in the voluntary sector working with youth offenders and children in foster care. This post was followed by an NHS position working in a secure unit with Home Office patients. From this period, I continued to work in the NHS up until and throughout my CoP training. Within this time, I have worked in an array of client settings including, neuropsychology, older adult services, memory clinics, recovery services, eating disorders, Primary Care Services (where I work from a psychodynamic stance), and for the past six years, a specialized Early Intervention Service for young (i.e. 14-35yrs) people experiencing a first episode of psychosis. The majority of my work has involved working in a multidisciplinary team environment and has largely involved seeing clients in the community.

Working therapeutically with clients in their home environments has undoubtedly impacted on my practice as a Counselling Psychologist. Asking clients to consider where they would prefer to meet, taking into account risk, clinical presentation, therapy goals and an environment conducive for therapy has become a routine intervention during the assessment stage. For me, seeing clients in their homes represents a flexible way of working that fits with the CoP principles I adhere to. It enables me to respond to the client's subjective needs whilst offering a therapeutic frame that "empowers rather than controls" (Division of Counselling Psychology, 2005 p.2). For many vulnerable clients offering an assertive outreach approach by seeing

them in their home, is very empowering and can prove to be instrumental in their recovery, where the alternative option is not to be seen at all.

At this point, it seems appropriate to say a little more about how my post in an Early Intervention in Psychosis Service (EIP) whilst training to be a Counselling Psychologist has endorsed my career development. Foremost, this post provides an opportunity to work autonomously in a thoughtful and supportive team. Regular peer supervision allows practitioners to examine their practice, and consider ways to best meet the needs of the client in an ethical, realistic and achievable manner. Moreover, the service ethos is one that encourages open discussions with clients about what is, and isn't working for them in respect of their care. Working in this way has enhanced my ability to respond flexibly and creatively to complex presentations, whilst specifically tailoring my style and therapeutic approach to the individual client.

Despite having this flexibility and autonomy in my clinical practice, I am aware that much of my experience and training draws on CBT concepts and methods. As a scientist-practitioner, I appreciate the evidence-base that underpins this model and on a personal level, as an individual who is organised in nature, I value the structure of CBT. In evaluating my practice, I have observed clients responding well to a focused approach, when appropriate to the presenting problem. I have particularly enjoyed the practical application of behavioural experiments, both in designing them with the client and reflecting on their efficacy when they have been successful in challenging dysfunctional beliefs (Levy, Butler, Fennell, Hackman, Mueller & Westbrook, 2004).

Is traditional CBT for me?

In light of my experience and training in CBT, an important question I have asked myself is whether this approach is for me?" I think the answer to this question is two-fold whereby I acknowledge the strengths of CBT (e.g. scientific value and collaborative nature), I also recognise its limitations (e.g.

it is not suitable with every client). Being introduced to the "third wave" approaches (Sanders & Wills, 2005 p20) such as Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 1999) and Mindfulness Based Cognitive Therapy (Segal, Williams & Teasdale, 2002) amongst others, has undoubtedly broadened my practice but nevertheless, has still left me feeling unfulfilled in relation to my theoretical orientation.

Prior to my training, I was largely influenced by psychodynamic concepts for two reasons. Firstly, my own personal discoveries (e.g. in therapy) had led me to align myself with wide research, suggesting that our past experiences are fundamental to our current interpersonal experiences (Jacobs, 2006). This belief along with my curiosity into the human mind and behaviour steered me towards a psychology career in the first instance. However, I have also been inspired by a very skilled and supportive Counselling Psychologist who was dual trained as a psychoanalytic therapist and supervised me for five years. Taking into account what I was learning and utilising from the CBT literature, I started considering how I might adopt CBT principles into a psychoanalytic frame (Garett & Turkington, 2011). Although my interest at this time related mainly to the field of psychosis, I began thinking about how some of the theory could be transferrable across other difficulties. For example, CBT techniques (e.g. eliciting beliefs and emotions about stressful events) are invaluable interventions in normalising and coping with symptoms, whilst psychoanalytic Object Relations theory is exceptionally useful in understanding trauma or how self-esteem is regulated (Klein, 1935). However, in practice interpretations of unconscious thoughts and defences, with clients who have little insight into their difficulties can be arduous, and not always appropriate (Huprich, 2009). Albeit a refreshing concept, applying CBT techniques within psychoanalytic framework is a young development, and the evidence-base for this approach is limited. Thus, attempting to integrate an array of therapeutic models into my practice has often left me feeling confused. This is further complicated by my endeavour

to work ethically and holistically, with a wide range of needs that are individual to each client, regardless of their presenting problem or diagnosis.

A sense of confusion...

This sense of confusion and uncertainty has generated waves in my confidence both in the therapy room and in terms of my academic performance. Whilst I appreciate that sitting with uncertainty can be considered healthy, par for the course, and a sign of professional growth in becoming a psychotherapist (Attard, 2008; Petrucelli, 2010; Samuels, 1997; Sanders & Wills, 2005), I would agree with Rosemary Rizq when she states that this type of uncertainty can produce "considerable emotional strain" for the trainee (Rizq, 2006, p.614). For me, this emotional strain was particularly evident in my second year of training.

During this time, I frequently recall being unsure of whether I was getting it (i.e. therapy) right. More specifically, I felt myself drowning in a sea of literature in my slightly optimistic endeavour to learn new therapeutic approaches as they were being introduced in my training. I have not so distant memories of driving from one placement to another, or from one client to another whilst thinking long and hard about my theoretical orientation. I questioned if I would ever be proficient in any of the approaches that I was attempting to deliver. Perhaps because I was not giving myself the opportunities to persist with one model for long enough to feel competent in it (Sanders & Wills, 2005). My enthusiasm to experiment with other approaches always prevailed. In normalising my experience in supervision I now feel more at ease with an air of uncertainty, and truly appreciate the view that "states of not knowing" are a positive aspect of practice (Attard, 2008 p.313). Attard suggests that self-doubt and not knowing represents curiosity and stimulates inquiry. Transferring this line of thought to the therapy room, uncertainty can allow for therapist learning both from the client and therapy processes. Moreover, it demonstrates a genuine sense of working to understand and learn from the client (Casement, 1985),

and I believe we continue to learn with every new client that walks through the therapy door.

But what fits with me and my natural style?

Putting aside my confusion, I'd like to expand on the idea of widening one's knowledge within the scope of therapeutic methods, and how this has been advantageous to my current practice. Learning about different approaches has helped me to establish which fit with my style of working. Substantial research suggests that therapists match their model(s) of choice with their personality or temperament (Sanders & Wills, 2009; Skovholt & Ronnestad, 1995). Skovholt and Ronnestad (1995) state "the individual gradually sheds elements of the professional role that are incompatible with one's own personality...and adopts elements of the professional role that are congruent with the self" (p.109). I would agree with this in as far as, perceiving myself as a pro-active person and organised person who is gratified in seeing results. Thus, in the early stages of my therapeutic practice I sometimes found the notion of *just being with a client* stemming from a humanistic value system (Woolfe & Strawbridge, 2010) uncomfortable. This discomfort related to a sense of not giving enough to my clients and not feeling confident in my practice. In having my own therapy, I have come to have another perspective. Whilst I seem to gain more in therapy from a directive approach, perhaps due to my own interpersonal style, I have found it very refreshing when my therapist spends time listening to, and trying to understand *my subjective experience* (BPS, 2006). Thus, being on the receiving end of this therapeutic skill has helped me to reflect on my own practice. This experience illustrates a competency required within the profession of CoP, in gaining an 'understanding of therapy from the perspective of the client' (BPS, 2006).

Thinking further about the match between personal and therapeutic styles, Sanders and Wills (2009) argue that working in the therapy field, is as much about the therapist finding an approach that works for them as it is

about the client having the right kind of therapy for their difficulties. Thus, thinking about a therapy approach for the client is also about me working from an approach that I feel comfortable and competent in. This has sometimes involved transferring a client to a specialist practitioner, to ensure optimum treatment provision in accordance to ethical principles (i.e. BPS Code of Ethics and Conduct, 2009) and protocols (e.g. National Institute for Health and Clinical Excellence guidelines). For example, during my early Primary Care experience (where I was working within a psychodynamic frame) a client was referred to me who had psycho-sexual issues. Despite having some knowledge in this field I did not have the specialist training required to address their difficulties. Consequently, and in consultation with my supervisor this client was referred to a psycho-sexual service. Showing an awareness of different positions and their validity within the therapy remit demonstrates respect for the 'Other' in respect of other views and other ways of practice (Cooper & McLeod, 2007). According to Milton (2010) this way of working represents a pluralistic perspective which in turn constitutes the foundation of CoP.

Towards a pluralistic perspective

Cooper & McLeod (2011) outline two main principles underlying the pluralistic approach. The first stipulates that there are a multitude of therapeutic interventions, (e.g. problem solving or simply talking) that can be helpful to clients. The second suggests that an open dialogue with the client is necessary to establish their preferences and needs in therapy. A pluralistic perspective encourages a foundation level of understanding of related therapeutic models, as in my work with the client presenting with psycho-sexual issues. Furthermore, a pluralistic perspective refers to the view that there is no one best therapeutic model (Cooper and McLeod, 2011). This approach therefore fits with the complexity of human nature in that one's functioning and dysfunction is "multifaceted, multidetermined, and multilayered" (Lazarus, 2005, p.112). Furthermore, a pluralistic stance acknowledges the diversities that come and need to be accounted for when

working with clients as individuals within their social contexts. It goes beyond an effort to develop specific services for different cultures and or religious beliefs (Pedersen, 1991;Pedersen, Crethar & Carlson, 2008).

I feel it is in my final year of training that I have really adopted a pluralistic approach to my practice, illustrated in my work with a young girl presenting with panic attacks. Under the National Institute for Health and Clinical Excellence (NICE) guidance, a course of CBT should be considered for the treating panic disorders (2011). However, in assessing this client I started to question whether CBT would be best approach, in light of the complex manifestation of this problem. That is not to say that CBT for panic does not fit with complex presentations, but more that I hypothesised a deeper meaning to this difficulty which stemmed back to an enduring traumatic interpersonal experience with an ex-boyfriend, and relational difficulties within her family. As I thought further about this case, both with my trainee peers and in clinical supervision, I made a decision to be transparent regarding my theoretical dilemma with the client. In doing so, I explained two different ways of working and referred to the evidence-base of each. For example, a desensitisation programme or a psychodynamic approach that would explore some of her past experiences in an attempt to understand her current distress (Jacobs,2006). This client chose the latter stating that she appreciated my transparency and compared this with a previous experience of therapy, in which she had felt obligated to conform to the therapist's mode of practice, due to her perception that the therapist was the expert and therefore knew best. Despite taking a psychodynamic approach, I encouraged an open dialogue and demonstrated a willingness to learn from my client. I made it explicit that I was happy to be guided by what she felt relevant (Cooper & McLeod, 2011).

Giving this client an informed choice allowed her to be honest about her therapy preference within a collaborative framework. This case example concurs with recommendations by Swift and Callahan (2009) who argue that choosing a treatment option is based on a partnership between client and

therapist where information is shared and preferences openly discussed. It also illustrates a point made by James and Bellany (2010) that working in a Primary Care setting is often complex whereby holding different theories in mind regarding human problems can be central in building a therapeutic alliance. This working alliance involves an essential step of heeding the clients preferred way of working (Cooper & McLeod, 2011).

Another example of utilising a pluralistic approach is exemplified in the way I review the progress of therapy (e.g. checking in with the client how they are finding therapy). I find this particularly beneficial when it is the client's first experience of therapy, and/or where they have exhibited anxiety and apprehension regarding what to expect. Furthermore, it is an intervention that has routinely felt natural for me as a therapist, and for the client conveys meaningful collaboration. I hold this belief more strongly since having my own therapy especially, as I have not been accustomed to the same intervention. I further recognise that in doing this, informative feedback can be provided, especially where the client requires permission to provide comments about the therapy process. To this end, personal therapy has contributed to my philosophy of practice, in terms of self reflection and in engaging with subjectivity and intersubjectivity (Division of Counselling Psychology, 2005).

A pluralistic perspective consolidates much more than my practice in the therapy room. It represents my way of work alongside clients and carers in my day to day life in the NHS within a specialist service. For example, I am currently coordinating a service development group with two clients in redesigning the EIP service leaflet. Involving clients in service improvements is not only empowering for clients in offering patient choice, but is also consistent with a pluralistic approach in utilising client resources (McLeod & Cooper, 2011).

In thinking further about service improvements, the creation of the 'New Horizons' programme (www.dh.gov.uk/en/HealthcareMental-

health/NewHorizons) with its vision towards patient empowerment and greater patient choice (Ford, Schofield & Hope, 2003, p590.) is harmonious to pluralistic principles. However, one might also question if the NHS (where the majority of clinical work takes place) is set up for the pluralistic perspective in practice. As a long-standing employee of this organisation, I am familiar with the constraints in adhering to policies and service protocols, along with the pressure of meeting performance targets especially in this difficult economic climate. I therefore question the realistic application of this free and liberating approach especially in light of its limited evidence-base and a need for more research in this area (McLeod & Cooper, 2011).

Conclusion

In referring back to my title, working with the complexity of human functioning is certainly *not simple* and to suggest that applying one theory to fit all would undermine this complexity. This essay has considered this concept in detail and has taken into account therapist growth in tolerating uncertainty both inside and outside the consulting room. It has highlighted that within the realm of therapy and research there is room at the table for more than one tradition, and this is the very nature of pluralism. Indeed this concept as a therapeutic approach requires further research and thought about its application in the evolving NHS. Nevertheless, for me its underlying principles invite fruitful and exciting prospects.

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Section C – Theoretical essay

With reference to two theoretical models, compare and contrast process and content interventions in working with a couple or a group.

This essay explores psychodynamic and Cognitive Behavioural Therapy (CBT) approaches to working with couples, covering issues of diversity, conflict and communication. From a reflective Counselling Psychology (CoP) stance, it will provide a descriptive overview of each model, whilst considering how each is applied in practice, drawing on their salient features. Thus, it begins by providing a broad understanding of the philosophies underpinning both approaches and a brief history of how each framework has developed guidelines for working with couples. It will subsequently compare and contrast some of the interventions used in each approach paying attention to process (e.g. relational dynamics) and content (e.g. therapeutic techniques). Consideration is given to the therapeutic relationship and evidence-based practice. In analysing these approaches, reference will be made to systemic theory and practice which is considered to be a fundamental ingredient of both. The essay will conclude by thinking about how CoP ethos fits with the notion of couple work. It will also discuss what I have gained in widening my knowledge of the assorted theories and methods of practice with couples.

Setting the Scene

The psychodynamic approach covers an array of theories that have developed over the past 120 years since the original work of Freud. There is often confusion regarding the definition of psychodynamic and psychoanalytic therapy. It is useful to clarify that Freud was the founder of psychoanalysis theory and therapy, yet, psychodynamic theory refers both to Freud's ideas and the work of his followers (McLeod, 2007). Psychodynamic therapy might best be considered as an 'umbrella term' for a way of working that focuses on a client's past experiences, as a way of understanding their present experiences. It is based on the theory that human functioning involves an interaction of, unconscious and conscious drives/forces within a person (McLeod, 2007). It

pays particular attention to relational dynamics often using what happens in the therapy room as a key therapeutic vehicle. Within this broad definition, there are a number of therapy schools that fit within the remit of psychodynamic theory including Psychoanalysis (Freud, 1900), Attachment Theory (Bowlby 1988), Object Relations theory (Scharff & Scharff, 1987; Dicks, 1963) and the Relational approach (Mitchell, 1998). The list is extensive, thus in relation to the assignment objectives and within the space permitted, this piece of work will consider very broad psychodynamic principles.

This will be compared with 'modern day' CBT practice with couples, which considers the core themes in relationships such as intimacy, characteristics of each unique individual, the interaction patterns of the couple and the context of the environment (Epstien & Baucom, 2002). Particular attention will be given to the work of Epstein & Baucom (2002) who consider an enhanced Cognitive-Behavioural model for couples, which expands on some of the traditional aspects of CBT. It is important to note at the outset that there are various ways of delivering CBT and psychodynamic approaches with couples according to one's own philosophy of practice (e.g. through training and experience), therapeutic style and often, service protocols (e.g. within the confines of the National Health Service (NHS) resources). Furthermore, it is also acknowledged that both approaches have laden histories whereby models have developed within models for these two wide and expanding theoretical frameworks.

The Philosophy of CBT with Couples

Early Cognitive Behavioural Couples Therapy (CBCT) stressed the significance of cognitive, affective and behavioural factors in exploring relationship distress (Epstein & Baucom, 2002). Yet, CBCT was originally developed from behaviour principles and techniques from the 1960's that had previously been applied to individuals (Dattilio, 2010). Behavioural principles

later shared ideas with the family systems approach in exploring factors in interpersonal relationships and how these are influenced by one or both partners' behaviour. Thoughts (namely cognitions) were introduced to couple approaches (not without some controversy by traditional behaviourists), as a means to help partners challenge their own dysfunctional thoughts and were also used in skills exercises to facilitate more adaptive communication (Baucom & Epstein, 1990). CBCT has historically been criticised for operating through linear thinking - focusing too much on how individuals in a couple operate and not enough on understanding the interactional processes of a couple. However, as CBCT approaches have grown they have undoubtedly adopted more principles from systemic theory (Dattilio, 2001), whereby contemporary literature refer unhesitatingly to the circular notion of questioning, a general consensus on couple values and understanding the couple in the context of their environment. CBT has now "entered the mainstream of contemporary" couple work (Dattilio, 2010 p. 1). It is increasingly more popular, particularly with Government initiaves like Improving Access to Psychological Therapies services (IAPT).

The Philosophy of Psychodynamic Practice with Couples

As with CBCT, systems theory is incorporated into contemporary psychodynamic practice (Kaslow & Magnavita, 2002). It understands individual unconscious and conscious drives whilst drawing on a systemic framework in respect of a focus on interpersonal dynamics. Other than this, the underlying principles of the psychodynamic approach with couples are similar to that of individual work. The basic tenets in this approach relate to the dynamic unconscious; anxiety and defence mechanisms; transference and counter-transference (Sander 1998). In psychodynamic couple therapy it is the relationship that is considered to be the client rather than the individuals (Scharff 1995). A psychodynamic position traditionally promotes a neutral and abstinent stance (Keijers, Schaap, & Hoogduin, 2000). However, more

contemporary psychodynamic literature is more encouraging of self-disclosure within an ethically appropriate therapeutic framework.

The Similarities and Differences in Content and Process

When thinking about the similarities and differences in these two approaches it seems logical to start at the beginning of the therapeutic work – the assessment stage. Thus, there are some differences between CBCT and psychoanalysis in respect of how couples are deemed suitable for therapy. For example, in psychoanalytic work it is important for the therapist at the outset of therapy, to explore how the couple respond to interpretations of any detected resistance (Scharff, 1995). Scharff cites that couples who are not deemed 'ready' for such interventions are given a choice of alternative or preliminary treatments (e.g. individual therapy). Similarly, CBCT tends to focus on motivation and commitment factors when couples enter therapy and also assesses whether individual work is appropriate for both or either individuals. Individual therapy can sometimes take place alongside couple work, however, in respect of ethical considerations and the existing therapeutic alliance with the couple this is nearly always done by another therapist. It is often helpful if the couple therapist and individual therapist know how the other works.

In terms of assessment, both models generally begin with an initial joint session to explore the couples' expectations for therapy, current difficulties and relationship history. However, the way this information is gained can differ according to the approach adopted and as always, depends on the style of the therapist. In CBCT this involves exploring predisposing and precipitating factors leading to the couples' relationship troubles. There is a focus on the present functioning of each partner, exploring assumptions about one another, core beliefs and how these affect the relationship and attributions in considering how one partner's actions affects the other (Dattilio, 2010). Psychodynamic therapy will usually explore similar issues to CBT but may be more inclined to think about how the couple's interactions fit into dynamically orientated relational patterns. For example, Sharpe (1997) categorises

relationships based on psychoanalytically developmental psychology taking into account gender conflict, oppositional power struggles and oedipal styles.

The next step in the assessment stage for both approaches usually involves the therapist meeting individually with each partner. Taking some personal history for each individual helps the therapist *and the couple* try to make sense of how their present difficulties came about (Datillio, 2001). Dattillio points out that CBCT have conventionally been "misunderstood as not being concerned with a couple's history" (p. 435). He conversely argues that in formulating individual and joint core beliefs of a couple, it is not uncommon from a CBT perspective to examine each person's family of origin in order to gain a better understanding of how these beliefs were formed (Dattilio, 2001). In psychoanalytic therapy with couples the therapist would take their history by investigating each partner's memories from childhood as well as, their relationship patterns with others. For both models it is useful to consider factors like communication, intimacy, sex, money and children. As a CoP trainee, all features that affect the couple's interpersonal and subjective experiences are relevant to the therapeutic work (DCoP, 2005).

Methods of assessment within the initial stage of CBCT can comprise of administering self-report questionnaires (Epstein & Baucom, 2002). For instance, it may be useful to ask the couple to complete Prager & Buhrmester's (1998) Need Fulfilment Inventory (separately) to explore what extent each person perceives their needs to be met in the relationship. This form of assessment can be helpful as a way of measuring one's ideal qualities and desires for a relationship, especially when the couple enter therapy questioning whether their needs are fulfilled. It can be quite a powerful tool in helping each partner to reflect on their personal identities, as it takes into account the significance of power in a relationship, individual achievement and autonomy.

In contrast, psychodynamic couple therapy would generally not entail these types of psychometric measures. Instead, it will typically concentrate more on the underlying issues of each partner and how these issues contribute to the presenting difficulty in the relationship. Assisting each partner to become aware of their own inner conflicts (with careful and thought-out therapeutic work), can prove to be a powerful intervention in itself in enhancing couple communication. For example, noticing how one projects unwanted feelings (i.e. projective identification) onto another can aid a couple in understanding their areas of conflict. However, this depth of self-reflection does not usually happen over one session and involves weeks, if not years of therapy.

After the individual sessions with each partner have taken place, a con-joint session is normally arranged and this is a common step for both approaches. The con-joint session is generally used to reflect with the couple about the process of therapy thus far, to summarise the salient issues between them and consider a plan of therapy from there. This session is often important in helping the couple to recognise wider contextual/systemic issues, other than the reason that brought them to therapy (Crawley & Grant, 2007). More generally in the assessment phase, it is important to discuss boundaries (in CBCT), or set the frame (in psychodynamic work) and consider the number and length of the sessions with the couple.

Thinking further about therapeutic interventions, CBCT usually offers quite directive interventions (Sander, 1998). For example, the therapist may steer the couple in eliciting dysfunctional beliefs using techniques such as Socratic questioning. As a consecutive intervention, CBCT may involve exploring the differences between each partners' belief systems, collaboratively questioning which beliefs they consider to cause most conflict in their relationship and in turn, which they would like to modify. Yet, this does not infer that a psychodynamically orientated couple therapist is less

active. In most couple work the therapist is viewed as being someone who can help them and remaining silent (albeit in reflection), can elicit confusion and evoke anxiety for the couple (Crawley & Grant, 2007).   By the same token, psychodynamic approaches with couples may also seem directive; with regard to interpretations generated by the therapist about the way a couple interact. Therapist interpretations can be considered direct or plain-spoken.

CBCT commonly includes a psycho-education component whereby the couple may be asked to read through material about relationships and specific difficulties (e.g. infidelity, communication or conflict resolution). The therapist may recommend self-help literature or books assigning particular chapters as a homework task for the couple. The couple would usually be asked to reflect on their reading as part of the agenda for the next session (Epstein & Baucom, 2002). Epstein and Baucom suggest that the objectives in this form of psycho-education emphasize collaboration in a partnership and mutual causation in conflict. In considering homework tasks, whilst these may automatically be associated with CBT interventions, homework is not an alien concept in psychodynamic couple practice. Assignments between sessions can be a constructive intervention in psychodynamic practice, especially in providing structure to a couple who lead a chaotic lifestyle or where it is difficult for them to focus on specific issues. For example, one partner may be asked to keep a diary of the times the other irritates them to help the couple understand the process of interaction between them (Nadelson & Polanksky, 1994).

CBT is commonly identified as a model that explores the 'here and now' in the therapy room. By this, it refers to the idea of working with the present (i.e. what is happening now) as opposed to the past (e.g. what happened in one's childhood). Psychoanalytic therapy however, also concerns the 'here and now' in terms of working with counter-transference within the therapeutic space. In this sense, by creating a listening space, the therapist is guided by

their own feelings about the couple. These feelings are then used to speculate and wonder with the couple about their interpersonal difficulties. Interpretations and explanations are offered by the therapist through a non-judgemental tone, in attempt to modify the relationship and resolve conflict with them. From a Counselling Psychology frame of reference, this concept of working in the 'here and now' is relevant to the therapist's ability to offer a dispassionate and thoughtful critique of the interventions employed (DCoP, 2005). By working in the here and now, we are more able to consider our own process (i.e. the use of self) and how it impacts on the therapeutic alliance.

Both therapy schools originate from Western philosophies and are not always so easily transferable to different cultures or countires outside Europe, which is an overarching similarity. CBCT and psychodynamic approaches increasingly need to consider diversity and equality, with migration and immigration growing across continents. When working with couples it is equally as important to consider other diverse factors such as gender, and age for both the couple and the therapist. An awareness of attendance to the social and cultural context is paramount to CoP practice (DCoP, 2005).

A Comparison of Evidence-Based Practice

According to Gilbert and Leahy (2007) CBT is united with psychological science and progressively more neuroscience. CBCT has been evaluated in more controlled outcome studies than any psychodynamic therapeutic modality, and evidence indicates that CBCT is effective in reducing relationship distress (Dattilio, 2010). However, as recognised by Dattilio (2010), the majority of these studies have focused on behavioural interventions (e.g. communication training and problem-solving training). It is also acknowledged that there are fewer studies including mental health populations. However, this is probably true of psychodynamic therapy with couples. Indeed, psychodynamic therapy has historically been more problematic to measure in terms of therapeutic outcomes. This is interesting given that psychoanalytic practice whether it be with individuals or couples,

goes back further in history than CBCT. Thus, one cannot forget that psychoanalysis has historically played a central role in establishing and defining psychotherapy (Sander, 1998). Moreover, one could argue that a substancial overlap exists in CBCT and psychodynamic theoretical concepts. For example, it is suggested by Gilbert & Leahy (2007) that transference and countertransference have similar conotations as core beleifs and schemata, yet only the latter are available for evidence-testing.

Reflections as a Trainee Counselling Psychologist

It has been challenging to consider the CBT and psychodynamic framework as two separate entities. As a psychologist working in the evolving NHS with clinical experience in a range of settings, including IAPT and Secondary Care Mental Health Services, it has become increasingly difficult to work from one specified approach. More specifically, how it is difficult to consider these approaches as antithetical (Sander, 1998). As I have adopted my own therapeutic style and increased my knowledge in the various models of practice, I have sometimes favoured one approach over another, depending on my personal and professional development at the time. For example, near the beginning of my training I found myself leaning towards psychodynamic practice, perhaps because at that time I already had considerable experience and training in the application of CBT. Nonetheless, in writing this essay and learning more about how CBT can be applied to couples relationships, I have felt encouraged and inspired by the realms of contemporary CBT. On a similar note, I have been enlightened by systemic theory and have enjoyed reading literature in this field. It seems difficult to comprehend how a developing therapist could enter the therapeutic arena with a couple without considering systems theory and relevant concepts like reciprocal influences (Dattilio, Epstein & Baucom, 1998).

Throughout this compare and contrast exercise, I have found myself continually thinking about the common thread that is prioritised in all of my

therapeutic work, regardless of whether it is with an individual, a couple, a family, a group or a multidisciplinary team. That is, my professional and ethical yearning to collaborate with the presenting frame of reference, utilising whatever intervention feels psychologically right in the context of the work. As a CoP in the final lap of training, this assignment is one of many that has broadened my view of how I can help others and specifically, couples enduring psychological distress. Furthermore and in relation to couple work it is suggested "that people exist in relationship" (James & Bellamy, 2010, p. 413). Perhaps then, we implicitly work with couples and families as part of our clinical practice with individuals.

Concluding Remarks

Indeed psychodynamic work with couples provides a rich and layered texture to the therapeutic frame – one that largely draws on process and interpersonal interactions in terms of interventions. CBT with couples on the other hand, provides a clear and definitive structure. CBT can be observed as a more organised or technical process, with a heavier research base. Both approaches have their strengths and limitations however, from a CoP perspective; they seem to equally consider the importance of a safe, holding and non-judgemental therapeutic environment. Therapies that are based on learning about and ethically respecting, two person's views have many common elements. To this end, a strong therapeutic relationship is a significant contributor in therapeutic outcomes (Gilbert & Leahy, 2007). From a CoP perspective, an emphasis on building rapport and trust with a client in a supportive, empathic and collaborative way is core to all therapeutic work, regardless of the theory or intervention applied (DCoP, 2005).

Furthermore, I believe there are times when integrating CBT principles, with interventions from psychodynamic theory is an appropriate and ethical way of working with a couple in some form of conflict. I believe there are therapeutic situations given the appropriate context where the two approaches

can complement each other. Moreover, couple work is most effective within a flexible and creative therapeutic framework, which from a pluralistic perspective may incorporate a combination of techniques and interventions from different models (Cooper & McLeod, 2010). In addition, and as modern day therapeutic models develop and expand it is becoming more difficult to distinguish between approaches, unless one views them through a polarised lens.

As a third year trainee CoP I have recently been thinking about what population I would like to work with as a qualified professional. In my current workplace I am fortunate enough to work with individuals, couples, families and groups. Whilst I really enjoy working with the wider system and perceive it as valuable learning and on-going development in my career as a CoP, I have never *really* thought about doing couple work. I now recognise that this relates to the lack of training and reading I have done in this area. In completing this essay I am eager to consolidate this new learning in my clinical work and begin thinking more readily about the prospect of couple work.

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Section D - Process report

How Do We Make Sense Of This? Understanding Human Complexity Within An Interpersonal Therapeutic Framework.

Introduction

This process report describes and analyses a piece of therapeutic work with a female named Claire (pseudonym to protect confidentiality), who is being treated under an Early Intervention in Psychosis Service (EIP). EIP is a Secondary Mental Health care team within the National Health Service (NHS) that works with people experiencing a first episode of psychosis. This service assesses psychosis under a diagnostic uncertainty framework, thus, involves working with clients who are experiencing psychotic phenomena, not specifically first rank (acute) symptoms. The sessions with Claire are ongoing and take place in a community setting, using Cognitive Interpersonal Therapy (CTI). This approach suggests that "psychosis is fundamentally a normal human `experience, the form and content of which reflect core cognitive, interpersonal and development life...experiences" (Gumley & Schwannauer, 2006 p.xii). Drawing on attachment theory, CTI incorporates a focused, collaborative approach to help clients with complex needs establish more adaptive ways of coping. Building on traditional Cognitive Behavioural Therapy (Beck, 1976), it highlights the importance of using a co-ordinated and multi-disciplinary team-based approach in maintaining a compassionate and mindful attitude to recovery. The report begins by providing an assessment and multi-theoretical formulation of Claire's difficulties whilst considering the research literature relating to complex cases. Process and therapeutic interventions are then evaluated from a transcript in relation to relevant theoretical constructs and CoP philosophy. This case has provided a key learning experience in contributing to the assessment and delivery of psychological therapy, for specialist clinical presentations within a multi-disciplinary team (MDT). Gumley & Schwannaur (2006) note the importance of integrating the therapist's work into a systemic context when providing

multi-disciplinary care. In writing this report, I have reflected on an ethical dilemma encountered in balancing a trusting therapeutic relationship, with demands from working in a NHS service bound by policy and legislation.

Client and Referral Information

Claire is a single, White-British, unemployed, 18 year-old female who is temporarily staying with her father and his partner, whilst seeking more permanent housing. She recently moved out of her mother's house, where she has lived since her parent's separation (aged 10) following a number of altercations between them. There is a long-standing history of past substance misuse for both of Claire's parents. Claire has one older half-sister and two older half-brothers, all of whom share the same biological mother but have different fathers. This is Claire's first experience of therapy but not her first contact with mental health services. She was referred to EIP by the local child and adolescent service (CAMHS). According to Claire and her clinical notes, her contact with CAMHS was brief and engagement was difficult. Claire was referred for therapy, by her mental health care co-ordinator to grasp some perspective on how her persona has developed. At this time, Claire had become increasingly frustrated with an unknown 'sense of self', given that others could not understand her in a way that made sense to her. Claire agreed with her care co-ordinator that psychological therapy may be helpful.

Assessment

During the assessment, Claire referred to not understanding herself, stating "I don't really know who I am". I initially considered this identity confusion to be related to her lifespan developmental stage as described by Erickson (1968). Erickson's psychosocial development stages characterises a struggle between fixed identity and role confusion in adolescence. However, in further questioning where Claire found it almost impossible to think of three words to describe herself, it became apparent that her confusion was deeper than a developmental account. Claire described her childhood as "being around" parents who drank excessively and used "lots of drugs". She recalled

memories of her mother being "passed out on the sofa" and generally unavailable. She expressed anguish about this, and it was difficult to ascertain if she had any understanding of her mother's feelings or behaviour. She further reported witnessing acts of domestic violence between her parents. Claire described her unhappiest period to be during her poorly attended school years. This coincided with a sexual assault accusation, made by her half-sister about her father. This accusation was never proven and Claire's father denies it. Claire reports' believing her father and therefore making sense of this allegation has been very difficult for her. Following a conversation with her half-sister, Claire has queried if she could have been sexually abused by her father. However, due to no memory of him doing so she is very unclear about this, and has surmised whether her trust in her sister, alongside her family's hatred towards her father, has triggered this speculation. Claire has asked to access historical social services notes, which EIP are supporting her in to help make sense of her past.

In relation to psychotic phenomena which have now subsided, Claire reported hearing a voice but found this experience difficult to articulate. Her attempts to describe it (by gender or tone of voice) appeared vague. She also referred to paranoid ideation and visual hallucinations in the form of "floating heads". Past maladaptive coping strategies include drinking "vodka" which has reportedly helped Claire to socialise and blunt her affect, in times of emotional distress. Claire's interpersonal presence appeared emotionally distant in our initial session, and for many after that. Gumley & Schwannauer (2006) suggest that difficult early interpersonal experiences can affect the ability to relate to, or trust others. They further argue that interpersonal difficulties can manifest in a more persistent attachment style, following the onset of psychosis.

Ethics and Risk Assessment

In accordance with NHS protocols, the Trust's safeguarding lead has been consulted regarding Claire's safety, in light of her staying with her father

when she is querying abuse from him. Claire's capacity to make this decision as an adult has been carefully assessed within the MDT framework. Other risks include a 'drunken' overdose three years ago. Although Claire has since contemplated suicide she has made no attempts. Confidentiality has been addressed in relation to self-harm/harm to others as per NHS policy (DoH, 2003), supervision and consent for audio-recording, in line with the Code of Ethics and Conduct (BPS, 2009).

Formulation

An array of trauma has manifested in anxiety, psychotic phenomena and mixed affective states for Claire. It is hypothesised that Claire's early adverse experiences are intrinsically linked to her difficulties, which stem from a disorganised attachment base (Main & Solomon, 1990). Gumley & Schwannauer, (2006) propose that parents under the influence of substances, or highly distressed from their own trauma provide a disorganised attachment base for a child. Not having a secure environment where Claire could grow or feel loved is at the core of her multifaceted difficulties.

Whilst a sturdy link is identified between insecure attachment, and vulnerability to mental health difficulties (Rosenstein & Horowitiz, 1996), Claire's complex difficulties do not fit into such a tidy 'formulation box'. A developed conceptualisation draws on the influential work of Bowlby (1973), and more contemporary theories suggesting a relationship between early attachment experiences and present psychopathology. This relationship is modulated by internal working models, underlying self regularity processes (Fonagy & Target, 1997) and behavioural adaptation (Gumley & Schwannauer, 2006). The notion that disorganised attachment and later maladaptive outcomes are mediated through self-regulation, and reflective functioning (an ability to reflect on the mental states of others, Fonagy & Target, 1997) makes sense in formulating Claire's difficulties. Children with insecure attachment are recognised to have difficulty understanding negative emotion (Labile & Thompson, 1998). Claire's observed inability to

comprehend her mother's distress, in combination with her own difficulties in regulating emotion, and other adverse risk factors (Kochanska, Murray, & Harlan, 2000) provide a basis for understanding her current presentation.

From this multi-theoretical perspective, Claire's avoidance and resistance in therapy are observed as defences that serve a self-protective function. Moreover, they relate to an insecure attachment style, in which Claire has learned to shut out difficult emotions to order to cope. Claire displays difficulties in regulating her emotions - revealed by alcohol misuse and intense emotional disarray. According to Briere (1992, 2002) individuals who have not achieved adequate affect regulation will often engage in maladaptive coping strategies such as substance abuse, dissociation, and avoidance.

This formulation also offers some explanation for Claire's experience of psychosis. Research examining predictors of psychotic relapse suggests that positive symptoms are related to "high levels of emotional distress and affect dysregulation in the period before during and following the acute phase of psychosis " (Gumley & Schwannauer, 2006 p. 18). One of many predisposing factors linked to psychosis, is the inability to achieve autonomy (Harrop & Trower, 2001). Claire's ongoing struggle in achieving independence and her lack of self belief that she can be autonomous has been noted in ongoing discussions with her care co-ordinator.

Therapy aims and overview

Claire has received 25 therapy sessions over a 14-month period as part of a collaboratively agreed open-ended contract. Despite a slow and disjointed beginning Claire has attended regular appointments since February 2012. Claire initially appeared ambivalent about therapy, noted by her tendency to not attend, to "close down" or dismiss difficult feelings. We have started to reflect on how Claire is slowly engaging with difficult feelings. In building rapport with her, I try to maintain a tentative pace recognising a potential power differential, marked by my (older) age and professional position.

Therapeutic aims include helping Claire understand herself and developing more adaptive ways of coping. Careful attention and considerable time has been spent nurturing the therapeutic relationship, in providing a secure base for Claire to explore difficult feelings (Gumley & Schwannauer, 2006). Therapy so far has helped to normalise Claire's sense of confusion in understanding herself, and we have begun to talk quite openly about her past.

Lead-in-to-session

The transcription is taken from session 25 which began by discussing Claire's attempts to find housing and an overview of how was feeling. My intention in this stage of therapy is to explore how Claire is coping as she reflects on difficult issues.   Just prior to the transcript starting, Claire asked "is this going anywhere?" to which I reply "no". I provide this answer on the basis of previous conversations about confidentiality when Claire has questioned whether information is shared with her mother. However, my immediate thought afterwards was that I have given an incorrect response and reassured Claire can trust me when I cannot hold to that professionally. This is reflected on in the evaluation.

Transcript and Commentary (28 minutes into session)

Client 1: Ok, erm....like when I was lot younger, my mum and my brother....don't think and my brother actually....they used to like....erm (said quietly)...say like...like my Dad's a paedophile and stuff... and erm....like...erm.....like I didn't, like I didn't know how to take it, but I didn't believe it for a while, like for quite a few years.....but, maybe because they keep saying it, I...start to believe it...but then my sister said its true, 'cos it was because of my sister and stuff...but, how am I supposed to know if that's even true 'cos like...I know it's my sister and I know she wouldn't lie, but I still feel like it's not right....(said in a faster tone of voice and purposeful manner).

Therapist 1: Mmmm...this seems as if it's quite painful, for you?

Comment 1: I recognise Claire's frustration as I consider how difficult Claire has found it, to think her father would cause her or others harm. My rationale for not discussing risk from her father (as previously done by myself and her care co-ordinator) is because (a) she has not made a clear accusation (b) I am working within an MDT framework where it has been advised that no further action can be taken on the basis of speculation. My comment acknowledges the cognitive dissonance Claire is communicating. However on reflection, I feel that my attempt to elicit her feelings could have been more directive. Whilst I have validated her internal experience, I have not facilitated her confusion (as identified in her closed response below). It may have been more useful to say something like..."it seems as if you are struggling knowing what to believe right now, I wonder if we can think about this for a while".

Client 2:....yeah.....(said quietly)

Therapist 2: And from what you're saying it seems as if (long breath)......there's some facts that, there could be facts there because your sist......you trust sister and.....

Comment 2: In a counter-transference reaction, I cautiously respond to Claire's confusion with my own confusion. Claire has recently started to open-up in what seems a mature attempt to understand her feelings. I am keen for her to remain engaged in the process as I try to make sense of her perspective and reflect it back.

Client 3:...yeah.

Therapist 3: she wouldn't...make stuff up but......(deep breath) it's hard to believe those facts...

Client 4: Mmmm..

Therapist 4: because this is...someone you...love and someone you have a relationship with...(silence)

Comment 4: I stumble with my words and mirror Claire's hesitation as I try to empathise with her mixed feelings. I repeat what Claire has said in previous sessions about her sister to try and convey my understanding of how difficult this is for her.

Client 5: But if I like...if I just know that, how, how do I know I don't like...know loads of other things that are really bad...

Therapist 5:.....(heavy exhale)....what sort of other things are really bad? Can you tell me?

Comment 5: My tone of voice changes and I sigh in an apprehensive manner. I anticipate that Claire may reveal more trauma. I then encourage Claire to explore her underlying meaning, inviting her to say more.

Client 6: I don't know

Therapist 6: What do you mean?

Client 7: I don't.....like 'cos I don't even know I don't...(pause) Like.... (sigh) I don't know anything (said boldly)..., and that's why I'd rather know, cos then I could like......build my relationships and stuff with people.

Therapist 7: Hmmmm...

Client 8: Instead of feeling like really hostile against everyone.

Therapist 8: Hmm hmm...mmmm...(pause in waiting for Claire to continue).

Client 9: ....but then again, I'll never really know the full story will I?...Or the truth 'cos....someone (mobile phone message sounds out) might be saying something else, and then someone might be lying and then...

Comment 9: Claire seems to be struggling with issues of trust which would be useful to explore with her. She seems to be saying that reading the notes won't provide the full truth. I feel confused with her and long to provide her some certainty.

Therapist 9: Hmmm........

Client 10: and maybe someone saw it differently and like, I don't know...

Therapist 10: Yeah.....there's lot's of different factors involved, there's different perceptions, different stories, (deep breath) different ways of telling those stories... (Silence while client nods in agreement - Sound of clock ticking in the background).

Comment 10: I tentatively attempt to stay with her confusion in paraphrasing her comment.

Therapist 11: Mmmm...What do you think would help you to...sort of...get through it...so we can...you know that there is the.....(mouth sound and deep breath), there's this idea of trawling through those notes and....seeing what you can find there but...how helpful do you think that will be in.....(deep breath and pensive thought), what sort of answers are you looking for at the moment, what wh.....(client heard moving in her seat) what do you think would...help you cope with this right now?

Comment 11: My intention is for Claire to explore what emotional effect reading through these notes may have. My pensive and cautious style represents respectful curiosity (Campbell, Draper & Huffington, 1989). I try to collaborate with Claire whilst allowing her autonomy, to consider how we can use therapy to prepare her. I am also trying to check-in whether she has the emotional strength to read them. However, in using the word "trawling" I perhaps suggest this will be an onerous task. Perhaps, I have interpreted her earlier comment (Client 9) as reluctance to read the notes. I wonder if Claire now feels confused by me.

Client 11:....I really don't know...(pause)...I think like...if I read like a few pages and stuff, like it would help me understand a bit more...

Therapist 12: Hmmm....

Client 12: ..Maybe...(said in an uncertain tone)

Therapist 13: Hmm, mm...

Client 13: but then there might be stuff on there that's not even been added because it won't have been said, 'cos my Mum...when...erm....she told me...she's like.... a really...well....and er she went to the......hospital or something and I think she like......fractured or broke her jaw.....when my Dad hit her...

Therapist 14: Mmmm hmm......

Client 14: And Mum was like "oh I fell over or something"...and I was like this little girl....and she was like....I was like erm, no my Dad did it...and like, I don't know why I just said that, I can't remember what I was talking about....

Therapist 15: So you were saying about if you read the notes, there'd be stuff in there that wasn't....there'd be....th, th, there could be stuff that isn't in there that happened.

Comment 15: Despite stumbling with my words I am able to refocus Claire as she replies assertively below. I feel satisfied and helpful for jogging her memory but I am aware of Claire's struggle to decide whether knowing will be better than not knowing.

Client 15: Yeah! (said confidently and loudly)...Like some o....like Mum could have said something....like to t….like to hide away from it – that's what I was getting at....so I don't...really know what's gonna be right or wrong...

Therapist 16: Mmmm....

Client 16: So I'm....I don't know....(deep breath)

Comment 16: Claire seems to be acknowledging that even on reading the notes she may never know the truth. Again, she draws attention to not being able to trust others and particularly her mother.

Therapist 17: So, Mum could have been covering up....for your Dad, at times?

Comment 17: My comment attempts to clarify and understand what Claire has said.

Client 17: Yeah...but...yeah I don't even know if they spoke to me...like the people....who like...wrote down everything.

Therapist 18: Mmmm...you don't know if they consulted you and got your opinion?

Client 18: I don't know

Therapist 19: You can't remember...

Client 19: I didn.....I didn't even realise that my sister was like sat telling me like...there's always like a social worker round...but I...I can't even like....I can't remember a social worker ever being there...

Comment 19: Claire reminds me of how chaotic her early life was; I notice myself feeling quite helpless and wonder if this is how she feels.

Therapist 20: Mmm...(Mobile phone message tone sounds).

Client 20: So I don't understand like...(pause)...I don't know...mum's never spoken about it.

Therapist 21: Never spoken about?.

Client 21: There being a social worker around...

Therapist 22: Right...

Client 22: Maybe she figures that I remember but I don't....

Therapist 23: Mmm...

Client 23: I really don't like this cover.....sorry. (Client giggles as she puts her phone away)...eugh...(deep breath).

Comment 23: As Claire is distracted by her phone I wonder about the underlying message of her abstract comment amongst what seemed like a meaningful dialogue. It would have been useful to reflect on this with Claire and show understanding that she may be finding this hard.

Therapist 24: Mmm.....(pause)...(clock heard ticking in the background). Do you think you still wanna read through the notes?

Comment 24: Instead of staying with Claire my question is direct, as I check that this is still what Claire wants. I suspect my own anxiety is driving this question as I feel the need to get back on track and move forward. On reflection, I seem to be struggling with the current uncertainty in Claire's life, and the confusion this brings to the room.

Client 24: Yeah (said in an upbeat confident tone).

Therapist 25: You do?

Client 25: But...I don't wanna like....literally crumble...if somethings' really bad in there...

Therapist 26: Mmmm....

Client 26: But then again if I can't remember what...I felt, I don't think I'd probably.....would know what I felt like then anyway, even if that comes true...

Therapist 27: Hmmm mmm....

Client 27: So maybe it's just...maybe like a kind of realisation or something but not actually knowing what it feels like...

Therapist 28: Mmmm....(pensive pause anticipating that Claire may continue)....and you're saying that....even if you do read it and...there's stuff in there that's...difficult to digest, you're not sure if you can believe it anyway.

Client 28: Mmmm......

Therapist 29: You're not sure how true that is?

Comment 29: In remaining aware of how Claire can close down, I try to guide her gently to clarify her thoughts.

Client 29: Mmmm hmm...maybe I should just like get over...it...(heard sniggering)

Comment 29: Although the chaos in Claire's early life has rushed her into adulthood, her childish snigger reminds me that she is still developing in terms of emotional maturation.

Therapist 30: What do you mean?

Comment 30: I reply with a curious tone, inviting Claire to explain. This is another point where I could have been more directive in exploring her meaning of "it".

Client 31: Like just not...worry about it anymore, just not think about it.....but....then again......I just can't (said assertively).

Therapist 31: Hmmm.

Client 32: But I wann'ou....I...

Therapist 32: It's a difficult thing to put out of your head, and I think the fact that you can't put it out of your head at the moment is.....(deep breath)...erm....perhaps a sign that things have changed for you, because when we first met....it was a lot easier for you to just....block things out.

Comment 32: I have mirrored Claire by not naming "it". Claire has never directly used the phrase 'sexual abuse' when talking about her father. Whilst being guided by Claire in using her choice of words, it may have been useful to reflect on our narrative here. As a counter-transference reaction, perhaps I am avoiding saying what she is trying hard to avoid thinking about. The second half of my comment aims to encourage self-reflection for Claire to consider how her experience of regulating emotions is changing. Gumley & Schwannauer (2006) note how the process of interpersonal change requires

clients to become aware of difference in their ability to engage with difficult emotions.

Client 33: Mmmm...

Therapist 33: In fact in some of the very early sessions we had....that's....what you used to describe doing....just blocking everything out, you can't recall anything because you'd blocked it out, that's how you coped...

Comment 33: In fostering Claire's emotional development, I aim for her to realise (shown in her response) that she has made progress in therapy in being able to express painful feelings. Helping Claire to acknowledge her inner resources is important for building self-efficacy (Schwartz & Flowers, 2006).

Client 34: ….Yeah I guess so (said softly in agreement)...

Therapist 34: Y...You know one of the things we......talked about at the beginning was about us....trying to understand *you* and (deep breath)......erm......sort of trying to work out who Claire is...and...what goes on for you and how you deal with things and I think what we are touching on now is....different ways of *coping* with things...

Comment 34: In revisiting the focus of therapy whilst attending to emotional recovery, I guide Claire to reflect on how her coping strategies are developing.

Client 35: Yeah...(Silence for 14 seconds).

Therapist 35: Is there anything...that you think....you know we could... in terms of preparing for this period when you read these notes...is there anything that you think that we....could do in our sessions or......the service could do to..sort of prepare you for that?

Comment 35: I attempt to empower Claire by inviting her opinion about what may be helpful to her multi-disciplinary care (Feltham & Horton, 2000).

Client 36: No idea......'cos I don't, I don't really know how I'm gonna react...

Therapist 36: Hmmm......but there is a very real fear of crumbling?

Client 37: Mmmm...

Therapist 37: What's your...what's your previous experience told you about when you crumble....what's crumbling look like?

Comment 37: I intend to remind Claire of a recent painful experience where she got through something she thought she wouldn't.

Client 38: Err...well (client laughs)...you know when I like....I think I might have rung?... you or something.

Comment 38: Claire remembers this experience in which she appropriately utilised EIP support. This irregular occurrence illustrates the diversity of my CoP role in an MDT context which has served to nurture the therapeutic alliance with Claire. Theoretically this has provided a corrective emotional experience, (Alexander & French, 1946) for the rejection previously received in response to her emotional distress. Providing a safe relationship for developing improved affect regulation (Fonagy, Gergely, Jurist & Target 2002) is pivotal to the therapeutic work with clients who have experienced neglect.

Therapist 38: Mmmm...

Client 39: When me and my ex-boyfriend broke up...

Therapist 39: Mmm hmmm...

Client 40: That's pretty crumbling...(client laughs)

Therapist 40: Yeah......

Client 41: So.....

Therapist 41: So when you were standing under the tree...

Client 42: Yeah....(said in a laughing tone)...

Therapist 42: ...in the road...

Client 43: Yeah...

Therapist 43: And couldn't move and were frozen? Yeah.

Comment 43: Claire and I then think together about how awful this incident was for her. In reference to the formulation, it's important for her to access these negative emotions.

Client 44: That was horrible.

Therapist 44: Mmm... I remember how distressed you were.

Client 45: Yeah....(pause).

Therapist 45: And I remember you thinking that...you know you were never going to get through that and.....how were you gonna cope and you just didn't wanna be around anymore...

Comment 45: In a soothing interpersonal stance, I show Claire that I recall how difficult this was for her.

Client 46: Yeah.....

Therapist 46: You said all those sort of things...

Client 47: Surprised I got through it to be fair...

Therapist 47: Mmmm hmmm.

Client 48: I don't understand how I did it, because everything was going wrong.

Therapist 48: Mmm....there was a lot happening back then.

Client 49: Mmmm...

Therapist 49: And there's a lot happened since then.

Client 50: Mmmm...

Therapist 50: You've now not got anywhere to live.

Client 51: Mmmm hmmm......(pause).....(mobile phone message tone sounds) Sorry...(pause – 17 seconds)...(tapping in background as client replies to a text message).

Comment 51: We appear to be in tune with one another before Claire's phone sounds. I have learned to work around such interruptions, partly in fear of sounding like someone that enforces rules, and partly because of allowing Claire to make that choice herself. I suspect her phone provides a safety measure, or acts as a psychological defence to escape unwanted feelings.

Evaluation

In analysing the transcript I am struck by how difficult the work remains despite the distance we have come. As part of preparing this report, I listened to some early sessions with Claire, which reminded me of how hard it was for her to trust me, and how challenging this felt. To this end, trust appears pivotal to this slowly built therapeutic relationship. With this in mind and reflecting on my false assurance of confidentiality I wonder if, this affected Claire's openness in the session. Although Claire did not disclose any new information in relation to risk, her openness in her struggle of 'knowing or not knowing' about her father represents a forward step in therapy. The bounds of confidentiality (in relation to above) have been reiterated to Claire.

In thinking further about the therapeutic process, I think there are times when I encourage "a respectful, collaborative" and "evolving narrative" (Mason, 1993 p.194). This attention within the context of an empathic and authentic framework has been momentous to the therapeutic alliance with Claire. When considering insecure attachment as a factor in pathological distress, a strong therapeutic relationship offers a secure base for clients deprived of and seeking closeness (Gumley & Schwannauer, 2006). From another perspective, there are times where I feel lost in Claire's confusion (e.g. comments 2 & 15) and

frustrated about not knowing where to go. Sitting with uncertainty can be anxiety provoking for me especially given a personal trait to be pro-active in other aspects of my professional work. In discussing this in MDT supervision, I have considered how I might slow down the narrative to hear more of what Claire is feeling. This may optimise Claire's self-reflection in understanding her sense of self and help me to connect with her on an empathic level (Schwartz & Flowers, 2006). In reference to my learning outcome, working with Claire has illustrated that clinical discussions within an MDT framework are essential in providing a consistent approach to her care. Furthermore, my CoP role in EIP has enabled me to engage with research and "to be practice-led" in building therapeutic relationships with my clients (DCoP, p.2) within a multi-disciplinary setting.

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