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Engagement In Psychoeducational Family Interventions For Psychoses

by

Carolyn Mary James

**A thesis submitted in partial fulfilment
of the requirements for the degree of
Doctor in Clinical Psychology**

**Coventry University, School of Health and Social Sciences
And
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Declaration

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Summary

The aim of this study was to examine relationship and process issues in psychoeducational family interventions in psychosis with particular reference to engagement. A review of the literature in this field demonstrated that whilst such approaches are beneficial in reducing relapse and readmission rates, the implementation of family work into routine clinical practice remains problematic. It was argued that research addressing therapist and client factors and the process of therapy may assist in understanding implementation issues. Six papers examining family and client factors were discussed. The majority of the studies were quantitative and focussed on family factors. The literature demonstrated that family factors were important in engagement and the process of therapy. However, there appeared to be an absence of studies addressing therapist factors, in addition to the dominance of quantitative methods. It was argued that further research should address these issues. The first study in this thesis was a questionnaire survey relating to therapist assessment of engagement. Results suggested that therapists were able to identify signs of engagement as changing over time. The relative importance of the signs was also reported. The findings and the low response rate were discussed. The second study used qualitative methods to examine engagement in behavioural family therapy (BFT). Participants were workers trained in the approach and families who had engaged in the therapy. Data collected by semi-structured interview were analysed using a grounded theory approach. A model depicting the therapists' experience of engagement emerged from the data. The core category of "humanity" and other categories were described. The implications of the model for research, theory and practice were suggested. The final paper in the thesis discusses the impact of the research process on the researcher.

Chapter One

Where now? Next steps for research in psychoeducational family interventions in psychoses

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Abstract

Outcome research in psychoeducational family interventions has demonstrated that they are of benefit in reducing relapse in schizophrenia. The following paper will summarise recent reviews examining the evidence for psychoeducational family interventions and discuss implementation issues. It will be suggested that research examining therapist and client factors, as well as the therapeutic relationship will contribute to our understanding about difficulties in implementation. The literature investigating these issues will be reviewed. The strengths and limitations of the research will be discussed, and the clinical and research implications will be outlined.

1.1 Introduction

To date, research in family psychoeducational approaches has focused on outcome. Whilst the efficacy of family interventions in psychosis has been proven, the implementation of such approaches remains a major concern. The focus of this paper will be to explore the use of process research and how this may lead to a greater understanding of factors that facilitate, or impede, the implementation of psychoeducational approaches. It will be argued that such research is a welcome contribution to the field of psychoeducational family interventions research and furthers the development and implementation of these approaches.

1.2 Background

The last twenty to thirty years has seen a marked change in the way mental health services are provided for people with serious mental health difficulties. Government policies such as the Carers (Recognition and Services) Act (1995), the adoption of the Care Programme Approach, and the emergence of user and carer groups have led to greater involvement of service users and carers in service implementation and development. These initiatives have led to a shift from viewing patients as passive recipients of health services to regarding them variously as “clients”, “customers” or “service users” (Department of Health, 1997).

Developments in policy, theory and practice are embodied in recent guidelines working in partnership with service users and carers across all phases of treatment (National Institute for Clinical Excellence, 2000). Specific

recommendations for care include a greater use of information, supportive and psychological approaches and the involvement of family members in assessment and treatment (Department of Health, 1999; NICE, 2002)

Advances in interventions for people with serious mental health problems have been responsible, in part, for the changes in the nature of health service provision. In understanding the diagnosis of schizophrenia, theoretical developments such as expressed emotion (Brown et al, 1972) and the stress-vulnerability model (Zubin et al, 1992) have led to a conceptualisation of schizophrenia, and other psychoses, as the result of a complex interaction of social, biological and psychological factors. This has resulted in the development of psychosocial interventions that have been shown to be effective in working with people with severe and enduring mental health problems (Bustillo et al, 2001; Pilling et al, 2002a, 2002b).

An extensive body of research has established the evidence for the effectiveness of psychoeducational family interventions in schizophrenia. Interventions may differ with regard to the content and duration of the work, and the format of delivery (either to individual families or in multi-family groups). However, common to all are their key components: a positive approach to the family, a genuine working relationship, structure and stability, a focus on the here and now, use of family concepts, cognitive restructuring and behavioural approaches and improvements in communication (Lam, 1991).

Despite evidence for the efficacy of such approaches, implementation of psychoeducational family interventions in routine clinical practice remains a key

issue. Difficulties in implementation have been highlighted by a number of authors (Fadden 1997; Fadden and Birchwood, 2002) and organisational and clinical barriers are likely to exist in implementation. Process research, which addresses the experience of client and therapist, the therapeutic relationship, as well as events within the therapy process, may provide further clues about implementation issues.

The main aim of this paper will be to examine psychoeducational family literature in terms of process research. The issue of definitions and terms used in the psychosocial literature will be addressed. In order to establish the status of family interventions, a summary of recent research up-dates and meta-analyses examining psychoeducational family approaches will be detailed and the subject of implementation will be discussed. A number of empirical papers examining process issues in psychoeducational family approaches will be reviewed and some initial conclusions and recommendations will be made.

Terms used to describe work with families are many and varied, with little consistency (Fadden, 1998a). There is also a question about whether the term “psychosocial interventions” refers to a set of interventions or an ideological and political paradigm that contrasts with the non-recovery medical paradigm (Brabban, 2001). The latter may be detrimental, in that it reduces attitudes, models and skills to a single term (Brabban, 2001). Thus for the purposes of this paper, the term “psychosocial interventions” will be used to describe specific models based on a conceptualisation of schizophrenia as a biopsychosocial phenomenon. The term psychoeducational has been used to describe family interventions, the primary aim of which is relapse reduction.

These approaches include the service user and adopt a didactic element to communication and problem-solving skills acquisition (Fadden, 1998a). This is therefore the definition of choice for this review.

1.3 Psychoeducational family literature

The term outcome research refers to studies designed to determine the efficacy of a specific intervention on a specific outcome. In the field of psychoeducational family approaches, many randomised controlled trials and evaluations have established that there is a beneficial effect on relapse and other “secondary outcomes” such as the emotional climate of the family, patient functioning and family well-being. The following section will briefly summarise the findings and conclusions of some of the most recent literature reviews and meta-analyses in this area.

1.3.1 The reviews

Recent studies on psychoeducational family interventions confirm earlier findings concerning the benefits to relapse and readmission rates (Dixon et al, 2000; Pilling et al, 2002a). Pitschel-Walz et al (2001) conclude that the inclusion of relatives in the treatment reduces relapse and rehospitalisation in patients with a diagnosis of schizophrenia. Barbato and D’Avanzo (2000) are somewhat more qualified, stating that psychoeducational family interventions as a standard treatment of schizophrenia have a positive effect on outcome “to a moderate extent”, and are effective in reducing the short-term risk of relapse. They conclude that the effect of family interventions is most evident when compared with “low quality” or uncontrolled individual interventions.

In terms of content, it appears that longer-term interventions offer an advantage over brief interventions (Barbato and D'Avanzo, 2000; Dixon et al, 2000; Bustillo et al, 2001; Pitschel-Walz et al, 2001). Furthermore, it appears important to include service users in at least some of the work, and the provision of education and information appears necessary but not sufficient in isolation (Barbato and D'Avanzo, 2000). Finally, it appears that interventions extended to a single family may offer some benefits over multi-family groups (those involving a number of families), although Pilling et al (2002a) urge caution when interpreting these findings. Other than the above it appears that, provided the key components outlined by Lam (1991) are included, different configurations of psychoeducational interventions are equally effective.

Caution may also be required when assessing findings in relation to different family characteristics. It has been argued that, as the majority of studies were undertaken in Anglo-Saxon cultural frameworks, generalisation across cultures is limited (Barbato and D'Avanzo, 2000). It is also difficult to draw conclusions about the benefit of family psychoeducation for families earlier in the phase of illness compared to later (Dixon et al, 2000). Furthermore, Barbato and D'Avanzo (2000) conclude that evidence is limited with regard to families with low scores on expressed emotion (EE). Dixon et al (2000) suggest that these results do not so much cast doubt on the use of family psychoeducation with families as highlight the importance of families understanding what their needs are, as well as knowing what the aims and methods of any intervention programme offered would be.

A number of studies have demonstrated a beneficial effect on outcomes other than relapse or readmission rates. In their review, Dixon et al (2000) found improvements in patient related outcomes such as self-efficacy, functional disability and employment. Family-related outcomes such as improvements in client-family relationships, family well being, reduced burden and increased knowledge about the mental health problem have been shown (Dixon et al, 2000; Bustillo et al, 2001). However, many original studies have not addressed outcomes to the same extent as relapse and readmission. Pilling et al (2002a) state that in the studies included in their meta-analysis, little attention was given to the potential benefit to family members. Even when non-relapse outcomes were assessed, they were usually reported as “secondary outcomes” (Dixon et al, 2000). The same authors state that the recovery paradigm emphasises the importance of including other variables, such as client and family functioning, when investigating programme efficacy.

Despite the strong evidence indicating the efficacy of psychoeducational family interventions, the inclusion of the family in the treatment or care of people with a diagnosis of schizophrenia is still not routine in many countries (Bustillo et al, 2001; Pitschel-Waltz et al, 2001). Dixon et al (2000) point out that the use of “usual care” as a control comparison highlights the fact that family work is not standard in many circumstances. As noted earlier, the absence of psychoeducational family interventions in routine clinical practice suggests that there are difficulties with the implementation of family work. Barriers to implementation may come from providers, commissioners, families and service users (Dixon et al, 2000). Furthermore, other difficulties in implementation may be due to the initial effort involved in setting up family work as well as a general

scepticism with regard to psychosocial interventions (Pitschel-Walz et al, 2001).

Many authors have offered a number of caveats to their conclusions on the effectiveness of psychoeducational family interventions. One major qualification centres on the fact that more recent studies appear to show smaller differences between intervention and control group. However, this may be due to a number of reasons. Pilling et al (2002a) highlight later studies that use active treatments as a comparison, and one would therefore expect a smaller effect size. Secondly, the quality of “standard care” has improved greatly compared to that of earlier studies and it would be difficult for any new treatment to demonstrate an effect (Bustillo et al, 2001; Pilling et al, 2002a). Furthermore, it is possible that interventions do not have the same effect on more heterogeneous groups of people, than the more homogenous groups included in early studies (Bustillo et al, 2001; Pilling et al, 2002a). Finally, it is possible that the effects found in studies will be due to enthusiasm (Pilling et al, 2002a) or investigator allegiance (Barbato and D’Avanzo, 2000) of early proponents of family work.

Other caveats include questions about the goals of psychoeducational family interventions, the optimal type of family intervention, the populations to whom family work may be best suited, as well as those concerning implementation and routine practice outlined above (Dixon et al, 2000) and methodological and design problems (Barbato and D’Avanzo, 2000). Pitschel-Walz et al (2001) note limitations in their own review and suggest that had they used intention to treat analysis, less significant results may have emerged. Furthermore, Pilling et al (2002a) state that negative results are rarely published and therefore such

evidence was not included in their review. Thus, a bias cannot be excluded from this, and indeed, other studies.

1.3.2 Summary of reviews

Recent reviews have consistently confirmed the efficacy of psychoeducational family interventions, although evidence for improvements on secondary outcomes is more modest at present. With regard to the nature of interventions, longer-term approaches appear to be more successful. Other than duration, as long as the work consists of the components listed by Lam (1991), there appears to be little difference between models. Issues raised by the research include the differential use and effects of psychoeducational family interventions across heterogeneous populations, the need for research to further refine interventions, as well as understanding the difficulties in the integration of family work into routine practice.

Authors share the recommendation that psychoeducational family interventions should be offered to those families with a member who has a diagnosis of schizophrenia, where they have frequent/regular contact (Dixon et al, 2000; Bustillo et al, 2001). Subsequent recommendations involving the application of psychoeducational interventions follow. Finally, a number of suggestions for further research are made. These include:

- Refinement of approaches by assessing the “active” components of psychoeducational family approaches, determining optimum duration, goals and content for different groups and establishing process measures (Dixon et al, 2000; Bustillo et al, 2001; Pilling et al, 2002a)

- Further outcome research, including other family and service user related outcomes (Dixon et al, 2000; Pitschel-Walz et al, 2001; Pilling et al, 2002a)
- Implementation and integration of approaches into “routine clinical practice” (Dixon et al, 2000; Pitschel-Walz et al, 2001; Pilling et al, 2002a)

The reviews vary in the search methods used, the criteria by which they selected papers, and the analysis undertaken. Despite this, the message is compelling: evidence consistently demonstrated the beneficial effects of family psychoeducational approaches with regard to relapse and readmission in schizophrenia. The following section will discuss the issue of implementation difficulties in family work.

1.3.3 Overcoming implementation difficulties

The implementation of psychoeducational family approaches has been slow, with little routinely available to families in the US, UK or Europe (Fadden, 1997; Lehman et al, 1998; Dixon et al, 1999; Fadden and Birchwood, 2002). Difficulties with implementation are likely to be the result of a complex interaction of numerous variables. Barriers may exist at a systems level or in the form of clinical issues such as therapist and family characteristics and the relationship between both parties.

The system in which practitioners work is key in determining whether or not they are able to practice family work. Core barriers such as historical

influences, the dominance of the medical model and limited training in family work have been identified (Fadden and Birchwood, 2002). Other issues include the way services are organised with regard to a lack of flexible working hours, demands in other areas of work, location, and the number of team members trained in family approaches (Fadden, 1997; Fadden and Birchwood, 2002). It is clear that a supportive organisational context is important if workers are to put their newly acquired skills and knowledge into practice (Milne et al, 2003). Furthermore, if family approaches are to exist with any longevity, the organisational context needs to be more than one of “benign neglect” (Hughes et al, 1996). Indeed, it has been shown that obstacles can be addressed through comprehensive work at all levels, from gaining sufficient management and professional support, to providing adequate training, support and supervision to workers (Smith and Velleman, 2002).

Although the systems must be able to support family work, a lack of appropriately skilled workers with sufficient competence, confidence and enthusiasm will impede implementation. Difficulties with engagement are often described in terms of family characteristics (Fadden, 1998a), but it is likely that therapist issues are equally relevant. Pilling et al (2002) state that the enthusiasm of practitioners that may have been present in early outcome studies is an important factor to consider in terms of the implementation of family work. In addition to a willingness to work with families, the training of the workforce is essential. Therapist competence is likely to be critical in relation to families who do not engage in treatment (Fadden, 1998a). Furthermore, the finding that therapists report that it is difficult to find “suitable” families to work with may have more to do with a therapist’s lack of confidence than it has with

family characteristics (Fadden, 1997). Indeed, it would appear that many staff have had little or no training in family work and, as a result, lack confidence in basic tasks such as talking with families and dealing with distress (Fadden and Birchwood, 2002). Research in training and supervision programmes has demonstrated that these can lead to an increase in skills and knowledge amongst workers (Milne et al, 2003).

Tailoring interventions to individual families is a complex task. It is possible that the intricacy of the work, and a lack of sufficiently skilled therapists to do this, could also be a barrier to implementation. Psychoeducational approaches are not homogenous set of interventions, rather a combination of different modules that are varied in their application (Barbato and D'Avanzo, 2002). This variation is likely to result from the comprehensive initial assessment that is an intrinsic part of the approach. Thus, whilst there are essential ingredients to psychoeducational family approaches (Fadden, 1998b; Lam, 1991) the application of these will depend on the needs and characteristics of the family. Other family characteristics, such as cultural background or previous experiences of health services, may also determine the nature of the intervention offered, as well as the extent to which they engage in therapy.

Finally, the nature of the relationships between workers and families may have a bearing on implementation. Important components of psychoeducational family interventions, such as establishing a genuine working relationship, and offering structure and stability are essential, regardless of how therapy is tailored to the family. It is possible these components will create some change within the family and will undoubtedly lead to greater satisfaction with services.

Indeed, it has been found that families greatly appreciate the professional conduct of practitioners who appear calm, friendly, understanding and competent (Campbell, 2000). However, it is likely that a therapist will need to provide more than a good working relationship, and in this sense the relationship may be necessary but not sufficient for change. The amount of variance that is due to these more generic common components, separate from the specific components of psychoeducational approaches (such as communication and problem-solving skills training) is unclear. Indeed, a number of authors have identified the need to examine the “active” ingredients of psychoeducational family interventions (Bustillo et al, 2001; Dixon et al, 2000; Pilling et al, 2002a).

Recommendations for further research in psychoeducational family approaches extend the field beyond outcome research to include investigation into the process of therapy, as well as how this links with outcome. Process research, which aims to establish *how* interventions work, may help understanding of the clinical barriers associated with implementation. Investigations into family and therapist factors might offer further insight into what works best with whom. The therapeutic relationship, and its role in facilitating the application of family psychoeducation approaches may also be investigated. The following section will examine process research within the field of psychoeducational family approaches.

Research in psychoeducational family interventions has tended to focus on outcomes, with a notable absence of process research. There is a need to establish the efficacy of interventions prior to their use in clinical practice.

However, outcome research alone cannot “test clinical theories about the nature and relative effects of different techniques and treatment strategies” (Pinsof, 1981, p700). The aim of process research is to address the events that occur in the process of therapy and help address the question of specificity ie “What are the specific effects of specific interventions by specified therapists upon specific symptoms or patient types” (Bergin, 1971 quoted in Pinsof, 1981, p700).

1.4 Process research in psychoeducational family interventions

The following will describe a critical review of studies that have addressed process type issues in the psychoeducational family literature. The strengths of each study will be outlined when describing each study, whilst discussion will focus on the methodological limitations of the papers.

Articles were identified through a computerised search of the Psychinfo database. The terms “psychotic symptoms” or “schizophrenia” or “bipolar disorder” or “manic depression” or “psychosis” were used and combined with “family” and “interventions/therapy/techniques”. Results of the search were examined for papers that appeared to investigate therapist and/or family characteristics. Studies addressing relationships between family members, service users and providers were also included. Of the 369 articles identified, some 70 described outcome research such as randomised controlled trials and large-scale evaluations, whilst eight addressed process issues in schizophrenia and bipolar disorder. Due to the small number of papers, those with participants with a diagnosis of bipolar disorder were included. Six of the eight

papers identified will be described below. Two were unavailable to the author: one was a dissertation abstract, the other written in German. Five papers examined family aspects whilst one addressed therapist behaviours as the focus of research.

1.4.1 Family factors

Families' views on the care of people with a diagnosis of schizophrenia or bipolar disorder have been explored using focus groups (Rose, 1998). Families' experiences of caring and coping were themes established following content analysis of the data. Carers' views of supportive and non-supportive behaviours and their awareness of staff limitations were also identified. The essential ingredients to interventions and a "wish list" were other categories found. Results suggested that families had a diversity of needs, ways of coping and family constellations. Thus, "generic" interventions need to accommodate this diversity and understand how the experiences of each family member impact on the family as a whole. With regard to communication with professionals, families' concerns related to improving the quality of informal contact with professionals, rather than the quality of "formalized interventions" (Rose, 1998).

Rose's (1998) findings reinforce the value of a thorough assessment prior to intervention and provide greater understanding of what families find helpful. Whilst detailed assessment is an intrinsic part of psychoeducational approaches, it is helpful in highlighting the complexity of the situation and the

necessity to approach work with families on a case-by-case basis (as outlined in Standard 6 of the National Service Framework for Mental Health (DoH, 1999)). Research involving families is consistent with changes in services in the UK, which focus on working with patients and carers in partnership. Finally, family members concerns about the quality of “informal” interventions may be due to the fact the “specific” interventions they were offered were already of sufficient quality, given that such interventions tend to be undertaken by committed, skilled workers who value working with families. Although this hypothesis needs testing, it nonetheless points to the necessity of a sensitive, respectful, collaborative approach to working with family members, regardless of the “formality” or otherwise of interactions. This is consistent with NICE (2002) good practice guidelines that recommend working in partnership in “an atmosphere of hope and optimism” (NICE, 2002, p5).

Montero et al (1990) have addressed the impact of family factors on continuation in therapy. Investigators found that levels of non-attendance for behavioural family therapy (BFT) for schizophrenia were similar to those for the comparison relatives’ group (28.2% and 26.8% respectively). However, once families had started attending, the drop-out rate in the BFT group was lower (6.5%) than the relatives’ group (19.5%) suggesting that retention in BFT is higher. Service user factors associated with a higher risk of leaving BFT were: being older at the time of recruitment to the study; educated to primary school level; a number of previous hospital admissions and “non-compliance” with medication. With regard to family factors, low family baseline knowledge of schizophrenia, and living in a small household (ie parents and one child) were also related to not attending or leaving therapy.

The above study highlights some of the factors that may affect engagement and suggests interventions that may be helpful in promoting this. Family knowledge appears to be important in engagement: psychoeducation will help families build a new understanding of the “problem” (and, it may be argued, a new understanding of the solution). Early intervention, as well as extensive efforts when attempting to engage older service users who have been unwell for sometime, may increase engagement rates. Furthermore, Montero et al (1999) acknowledge, the supportive elements of the intervention may be important to families and whilst these may not be active in terms of change, they may be linked to continued engagement (or otherwise) of families. Finally, the higher attendance rates in the BFT group, reinforces the need to make greater efforts in understanding the engagement process.

The emotional climate of the family, in terms of attitudes and behaviour, has been researched by a number of investigators. Brewin (1994) investigated whether reductions in aspects of expressed emotion (EE) were associated with changes in family members’ attributions concerning the causes of symptoms and negative behaviours. Following family intervention aimed at lowering high EE in family members, relatives made less critical comments and demonstrated a change from personal attributions to more universal ones. The words “illness” or “schizophrenia” were more frequently used in relation to the cause of negative outcomes, and there was a reduction in disturbed behaviour. There was no evidence to support the hypothesis that changes in attribution and reductions in criticism were linked. However, reduction in hostility was associated with shifts to universal and uncontrollable attributions, although the

latter relationship was not significant. Brewin (1994) concluded that the results support the notion that some emotional attitudes in family members have an attributional origin. Furthermore, the effect of family interventions may be to change personal attributions to more general ones, leading to a reduction in levels of expressed emotion (Brewin, 1994).

The attitudes and communication behaviour of families and service users with a diagnosis of bipolar disorder has been examined by Simoneau et al (1999). Investigators found that, when compared to a control group, more positive non-verbal communication behaviour was evident in service users and, to a lesser extent, their relatives following participation in family focussed psychoeducational therapy (FFT). This was perhaps unsurprising given that improvements in communication are a key aim of family interventions (Simoneau et al, 1999). They suggested that the absence of change in verbal communication might be due to patterns being more habitual and thus more resistant to change through modelling and rehearsal. The lack of change in negative behaviour ran counter to other findings, but it was suggested this might be due to differences in the methods used or families' responses to different disorders. (It is also possible that an increase in positive behaviour, leading to a balance between negative and positive, was sufficient to change family climate). Further analysis by Simoneau et al (1999) demonstrated that that whilst FFT had a direct relationship with symptoms, the effect of FFT was also mediated by patients' positive non-verbal behaviour. Patient's positive non-verbal behaviour appeared to be a key variable in the effect of family treatment and nonverbal engagement with others was identified as a possible

index of mood or stability in people with a diagnosis of bipolar disorder (Simoneau et al, 1999).

Both Simoneau et al's (1999) and Brewin's (1994) studies help us to understand some of the mechanisms associated with change in emotional attitude and communication behaviour within families undertaking family work. It appears that involvement in psychoeducational family intervention leads to changes in variables relating to EE, communication behaviour, family attributions and symptoms. However, the nature of the relationships between these variables is unclear and the authors of both studies acknowledge this limitation. Brewin (1994) points out it is possible that changes in EE and attributions are both jointly influenced by another aspect of the service user's behaviour not measured. Furthermore, although EE and attributions may be related, it is not possible to infer the direction of this relationship. Similarly, Simoneau et al (1999) acknowledge it is unclear whether FFT leads to improvements in communication behaviour and subsequently in symptoms, or whether symptom improvements lead to more positive interactions between family and patient. Whilst the direction of the relationships may be unclear, their findings help clarify variables that may be worthy of investigation in future empirical studies.

A recent study examines how emotional climate the family may affect the therapy. Tompson et al (2000) investigated the extent to which emotional attitudes (EE) and affective style (AS) (ie the way in which family members interacted) predicted therapist and independent observer ratings of the difficulty of implementing family interventions for people with a diagnosis of bipolar

disorder. Investigators found that independent ratings of difficulty tended to be influenced by patient-related challenges, whilst therapist ratings were influenced by family difficulties such as relatives' resistance, affective problems and communication problems. This difference may be due to the fact that observers rated three videoed sessions, whilst the therapist had more extensive contact with the family. Authors found neither pre-treatment family measures of AS or EE predicted therapists' perceptions of overall difficulty in treatment. However, detailed analysis indicated that AS was related to therapists' ratings of more specific treatment problems in therapy. Relatives' pre-treatment negative affective style predicted therapists' assessment of relatives' resistance and affective problems in treatment. Furthermore, harsh criticism within AS accounted for much of the variance in therapists' ratings of relatives' difficulties. Finally, investigations found that the presence of residual symptoms pre-treatment was the strongest predictor of therapists' ratings of patient resistance. The authors suggest that rather than being an enduring feature of patient behaviour, resistance is influenced to some extent by their clinical state (Tompson et al, 2000).

Tompson et al's (2000) finding that affective style was related to therapists' appraisal of treatment difficulty suggests that a family's communication behaviour may have an impact on the course of therapy. This supports the need for thorough assessment, which is an integral part of psychoeducational approaches. The assessment of a family's interaction style is key in the planning and implementation of intervention. It may also assist in predicting implementation difficulties that may occur in treatment. The finding that therapists' ratings of difficulty were affected by the presence of residual

symptoms suggests that therapeutic work should be responsive to these difficulties and may require the availability of extra training and supervision in order to do this. Again, these issues are, or should be, inherent in psychoeducational programmes. Furthermore, the impact of harsh criticism on therapists' rating of difficulty suggests the form rather than the content of negative feedback is important and highlights the need for communication training which alters the way negative feedback is conveyed (Tompson et al, 2000). Finally, given that residual psychotic symptoms may affect the overall treatment difficulty and therapist's perception of patients' resistance, pre-treatment assessments of both AS and BPRS may be useful when planning appropriate family interventions.

1.4.2 Therapist factors

One paper examined therapist behaviours. Halhweg et al (1990) describe the use of a number of coding systems, the first of which related to the amount of time spent on various components over the course of therapy, as well as the extent to which therapists adhered to the model of therapy used. Fifty percent of an average session was used for the purpose of communication or problem-solving skills training, or the application of problem-solving skills strategies by the family. With regard to therapist competencies, global and specific skills were rated. Global skills referred to structuring and therapeutic relationship competence, whilst specific skills related to competencies in behavioural family therapy eg didactic competence, initiation of behavioural rehearsals. Results demonstrated that therapists were able to implement therapy as planned (or that families accepted this) (Halhweg et al, 1990). Furthermore, the "moderate

inter-correlations” between competency scales indicate that the scales assess different therapist competencies. These findings are helpful in terms of describing therapist behaviours, and points to future research on how these may be associated with process and outcome. The measures may be useful for training, supervision and investigating treatment integrity.

1.5 Summary

Research into process issues in psychoeducational family interventions is very much in its infancy. Some interesting and helpful studies have been undertaken, and it is hoped that more will follow. The literature to date demonstrates that the quality of interactions between professionals and family members is of concern, particularly to the latter group. Furthermore, it confirms the value of the intrinsic principle of all psychoeducational approaches ie that interventions are tailored to individual families. Investigators have established some of the factors associated with attributional change in family work, as well as some of the characteristics that may predict whether families are at greater risk of disengaging from therapy. Work on coding and analysing therapist behaviours with regard to the practice of therapy has begun, and will aid understanding of what is helpful in therapy, as well as provide useful assessment tools for treatment adherence and supervision in the future.

1.6 Discussion

The strengths the research completed so far, together with theoretical issues, have been discussed in individual descriptions of the papers. The following section will focus on issues associated with the methods and paradigm utilised thus far.

1.6.1 *Methodological limitations*

Generally, studies described above appear to be methodologically sound. In instances where rating scales were used, coders were trained and inter-rater reliability assessments were completed (eg Hahlweg et al, 1990; Simoneau et al, 1999; Tompson et al, 2000). In studies involving different conditions, participants were randomly assigned and assessments were performed blind (eg Montero et al, 1999; Simoneau et al, 1999; Tompson et al, 2000). However, a number of specific design limitations are apparent.

The absence of a comparison control group in Brewin's (1994) study means it is unclear whether changes evident in the analysis were due to the intervention. The small sample size and lack of power was an issue in the Montero et al (1994) study. No clinical or demographic differences between "never attended" and "drop-outs" were apparent and the two groups were analysed together as a "non-adherence" group. The investigators acknowledge the samples were too small to enable detection of significant differences. Thus, it is possible there were differences between the two groups and different factors lead to non-attendance compared to "non-adherence" (or drop-out). Furthermore, the lack of power in the study means that they failed to rule out gender and education

level as a predictor of “compliance”. Finally, a number of studies undertook an exploratory approach using correlational analysis (Brewin, 1994; Simoneau et al, 1999). As is always the case with such analysis, the direction of the relationship between the two variables is unclear. It is also possible that changes in variables are the result of other unidentified variables. In addition to examining events leading to emotional and attributional change during an intervention, the use of experimental design would help establish a causal relationship.

1.6.2 Limitations of the existing paradigm

There is an absence of research using qualitative methods. Whilst studies such as Simoneau et al's (1999) offer some understanding of what communication changes, and how, it may be argued that valuable information is lost in reducing such experiences to dichotomous variables such as positive or negative communication. Indeed, in their discussion the authors highlight the value of a two-factor model for communication, using dimensions of positive-negative and high-low arousal. Findings by Hahlweg et al (1990) are helpful in addressing therapist behaviours but they fail to consider aspects of the experience of therapy from either the therapist or family's point of view. Although findings detail the proportion of a session a therapist spent on communication skills, it omits to take into account the quality of the interaction, which may be as important to outcome and process. Furthermore, it is possible that rather than attempting to establish the causal direction of a linear relationship such as those identified in Brewin's (1994) and Simoneau et al's (1999) papers, qualitative methods may capture the complexity of how variables change and

interact upon one another. Finally, it is interesting to note that both Brewin (1994) and Montero et al (1999) provided quotes from family members to support their quantitative findings. It could be argued that evidence of this type is equal to that resulting from quantitative research.

Research outlined in this paper has been mainly quantitative and thus the paradigm of natural science¹ is dominant throughout the above research. This broadly reflects the research endeavour within psychology (Rennie and Toukmanian, 1992). The adoption of a narrative² paradigm that attempts to describe, rather than explain, phenomena may address some of the issues outlined above. The quantitative methods used may lessen our understanding of concepts by reducing them to singular dimensions, rather than exploring their depth and “richness”. The use of qualitative methods would be particularly helpful in encapsulating the richness and quality of communication between family members, service users and therapists, as well as their experience of interventions.

Secondly, the research role that is adopted within the empirical paradigm may curtail thorough examination and discussion of the phenomenon under investigation. For example, whilst Montero et al’s (1994) study informs us of some of the factors that may affect adherence, many others not included by investigators may still play a role in determining whether people attend or

¹ Under this approach it is assumed there exists a reality that “consists of a world of objectively defined facts” (Henwood and Pidgeon, 1992, p98). Experimental quantitative methods are used to test hypotheses about the causal relationships between variables in order to advance our understanding about this world.

² Rather than assuming a single objective reality, it is accepted that there exist representations of reality that need to be understood from participants’ perspectives. The meaning of experience and behaviour is examined in context, in its full complexity. Science is regarded as a process of developing working hypotheses that emerge from data collected using qualitative methods (Henwood and Pidgeon, 1992).

continue in family psychoeducational approaches. Factors associated with non-adherence in relatives' group were not presented. It is therefore difficult to establish whether the variables reported relate to BFT alone or family work in general. Furthermore, they suggest apathy or pessimism associated with chronic conditions may result in families not taking up, or leaving therapy. Whilst this may be the case, the association between lack of family knowledge and "non-adherence" implies that families may have been unaware that assistance with the management of schizophrenia was available, or indeed possible. Non-adherence may also be due to relatives' anger about not having received a service in the past, as well as their distrust of services and professionals due to past negative experience of services. These issues may be worthy of exploration. Finally, only one of the studies described above have examined therapist factors (Hahlweg et al, 1999) while most have focused on the family. Whilst it is helpful to focus on families, to do so to the exclusion of therapist factors or the interaction between practitioner and family provides us with only part of the jigsaw. Some authors have attempted to examine this. Durr and Hahlweg's (1996) analysis included interactions between outcome variables such as relapse and family communication and process variables such as characteristics of therapy sessions, service users, relatives and therapists.

Nevertheless, most research to date has centred on the researcher asking predetermined questions about factors they deem to be relevant. Thus, decisions surrounding what phenomenon to investigate are made from the researchers' frame of reference. Questions have tended to focus on family factors and neglected to address therapist or relationship factors. This may lead to the omission of important data or neglect in areas of research.

Furthermore, the focus on aspects within the family that lead to disengagement, or to difficulties during the course of therapy, locates problems with the therapy process within the family, as opposed to acknowledging these may also be the result of other issues. Asking different questions of the family may lead to a greater understanding of the difficulties or obstacles for families and how we, as clinicians can help overcome them.

1.6.3 The need for a collaborative approach

Despite the recency of many of the publications, the language of partnership is not evident in some papers. A number of authors used terms such as “non-compliant” or “non-adherent” (Montero et al, 1994; Pilling et al, 2002a) when describing families who do not engage in therapy. It may be argued that the use of such language encapsulates the power imbalance inherent in many encounters between professionals (academic and clinical) and families and service users, therapeutic or otherwise. A more collaborative approach to research such as that described by Repper et al (2003) may address some of this imbalance and prove productive in terms of informing us about why families choose not to engage in services or particular interventions.

In the course of this review it was noted that some authors adopted a more critical approach than others. For example, Barbato and D’Avanzo (2000) highlight the differences in design and methodological quality and suggest, the critical remarks by Thorney and Adams (1998) directed at interventions studies in schizophrenia are “fully applicable” to trials of family intervention. Whilst such opinions are to be respected, it is perhaps helpful to consider the research

enterprise as a process, where methodological and theoretical limitations are a fact of life.

1.7 Future directions

The process research undertaken to date within in the field of psychoeducation in psychosis has lead to some interesting results. However, the field is still very much in its infancy. Sustained work in the fields of both outcome and process research is vital. It is also important to consider how to establish links between process and outcome in this area. Some areas worthy of investigation are outlined below.

Continued use of quantitative methods to replicate the work done to date will help consolidate existing evidence. The refinement of methods to include the use of control groups, larger samples and a choice of measures informed by results of more exploratory research would also be valuable. Experimental designs may be used to establish causal relationships between variables that have been found to change throughout therapy. Research aimed at linking participant factors and events in therapy to outcomes may assist in further refinement of psychoeducational approaches.

As the majority of research to date has focused on quantitative methods, the use of qualitative methods such as grounded theory may help to capture the richness and complexity of participants' experience of therapy. They may also encapsulate the context in which the therapeutic approach is placed.

Suggestions for future research using qualitative methods include the process of engagement, the nature and course of the therapeutic relationship, and the experience of therapist and family before and during the therapeutic process. Helpful and unhelpful events in therapy warrant further investigation. Finally, it may be helpful to explore the impact on therapy of factors such as communication style, affect, attributions and attitudes of the therapist. It is likely that therapist behaviour and beliefs have an impact, and therefore it would be helpful to explore this further.

A collaborative spirit in research may also prove fruitful. As discussed above, using both qualitative and quantitative methods and adopting methodological pluralism is one example. Another is perhaps an attitude shift for professionals to acknowledge families as experts and include them in the research that informs developments in service and intervention. It has been acknowledged that true collaboration in helping relationships “carries profound and, to some, unsettling implications for traditional notions of professionalism” (DeChillo et al, 1994, p575). However these authors go on to argue that adopting the role of facilitator and using the client’s perspective as a resource leads to their empowerment. It may be that such an approach to research would prove beneficial to both professionals (academics and clinicians) and families. It is also consistent with the developments in health care outlined at the start of this paper.

1.8 Conclusion

A number of themes are apparent in the literature reviewed. Outcome research is necessary and clearly important in establishing the efficacy of an intervention. These methods have demonstrated that family psychoeducation is effective in reducing relapse and readmission rates. Research addressing process issues has begun and it is essential to continue this work. Literature available on process issues, gained from both empirical and narrative research approaches needs to develop. It may be unreasonable to expect researchers to be fully conversant in all aspects of both qualitative and quantitative research methods, in the fields of both outcome and process. However, a continuing dialogue between experts in their respective fields ie families and service users, practitioners using different approaches, and researchers using different research paradigms will only serve to enrich both interventions and the associated research endeavour.

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Chapter Two

Development of a measure of engagement in Behavioural Family Therapy

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Abstract

The following paper reports on a postal survey concerning engagement in behavioural family therapy. A questionnaire was developed drawing on research undertaken in the field of assertive outreach. Participants were mental health workers who had been trained in behavioural family therapy. The focus of the study was therapists' perceptions of signs of engagement in behavioural family therapy. It was found that therapists were able to rate signs as changing over time. Important signs of engagement related to the nature of the contact family members had with the therapist. The results of the survey and reasons for the low response rate are discussed.

2.1 Introduction

Recent changes in National Health Service (NHS) policy in the UK have placed an emphasis on the needs of families and carers (DoH, 1999). Furthermore, the strong evidence base for family interventions in psychosis (eg Pilling et al, 2002) has led to the inclusion of family work in clinical guidelines published by the National Institute for Clinical Excellence (NICE), an organisation formed with the remit of promoting good practice within the NHS.

Despite these changes, the implementation of family approaches remains a concern (eg Fadden and Birchwood, 2002). Service issues such as inflexible working hours may prevent successful implementation of family work. Furthermore, difficulties at a clinical level (eg a lack of confidence and competence on the part of the therapist) may make engagement, and thus implementation, problematic (Fadden, 1997, 1998). Smith (1992) summarises studies describing “non-engagement” (ie refusals and withdrawals) rates of between 54% and 73% in a service setting. Research exploring the family/client factors that may affect families leaving therapy has been undertaken (Montero et al, 1999). However, understanding the process from the professional’s perspective may assist with developments in training, supervision and practice.

Whilst little research has been done with regard to engagement in psychoeducational family work, the definition and measurement of engagement with people with long-term serious mental health problems has been addressed

(Hall et al, 2001). In a qualitative study, Gray (2001) interviewed assertive outreach workers about their work and how they viewed their role. Workers identified a number of signs that indicated to them clients were engaged with the team and worker. Signs included the client's willingness to have contact with a worker, a sense of their being actively involved in the relationship with the worker and being increasingly open. These may be relevant in family work. The aim of the present study was to pilot a measure to investigate the process of engagement of families from the therapist's perspective using signs identified in Gray's (2001) study. It was anticipated that use of the measure would determine:

- Whether therapists perceive these signs as changing over time
- What signs therapists regard as important in family work
- The relationship between how therapists perceive a change in the signs and how they rate their importance.

2.2 Method

A survey design was adopted. Participants were selected from a group of over one thousand therapists trained as part of a large multi-disciplinary cascade-training programme in the West Midlands (Fadden and Birchwood, 2002). Participants from different disciplines were included if they had been trained in behavioural family therapy for at least 6 months, had offered the approach to at least two families, and worked with one family for at least three sessions.

The measure used was built on the definition of engagement given by Gray (2001) (see Appendix 3). The sub-categories were taken as signs of

engagement and behavioural descriptions of each were developed in discussion with project supervisors. Items on demographic information were included. Respondents were instructed to think about a family they had worked with for at least 3 sessions and with whom they had established a good relationship. Respondents were then asked to use a 7-point scale to rate how signs changed over time and a five-point scale to rate them with regard to importance. Finally, respondents were asked for any comments with regard to the process of engagement (see Appendix 4 for questionnaire).

One hundred and sixty-eight participants were identified using the above criteria. Questionnaires and informed consent sheets (Appendix 5) were sent out. In order to ensure a maximum response rate a reminder letter was sent out three weeks later.

2.3 Results

Thirty-eight participants responded to the mail out (response rate of 22%). Of these, seventeen people gave reasons as to why they were unable to participate (Table 1). Of the twenty-one questionnaires returned, six participants had not worked with enough families to fulfil the criteria. Thus fifteen were suitable for analysis. Due to the small number of questionnaires, correlational analysis relating how signs changed with their relative importance was not possible. However, descriptive analysis of the data was performed using SPSS.

Table 1: Reasons for being unable to participate (n=17)

Not worked with enough families	11
On maternity/sick leave	3
Change of role therefore not working with families	2
No reason given	1

The majority of participants were female, in their mid-thirties to forties, and White European. Respondents had a mean of 2 professional qualifications (n=15, range 1 – 5). Participants had a mean of 16.6 years clinical experience (range 3.5 – 29 years) and had been trained in family work for a mean of three years (range 1 – 5 years). The mean number of families that participants had attempted to engage in family work was 5 (range 2 – 10). The mean number of families worked with for more than three sessions was 4 (range 2 – 12).

2.3.1 Therapists' views of how engagement changes over time

Table two shows therapists varied in how they saw contact changing (items 1-3), with responses ranging from “staying the same” to “increasing quite a lot”. A majority of therapists rated four signs as “increasing a little” during family therapy (items 5, 6, 11 and 14). These signs were associated with family members being able to ask for what they wanted from the therapist (46.7%), asking for help (53.5%), demonstrating they valued their advice (53.3%) and it not being obvious the therapist’s input was valued but it was apparent later (60%). Three signs (items 4, 8 and 12) were rated by a majority of therapists as “increasing quite a bit”: families appeared to be more than “just compliant” (60%), they seemed increasingly willing to talk openly about their feelings

(46.7%) and demonstrated increased warmth over sessions (53.3%). Nearly all therapists stated that the extent to which family members demonstrated they valued their input increased a little (40%) or quite a bit (40%) (item 15). Finally, there were a range of responses on items 7, 9, 10 and 13.

Table 2: Number of therapists rating the extent to which signs of engagement changed over time (n=15)

	Signs of Engagement and Trust	Decreased			Stayed the same	Increased		
		A lot	Quite a bit	A little		A little	Quite a bit	A lot
1	Family members allowed contact with you eg they spoke to you when you called, saw you when you dropped in				2	5	4	3
2	You had pre-arranged contact with family members eg you were able to arrange a meeting with them				5	3	7	
3	Family members allowed you into their home, members seemed to feel comfortable about you being there				3	3	6	3
4	Family members were more than just compliant – eg family members appeared willing to keep appointments, do homework tasks		1	1	1	2	9	1
5	Family members seemed able to ask for what they wanted – eg asking to go over early warning signs in the next session			1	4	7	3	
6	Family members asked for help eg in problem-solving, support at the next outpatient review			1	4	8	2	
7	Family members seemed to want to do things with you eg they were already together when you arrived for sessions			2	3	6	4	
8	Family members seemed willing to talk openly about their concerns		1			4	7	3
9	Family members were open about their feelings and thoughts eg they appeared willing to discuss their thoughts and feelings with you			2	3	2	6	2
10	Family members seemed to want to speak to you eg calling you and requesting an additional meeting			2	6	5	1	
11	Family members seemed to value your advice eg requesting your advice on a goal they were working on				2	8	4	1
12	Family members demonstrated increased warmth over sessions eg making you feel welcome on arrival, you felt comfortable in their home					5	8	2
13	Family members demonstrated concern for your welfare eg asking how you were after being on sick leave, asking where you went on holiday			1	1	3	5	4
14	It was not always obvious but you found out later - eg you hear from other workers that family members value the work you have done			2	2	9	3	
15	Family members demonstrated they valued your input - eg by giving feedback about a previous session, expressing a positive feeling about the work, continuing to work towards goals			1		6	6	2

2.3.2 Signs that therapists regard as important in engagement

The mean ratings of importance can be seen in Table three below. The three most important signs as rated by therapists were associated with the contact family members had with the therapist, whilst the following four were concerned with openness, the family being actively involved and demonstrating warmth towards the therapist. There was no apparent pattern in the data on later questions, with items relating to families initiating contact and providing positive feedback to the therapist being regarded as less important.

Table 3: Therapists' ratings of importance of signs of engagement (n=15)

Signs of Engagement and Trust	Mean rating	Range	SD
Family members allowed contact with you eg they spoke to you when you called, saw you when you dropped in	4.6	3 – 5	.6
You had pre-arranged contact with family members eg you were able to arrange a meeting with them	4.3	2 – 5	.8
Family members allowed you into their home, members seemed to feel comfortable about you being there	4.3	2 – 5	.9
Family members were more than just compliant – eg family members appeared willing to keep appointments, do homework tasks	4.0	2 – 5	1.1
Family members seemed willing to talk openly about their concerns	4.0	2 – 5	.8
Family members were open about their feelings and thoughts eg they appeared willing to discuss their thoughts and feelings with you	3.9	3 – 5	.8
Family members demonstrated increased warmth over sessions eg making you feel welcome on arrival, you felt comfortable in their home	3.9	2 – 5	1.0
Family members seemed to want to do things with you eg they were already together when you arrived for sessions	3.7	2 – 5	.7
Family members demonstrated they valued your input – eg by giving feedback about a previous session, expressing a positive feeling about the work, continuing to work towards goals	3.6	2 – 5	1.2
Family members asked for help eg in problem-solving, support at the next outpatient review	3.3	2 – 5	1.0
Family members seemed to value your advice eg requesting your advice on a goal they were working on	3.3	2 – 5	1.2
Family members seemed able to ask for what they wanted – eg asking to go over early warning signs in the next session	3.3	1 – 5	1.2
Family members demonstrated concern for your welfare eg asking how you were after being on sick leave, asking where you went on holiday	3.0	1 – 5	1.5
It was not always obvious but you found out later - eg you hear from other workers that family members value the work you have done	2.9	1 – 5	1.3
Family members seemed to want to speak to you eg calling you and requesting an additional meeting	2.7	1 – 4	1.1

Of the six respondents who wrote comments on the process of engagement, three stated engagement had been difficult. Reasons give by three therapists attributed difficulties in engagement to the family. The following quote is typical:

“Engagement proves difficult with families who believe that family problems should be private and confidential...”

Other comments surrounded the use of the family therapy model, their practice and family feedback on the approach.

2.4 Discussion

The return rate for the above survey was lower than expected, despite attempts to maximise responses. It is of concern that half the respondents (17) were unable to fulfil the criteria of having worked with one family. This finding is consistent with other research that suggests only a small number of people who trained are able to put their training into practice (Fadden, 1997). The low response rate may also be due heavy workloads, other research projects, a lack of interest in family work, its absence from the agenda in many teams, and difficulties with implementation.

It appears that therapists were able to rate some categories as changing over time. The active involvement of families, in particular their seeming to be more than “just compliant”, as well as their demonstration of positive regard supports the notion of a deepening and reciprocal relationship between worker and family. However, some therapists indicated there was little change in other

signs. It is possible that therapists knew family members prior to starting behavioural family therapy and whilst the nature and content of the contact and requests from the family may have changed, the amount remained the same. Alternatively, it is possible that whilst a relationship may have developed, the power imbalance that is arguably inherent in such a relationship, continued to inhibit family members asking for help. Finally, whilst some signs on the scale did seem appropriate to family work, others such as “wanting to do things with you” may have been more appropriate to assertive outreach work.

With regard to the relative importance of signs of engagement, it is possible that therapists regard all signs as important and found distinguishing between them difficult. Alternatively, the measure may not be sensitive enough to pick up the relative differences. Some small differences were apparent, however. Therapists appeared to regard contact as the most important sign of engagement, perhaps understandably, as the extent to which workers could carry out family work would be limited without it. Furthermore, working in the family home is emphasised by the approach. Patterns in the data were less apparent in later items with regard to importance. However, there were some items relating to the active involvement of the family, increased openness and positive regard. It is possible that this demonstrates therapists’ expectation that families become active participants in the process, rather than passive recipients of a treatment. Finally, it suggests that a family’s positive feedback is an important indicator of their level of engagement.

Difficulties in engagement are often described in terms of family characteristics (Fadden, 1998) and it appears to be the case in the present study. One therapist commented that families often disengaged during the communication skills training. Families may be inclined to disengage because they dislike a particular aspect of the approach. However, it may be argued that this need not be the only option if the therapist is able to facilitate an open negotiation about the material to be discussed in family meetings. This requires some skill on the part of the therapist, as well as an understanding that family members' choices are as valid as the therapist's in terms of setting goals for therapy. Furthermore, disengagement at certain points, may also reflect the feelings and beliefs the therapist has about this particular component of the model, which in turn affect how it is implemented.

2.4.1 Limitations of the study

There were several limitations with regard to the measure and methodology used. Due to the sample being self-selected, results may have been biased, with only committed and interested therapists replying. Thus, results may not reflect the opinions of therapists who may have less experience or interest in the subject of the study. It is therefore difficult to generalise the results to this population.

The low response rate meant that it was not possible to assess the psychometric properties, in particular the internal consistency, of the measure. Had the sample size been larger, it would have been possible to establish the internal reliability of the questionnaire by using methods such as Cronbach's

Alpha to provide a numerical description of internal consistency. Split-half reliability would also have established the extent to which items correlated with each other. Furthermore, had the sample size been larger it would have been possible to perform factor analysis and thus identify factors which may be important in the engagement of families in BFT.

It would have been helpful to obtain additional information on a number of aspects. For example, where therapists work may have an impact on how they approach engagement (eg assertive outreach workers may find this easier than others). Other information from the therapist in terms of their part in the process and their reflections on their role is also an important aspect of engagement. Responses suggest that some signs decreased over time and it would be helpful to know the outcome associated with these decreases. If the items are a sign of engagement then presumably a decrease in signs would lead to disengagement. Family factors such as demographic or clinical aspects may have affected therapists' ratings. More information on these factors would be helpful.

The design was retrospective and it is possible that therapists' views of change did not reflect the course of therapy at the time. Furthermore, the behavioural markers of each sign may need to be revised. Whilst some items were more concrete than others, and thus easier to rate, others were vague and require better definition. For example, one category in Gray's study related to clients being more open and less guarded about symptoms. Given families' responses to be judged or challenged (Rose, 1998), being less guarded about family history may be a more appropriate behavioural marker.

Finally the way in which the questions were posed may not be appropriate to clinical practice. Rather than asking the extent to which items changed or were important, it may have been more helpful to ask the extent to which signs were present. Thus a practitioner could use the scale following an initial session to determine a total score indicating the extent to which a family were engaged, as well as highlighting areas where attention may need to be focussed.

2.5 Conclusion

It is difficult to draw firm conclusions about the data given the low response rate. This pilot suggests that it is possible to measure engagement. Furthermore the findings point to further directions. A replication of this study with a larger sample, utilising an amended questionnaire may establish the psychometric properties of the measure. These findings could be triangulated with results from studies using other methods. Additionally, research that is service user/family led will contribute their perspective. The development of measures to assess the extent to which families are engaged (from both the practitioner and the family perspective) may be helpful in determining which aspects of the process are linked with disengagement or continuation in family work. Finally, it is clear that engagement is a complex process that is dependent upon many variables. Research linking signs of engagement with such variables may assist in the development of both practice and service provision.

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Chapter Three

What works in engagement of families in behavioural family therapy? A positive model from the therapist perspective

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Abstract

The following paper reports on a qualitative study examining engagement in behavioural family therapy (BFT). Data was collected via interviews with trained therapists and family members engaged in BFT. A grounded theory approach was used in the analysis of interview transcripts. A model of engagement from the therapist perspective was developed. A core category of humanity emerged. The model is described and discussed in relation to the implementation literature regarding psychoeducational family interventions. Clinical, research and systems implications of the model are discussed.

3.1 Introduction

Strong evidence exists to support the use of psychoeducational family interventions for schizophrenia (Pilling et al, 2002). Evidence for family approaches is such that they are now recommended as routine practice (NICE, 2002). Furthermore, families and those with a diagnosis of bipolar disorder could benefit from family interventions (Reinares et al, 2002). Research demonstrates that implementation of these approaches has been problematic (Fadden, 1997, 1998; Fadden and Birchwood, 2002). One aspect of these difficulties is the clinical application and engagement of families in family interventions. This will be discussed in the following section.

3.2 Engagement in psychoeducational family interventions

Despite the efficacy of psychoeducational interventions and the difficulties families may face in caring for someone with severe mental health problems, the engagement of families appears to be a complicated aspect of therapy. Families may choose not to take up the offer of therapy or may decide to end after just a few sessions (“refusing” and “withdrawing”, respectively, (Smith, 1992)). Reports on the rates of engagement in family psychoeducational approaches vary. Barrowclough and Tarrier (1992) cite research that suggests that between 7 – 35% of families offered psychoeducational family interventions refuse, whilst between 7-50% withdraw after a few sessions. Smith (1992) summarises studies describing non-engagement rates of between 54% and 73% in a service setting. Montero et al (1994) reported that over a quarter of the people offered behavioural family therapy did not attend. This rate was similar to that of the control comparison (relatives’ group). However, once BFT

had started, the dropout rate was lower in the group receiving family interventions (6.5%) than in the comparison group (19.5%).

3.2.1 Reasons for non-engagement

The factors associated with difficulties in engagement are unclear. Fadden (1998) points out that these are often discussed in terms of family characteristics. Indeed, some family factors may be associated with non-engagement (Montero et al, 1994). However, examination of these provides only a partial explanation of the phenomena of non-engagement. Research in the field of implementation of psychoeducational family approaches suggest staff-related factors are also relevant. Therapist competence and confidence may be important factors in identifying and engaging families (Fadden, 1997; 1998). Comprehensive training and supervision programmes are likely to address these issues to some extent, but the effect may be limited if the system in which therapists work does not support their practice. It has been found that therapists were more likely to work with families if a number of workers in their team were trained (Fadden, 1997).

It is likely that the extent to which therapist and family can form a collaborative working relationship will have an impact on engagement and continuation in therapy. The alliance has been described as a common relationship variable across all forms of therapy (Horvath and Greenberg, 1994). Important characteristics of the alliance are collaboration, the interactive nature of the relationship and the integration of technique and relationship components (Horvath and Greenberg, 1994). Whilst there is a consensus that alliance

exists, there is less on its constituent elements (Horvath, 1994). Furthermore, it has been suggested that alliance as traditionally measured in psychotherapy, may be a parallel but different construct to that of engagement in working with people with severe mental health problems (Gray, 2001).

3.2.2 Rationale for study

It appears that, once engaged in BFT families may be more likely to remain engaged (Montero et al, 1994). Given the benefits to families and service users, it is essential to facilitate engagement. It has been found that, in families who do not engage in family therapy, 67% of those with a diagnosis of schizophrenia experienced a relapse by 9-month follow-up (Barrowclough and Tarrier, 1992). Examination of experiences of engagement, from family and therapist perspective, may help our appreciation of the difficulties in the clinical application of the approach. The aim of the study was to establish what therapists and families believe to be helpful (or otherwise) in the engagement of families. In addition, the nature of the relationship was explored.

3.2.3 Rationale for use of qualitative methods

Little is known about engagement in BFT. Qualitative approaches may be used to understand the meaning or nature of experience, explore substantive areas about which little is known and obtain rich details from phenomena (Strauss and Corbin, 1998). Thus, a qualitative method was adopted for the study.

3.3 Method

3.3.1 Design

The grounded theory approach used in this project allows the study of the development, maintenance and change of individual and interpersonal processes (Charmaz, 1995). Rather than imposing a predetermined hypothesis on the data, this approach leads to a theory about a phenomenon that is grounded in the data collected.

3.3.2 Participants

Interviews were conducted with both families and therapists (see Table 4). Workers known to be practicing BFT were identified in collaboration with one of the project supervisors (GF) and co-ordinators of BFT training located in each of the Trusts participating in the research. Prospective participants were contacted by telephone. Of the 15 professionals approached, 12 agreed to participate in the research. Seven interviews were undertaken until analysis demonstrated that no new concepts were emerging from the data (saturation). Therapists were trained in behavioural family therapy (BFT) (Falloon, Boyd and McGill, 1984). Just over half the sample (5) had been trained as trainers in the approach as part of a multi-disciplinary cascade training programme (Fadden and Birchwood, 2002). Seven family members, from three families, were interviewed. All three families had successfully engaged in BFT in the last three years. Two families (A and C) had extended involvement, whilst family B had approximately 12 sessions.

Table 4: Details of participants

Name	M/F	Age	Ethnic group	Profession	Trained in BFT	Team	N families worked with
Ron	M	46-55	WE	Nurse	5 years	BFT project	4
Kevin	M	46-55	WE	Nurse	4 years	Day centre	3
Anne	F	26-35	WE	OT	5 years	Assertive outreach (AO)	6
Ellen	F	46-55	WE	Clinical psychologist	7 years	Rehab and recovery	10
Caroline	F	56-65	WE	Physiotherapist	4 years	Physiotherapy department	4
Sam	M	36-45	WE	Social worker	3 years	Assertive outreach (AO)	4
Eileen	F	36-45	WE	Nurse manager	6 years	Ward	6

	Name	M/F	Age	Ethnic group	Position in family	Relative with diagnosis	Diagnosis	Contact with services	Team
Family A	Andrew	M	66-75	WE	Step-father	Step-son	Schizophrenia	10 years	AO
	Andrea	F	66-75	WE	Mother	Son	Schizophrenia	20 years	AO
Family B	Beth	F	25-36	WE	Daughter		Bipolar disorder	5 years	Resource Centre
	Brenda	F	76-85	WE	Mother	Daughter	Bipolar disorder	5 years	Resource Centre
	Brian	M	76-85	WE	Father	Daughter	Bipolar disorder	5 years	Resource Centre
Family C	Cath	F	46-55	WE	Mother	Son	Schizophrenia	8 years	AO
	Colin	M	46-55	WE	Father	Son	Schizophrenia	8 years	AO

3.3.3 Ethics

The protocol was designed in accordance with ethical guidelines published by the British Psychological Society (BPS) and Division of Clinical Psychology (DCP). Local research ethics committees approved the research (Appendix 6). All names and identifying details were changed to ensure confidentiality.

3.3.4 The Researcher

The researcher was a third year clinical psychology trainee. She had remained interested in family work since holding a post as Assistant Psychologist with the Meriden programme. There she was aware of her own and other therapists' anxieties about engagement, where often failures in engagement were assigned to family characteristics. Whilst this may be the case for some families, given that any therapeutic encounter is a two-way process, she believed other aspects of the engagement experience were worthy of examination. She did not adhere to any particular model at the time of writing. Much of her practice to date had been cognitive-behavioural in orientation, although she had used systemic and psychodynamic ideas in supervision.

3.3.5 Procedure and Measures

Following initial agreement to participate, detailed information and informed consent forms (Appendix 7) were sent. Once informed consent was given, participants were interviewed on the basis of semi-structured questions (Appendix 8). Whilst interviews covered questions outlined, the order in which they occurred varied. Other themes were explored as they arose in the course

of the interview. Interviews were conducted in participants' work place. During the interviews, which took about an hour, participants were asked to think about a family they had worked particularly well with.

BFT practitioners working in the field identified family members. Once identified, workers obtained verbal permission from the family for the researcher to contact them to discuss the research further. Information and informed consent forms (Appendix 9) were sent to the participants prior to interview. Once informed consent was given, interviews were conducted in the families' homes (Appendix 10). During the interviews, which took around an hour and a half, participants were asked to think about the therapists they had worked with.

All interviews were taped and transcribed verbatim. Copies of the transcripts were sent to all participants. They were asked to comment or add further information if they wished. Data were analysed following procedures described by researchers (Charmaz 1995; Chamberlain, 1999; Giles; 2002).

3.3.6 Analysis

The processes of data collection and analysis were interwoven with later data collection being informed by hypotheses and questions arising from earlier data.

Open coding

Initial or open coding was applied to three interviews. Open coding refers to the close examination of data by coding lines of text. This allows for identification of categories and concepts, and ensures that the theory developed remains

close to the data (Charmaz, 1995). Such codes emerge from the data rather than being preconceived by the researcher, who then imposes these upon the data collected (Charmaz, 1995). (See Appendix 11 for an example of line-by-line coding). Codes relevant to the subject of engagement were selected and used to code larger chunks of data. These initial codes were organised into 27 lower order categories that link the codes together at a conceptual level (Giles, 2002). A table describing the lower and higher order categories can be found at Appendix 13.

Axial coding and relational sampling

Relational sampling is purposive and was used to collect more data to further develop lower order categories in terms of their properties and dimensions, as well as establishing how they relate to one another (Chamberlain, 1999). Data from four interviews was sampled in this stage of the process.

In parallel to this stage of data collection, axial coding took place (see Appendix 12 for an example of axial coding). This process involved organising the basic lower order categories into conceptual groups (higher order categories). Higher order categories were described in detail and links were made between them to the development of a theoretical framework (Giles, 2002). This analysis resulted in 8 higher order categories (Appendix 13). At this stage of analysis, memos were used to explain how higher order categories have been developed (Giles, 2002). They include detailed definitions of the categories outlined in the model (see Appendix 14). Memos assist the researcher in helping them clarify thoughts, develop theory and consolidate work previously done. They also lay a paper trail that helps track development of the theory.

Selective coding and discriminant or theoretical sampling

Discriminant sampling refers to the deliberate sampling of data from participants in order to confirm the theory as a whole (Chamberlain, 1995). Three families were interviewed in order to understand their experience of the therapy and the therapists. The stage of selective coding is where the central category that ties all other categories in the theory together is identified and related to other categories (Chamberlain, 1995). Data collected served to confirm the core category identified during selective coding. Data in support of the other categories were also evident. Additional data, which related to the families' experience of caring and context in which this took place, was also collected and will be subject for further analysis (Appendix 15).

Quality

A number of techniques were adopted to ensure the analysis was reliable and of good quality. A reflexive journal was used to log the progress of the study, methodological decisions made and personal reflections with regard to values and expectations (Appendix 16). The journal, memos and precise written definitions of categories laid a paper trail to enable external audit. Verification methods such as analytic auditing and respondent validation took place. In analytic auditing coding and theory development was discussed at regular intervals with three colleagues who were also undertaking qualitative research. In respondent validation, participants were sent a summary of the draft model (Appendix 17). Two participants (workers) responded to the effect that it captured their experience of engagement.

3.4 Results

Analysis resulted in a model depicting engagement from the therapist perspective. A core category, which was labelled “humanity”, emerged from the data. This and other categories will be described, following a more detailed description of the model itself.

3.4.1 *Therapists’ experience of engagement in BFT*

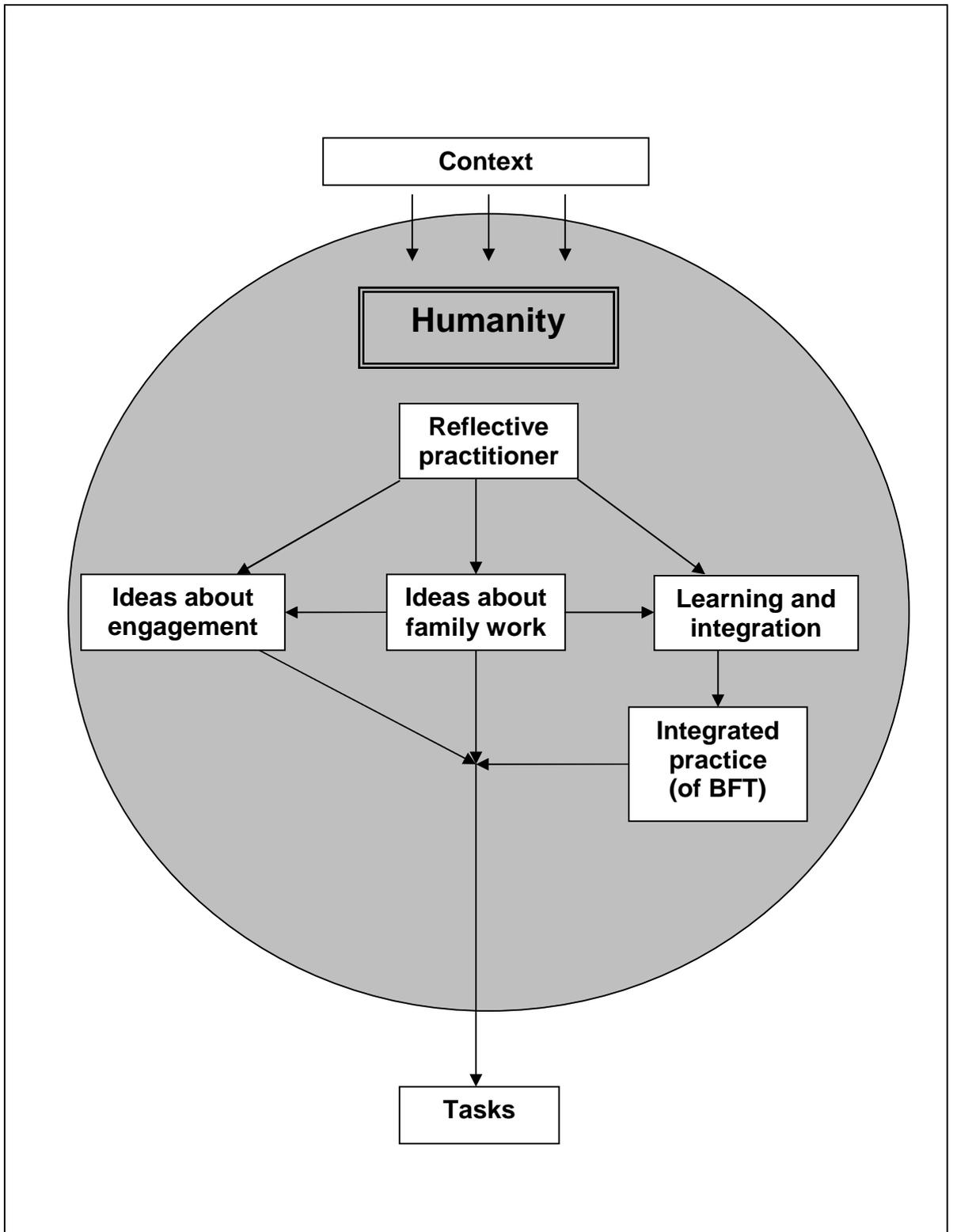
The model in figure 1 represents engagement in BFT as seen from the therapists’ point of view. The space within the circle represents the internal world of the therapist. This comprises their thoughts and feelings about engagement, family work and their practice. It also includes the processes they go through in learning the approach and developing their practice. The core category of humanity runs throughout. This is a personal quality therapists bring to their work and is present in all other categories. In the absence of **humanity** the professional would be a technician

Reflective practitioner is a professional quality and facilitates the processing of therapists’ feelings and the development of their ideas and their practice. It allows the therapist to approach family work with an understanding of the family’s position and the problems they face. Thus, reflective practitioner works on the therapist’s **ideas about family work**. These ideas link to the therapist’s **learning and integration**. For example if they are motivated to work with families, they are likely to have a positive view of BFT and this impacts on the extent to which they integrate it into their existing skills and experience. The therapist’s ability to reflect facilitates their learning of the approach, as well as

the process of integration. The outcome of this learning process is an **integrated practice of BFT**. This involves flexible application of principles inherent in the model. Reflection leads to the development of their **ideas about what engagement is** and an awareness of it as a process. Furthermore, their **ideas about family work** will impact on those of engagement. For example, an awareness of the family position and belief that they are central to their practice will give the therapists a reason to persist with engagement.

The space outside the circle is the world external to the therapist. It includes the team and service in which they work (**context**) and the **tasks** they perform in engagement. **Context** impacts upon the therapist in the extent to which they feel supported in their work. For example it may provide co-workers with whom they can develop their practice. It may also inform their ideas about **engagement** and **family work**. The **tasks** the therapists perform in engagement are informed by the concepts within the circle. For example, if they believe in the approach, but understand the family's position as not being able to see the relevance, they will present BFT in a positive manner that is applicable to that particular family. Each of the constructs will now be described in more detail. The lower order categories that make up the higher order category under discussion will be listed in a box at the start of each section.

**Figure 1: A model of engagement in Behavioural Family Therapy:
The therapists' perspective**



3.4.2 Humanity

Qualities	Humanity
Delight	
Being themselves	
Humility	
Family as like self, not other	

The core category of humanity runs throughout the model. The extent to which the therapists possessed this quality varied, but all had a sense of professional integrity and honesty about who they were and how they presented themselves.

Qualities such as mindfulness, persistence, reliability, and transparency about who they were and what they were doing were apparent in the therapists. Participants were comfortable about bringing something of themselves to their work. In doing so they were demonstrating some of these qualities.

“because by sharing your own experiences ... the fact that you’ve got children, the fact that you understand, you know, um, the frustrations of having a family, and perhaps a full-time job and sometimes actually having that shared experience helps families to relate to you” (Eileen, 213-217)

Participants were also comfortable owning they had limitations and they needed to learn from others. Therapists would admit that they too had difficult moments:

“it’s hard being able to relax with a family, because sometimes we do get nervous, you know. Well, a lot of times I get nervous”
(Kevin, 350-352).

Fundamental to humanity is the capacity of the therapist to regard the people they work with as similar to themselves. This was a belief that the people they were working with were just that, people first and foremost. Family members may have had qualitatively different experiences and responses but there were, in essence, similar processes at play. Many workers were able to place themselves in the position of client/family member. Here Eileen describes why she welcomes families onto the ward with a cup of tea:

“It’s just a human type behaviour... or courtesy that you would offer to anybody...that’s how I hope somebody would treat me and so that’s something that you try to bear in mind, ‘if it was me that was coming in with my loved one, how would I be treated?’” (Eileen, 281-285)

Data from family members supported this category of humanity. In their descriptions of workers, family members supported therapists’ ideas that families could get a sense of whether workers were being “real”.

“even when you’re psychotic... you get a sense about people and whether they are genuine or not, and whether you can trust them or not ...I know that because when I’ve been ill, I felt, I felt

that...and if you don't feel you can trust people, if you don't feel they're on your side or they're genuine, then there's no point really"
(Beth 961-966)

3.4.3 Reflective Practitioner

Open-ness	Reflective practitioner
Thinking about experience	
Questioning/hypothesising	
Thinking about meanings	

This concept of reflective practitioner is an active, dynamic one. Rather than being rigid in their mindset, practitioners had the capacity to stand back, look at their experience and question it. Therapists gave numerous examples where they had revised their ideas or practice in the light of their experiences with families:

"I think I've shifted a lot actually ...I identify much more now, particularly with carers, than I did then.... I think that I was very much on the professionals' side" (Ron, 405-408)

Workers also demonstrated an awareness that certain actions or events carry with them negative messages to families. This awareness links with the practitioner's ideas about the family and their sensitivity to the family's position in mental health services (see "Ideas about family work"). Ron described how families he had worked with regularly experienced other workers failing to turn up appointments:

“I mean, it gives people the message, well, “I’m not that important, you know, he’s had something else to do, and I’m not that important to him” (Ron, 380-382)

Therapists would endeavour to counter such messages conducting themselves in a different way to other professionals or drawing on BFT (eg goal setting as giving permission for people to have their own lives). Ellen described how she was aware that in offering family therapy the family may hear the message that the “problem” was with them family. She works to counteract that by telling the family:

“if one person is unwell and this has an impact on everybody else and we’re concerned about all of you, and how you’re managing and coping and we want to work with you as a family” (Ellen, 124-127)

3.4.4 Ideas about family work

Family as equal	Ideas about family work
Attitude re working with families	
Family position	
The “problem”	

This category concerns therapists’ ideas about the reasons for families being involved in services, as well as some understanding about the position families were in. Their attitudes about working with families is more general than their orientation to BFT specifically see (“learning and integration”). Therapists were positive about working with families:

“I’ve always seen families as central to um, what I do... I’ve never seen clients as being distinct from their families and I hope that’s in a positive way”. (Sam, 58-61)

The family as equal

Therapists regarded “the family” as their equal. Equality may still involve difference and so contrasts with “family as like self” (in humanity). In being equal the family is given as much say as the worker in negotiating the practicalities around family meetings. Furthermore, family members were respected as being experts in their experience and seemed to be regarded as colleagues, as much as users of a service:

“I think with some families it is kind of this big team... you know the family members and us as a team kind of have this kind of direction that we’re all kind of tootling on in and, um, it is like a sort of bigger team.” (Anne, 836-839)

Family members appeared to share this sense:

“If you have a common goal and you all know where you’re headed...It’s easy to all go together. We do have a common goal and we’ve always recognised that” (Cath, 929-935)

Understanding the family position

Therapists understood the family's position in terms of having been recipients of a poor service. Thus, they believed the offer of BFT would sometimes not be immediately welcome. Data from family interviews supports this category to some extent. Family members described negative experiences of services, but rather than being reticent to engage, they said they were positive about the offer of family work. This was due to desperation and a wish to improve the situation. One of the helpful factors identified by a number of therapists was desperation, and in this instance, it seems they were accurate.

“And if they're desperate they do tend to clutch at straws a bit, but they're also, they tend to be more open to new ideas because they've tried everything else.” (Caroline, 391-393)

“when it was offered to me I didn't know what it was but anything.... I was in the bottom of this black pit...just anything, anybody, anything... ‘please, come in, talk to me, try and let me get an angle on this please’” (Cath, 1245-1248)

The view of the “problem”

Therapists perceived that things may be difficult for families, but felt that there was room for change. Furthermore they were able to understand that the family might see things differently.

“In some ways they’ve learned to live with the difficulties that they’ve got ... it’s familiar I think, and...because to my mind things could be a lot better” (Ellen, 344-347)

Ellen had said earlier it was important that the family understood how they might benefit from the intervention. Thus in addition to “desperation”, therapists believed family members needed to see how the intervention would help. This may take some time and links with “ideas about engagement”, and as well the need for the therapist to present the approach as relevant:

“Well I was looking for anything to give us some strength with the problem... at first it all seemed a bit vague and it wasn’t until later on that pieces fell into place, you know....derived some benefit from the actual meetings...”(Brian, 257-260)

3.4.5 Ideas about engagement

Meaning of engagement	Ideas about engagement
Process ie description of how it happens	
Time	

Therapists’ theories about “engagement” per se appeared important in how they approach engagement in BFT. Engagement was seen as a matter of timing in a number of ways. It may take a while, is more important at sometimes than others and there is a right (and wrong) time for the family to feel ready to engage:

“it’s when it feels appropriate, when the family feel that it’s time...And as I say sow the seed and then just nurture it a little, and hopefully as you go down the line things will start to happen (Sam, 845-852)

Engagement is a shared involvement between family and therapist, rather than a one-way process (so links with “ideas about family work”). It refers to the establishment of a trusting relationship and involves commitment to an agreed piece of work:

“I’d say gentle preparation, sort of take that step towards being willing to actively sort of do some work on a problem or an issue.... they’re making a judgement about you as much as you’re making, beginning to make judgements ... I see it very much as a two way process” (Ellen, 150-154)

Workers would often struggle to describe the process of engagement. Nevertheless they tried, and in doing so conveyed a sense that the process was a fragile one. Workers would attempt to be balanced in their approach eg being enthusiastic but not “going in with me books blazing” or to “steam roller on”. The process is also a dynamic one, where there is a certain order to things:

“you’ve just got to go with the flow really, and just fit in and try and pick up on, you know, the family’s sense of humour” (Eileen, 721-722)

3.4.6 Learning and integration

Orientation to approach	Learning and integration
General therapeutic skills and experience	
Learning the approach	
Identity	

Through a process of learning and integration, the therapist makes the model their own. The category of reflective practitioner is key in supporting this development. Therapists varied as to where they were in this process. However, all conveyed a sense that their confidence and competence grew and they moved from rigid use of a model to the flexible utilisation of the principles and structure applied to a specific family’s circumstances.

The extent to which this happens is determined by their identity as a mental health worker and their view of their role in their work. It also draws upon their existing skills and experience. Fundamental to the process is the way they regard the approach. The therapists interviewed believed strongly in the approach, although they may have reservations about some aspects. Many regarded it as central to their practice:

“I really think BFT is core. There isn’t anything in BFT that you shouldn’t be doing anyway.” (Sam, 112-113)

As with other actions and attitudes they were aware that the family may pick up on these:

“I don’t think you’re, you’re going to engage the family unless you sort of genuinely believe that it’s going to be of benefit. I think that would be really difficult” (Anne, 473-476)

3.4.7 Integrated practice of BFT

Positive use of structure	Integrated practice of BFT
Tailoring	

The outcome of the above process was a practice that utilised the principles in a manner appropriate to the family they were working with. Rather than constricting their practice, structure was seen as informing and guiding their work:

“you also need structure otherwise you don’t actually achieve what you’re setting out to do” (Caroline, 69-70)

Families did not view this application of structure as negative, but found it beneficial:

“They had a programme for each meeting...so it would be anchored in your mind... That was very helpful” (Brenda, 480-488)

The individual application of the structure to a particular family was the outcome of the process of learning about and integrating the approach.

Rather than fitting the family to the model, practitioners were attempting to fit the model to the family:

“You’ve got the principles there, and that’s just fine, and you just need to go out and go with the flow and see what comes up with people” (Eileen, 730-732)

3.4.8 Tasks

Establishing the relationship	Tasks
Presentation of approach	
Getting to know family	

Certain tasks were seen as necessary in engagement. The order in which the tasks were fulfilled may differ for therapists according to their approach to the work. For example, some workers found it helpful to work on establishing the relationship and introducing BFT. Others would focus on one, then the other:

“you need to kind of deal with a relationship for them to see you as being okay...so to do kind of groundwork really, I think that’s really important, before going in and offering the whole approach to families. They need to trust you first” (Ron, 101-105)

Therapists took responsibility for the process and were active in their attempts to establish good relationships with the families they worked with. Drawing on their humanity and their ideas about the family did much of this. Workers described the relationship itself as warm, interested, supportive friendship with essential elements of trust and sharing.

In establishing a relationship therapists were assessing the appropriateness of the intervention, as well as aspects of family life where the approach might be useful. This knowledge was helpful in introducing or “selling” the approach as relevant to the family concerned. This also relates to the extent to which they are able integrate the principles of BFT into their work.

“I think placing that [the offer of BFT] in the context of, um, the kind of experiences and the difficulties the family are having, so drawing on some area you feel... would benefit in, for that particular family”
(Ellen, 225-228)

Therapists would also present BFT in a realistic but optimistic manner and many would avoid using jargon, or the words “therapy” or “behavioural”.

3.4.9 Context

Service context	Context
Immediate context: team/job	

This category comprises of the workers’ immediate team and the service in which they work. Context refers to the backdrop against which therapists are attempting to engage families and impacts on the therapists in a number of ways. A flexible team that had a shared “culture” of working with families gave workers a sense of being supported. This appeared to be as much about sharing a philosophy as it was about practical issues such as time, supervision and co-working. A number of participants acknowledged a “team

culture” that supported their work. This contrasts with another participant who worked where fewer people were trained:

“and if there’s only one or two of you that perhaps have a similar philosophy, um it’s difficult building that into a ward culture” (Eileen, 363-365)

This team culture may be dependent upon the nature of the service the team offers. One participant described how her ideas about her working relationships with families had changed as she moved from one service to another:

“If you talked to me when I was in the day hospital about families, “oh yeah, we have contact with families, we have good relationships with families” but it would have been once every six weeks somebody from the families would have come to a review ... but it’s nothing at all like it is with the families here” [in assertive outreach] (Anne, 753-763)

3.5 Discussion

Seven therapists and seven family members were interviewed about their experiences of engagement in BFT. Grounded theory analysis resulted in a model of successful engagement from the therapist perspective. It appears that the therapist’s humanity, attitudes to family work, ideas regarding engagement and their flexible practice facilitate engagement. Context is

important in supporting these constructs. The model will be considered in relation to issues with engagement and implementation. The limitations of the model and the methods used will be discussed. Finally the implications of these findings will be outlined.

3.5.1 Therapist factors in engagement

The study presented here adopted a qualitative approach in exploring therapist's experience in engagement. In this sense it complements Montero et al's (1994) study, which focussed on family factors associated with disengagement. Their study was useful in establishing significant relationships between family factors and non-engagement. However in using quantitative methods, Montero et al's (1994) study failed to capture the complexity of the families' experience. Furthermore, it did not examine therapists experience and factors that may be relevant. The model presented here described therapist factors that may be helpful in engagement and, thus, suggests areas where difficulties may lie. These factors will now be discussed in more detail.

Successful engagement appears to depend, in part, upon the therapist demonstrating certain qualities. The aspect of "being oneself" is consistent with Rogers' (1951, 1986) core condition of congruence or genuineness. This has been described as the ability to be oneself in the relationship without "putting up a professional front or a personal façade" (Mearns and Thorne, 1988). Furthermore, the therapists' perception of family members as "like self", suggests an absence of defence mechanisms that professionals

may use to protect themselves from the more challenging aspects of working in mental health. Dale (1997) has described some of these and they include displacement, vicarious healing and projection. This absence of distancing and ability of the therapist to be with the family is likely to be the result of a number of factors. Personal qualities may be important. However, confidence in skills may also be relevant. Fadden and Birchwood (2002) have found that staff lack confidence in the basics of talking to families and this lack of confidence is often projected onto the family.

Related to confidence is the issue of competence. The way the therapists described their practice suggests they were able to apply the model in the context of a good working relationship. Blending the active components of BFT with the relationship is likely to require some skill. It appears that therapists who were successful in engagement achieved something akin to a synergy between technical and process factors described by Horvath and Luborsky (1993). This synergy utilises the therapeutic alliance and “makes it possible for the patient to accept and follow treatment faithfully” (Bordin, 1980, p2, quoted in Horvath and Luborsky). At the heart of BFT is the principle of establishing a collaborative working relationship with the family. Thus, the therapeutic alliance is as important to this model of therapy as any other, perhaps more so, as the process is placing the family in a situation where high demands are made for changing their behaviour and attitudes (Falloon et al, 1984). As Montero et al (1994) suggest, whilst it may not lead to change, the nature of the relationship between worker and family is likely to be important in continued engagement.

The warmth with which workers and families described their experience ran counter to concerns about therapies described in manuals. In discussing negative attitudes about “manualised” approaches, Barlow et al (1999) describe research concerning beliefs that manuals may “dehumanise” practice. The positive attitude that these therapists had about BFT, and working with families, runs counter to these concerns and may be related to successful engagement. This is consistent with other research in field of implementation. Corrigan et al (1998) found that that experience with behavioural approaches is associated with positive attitude towards such approaches. Training in family interventions has been found to result in positive attitudes amongst mental health workers (Farhall et al, 1999). Furthermore, therapist attitude appears to affect the number of families worked with (Farhall et al, 1998). It is likely that positive attitudes and experience interact, such that successful engagement of families builds more positive attitudes towards BFT and working with families in general. These attitudes in turn may lead to workers being more likely to engage with families.

Finally, it appears that engagement in BFT is informed by beliefs about engagement per se. Therapists’ ideas were similar to the ones identified by Gray (2001) where trust, the active involvement of clients and their positive regard for the worker were seen as key signs of engagement in assertive outreach. Furthermore, participants in the current study saw engagement as an ongoing process. This understanding is consistent with that of Flaska’s

(1997). In writing about theories of engagement in systemic therapy she states that much of the theory is located in textbook chapters on the initial session between family and therapist. This, she argues, reduces engagement to a technical task, as opposed to a complex and ongoing process that is necessary for change.

3.5.2 Implementation issues

The professionals taking part in this study were well supported by their Trusts and had close contact and supervision with the Meriden programme. It is likely that this contact supported the above constructs in a number of ways. Regular training and supervision may facilitate development of competent and confident practitioners. Additionally, it will support them in dealing with the challenges to humanity that may be present in their work. Furthermore, it allows an increased familiarity with the approach leading to a greater understanding of the collaborative principles and a need for persistence in engagement.

However, this persistence is likely to dissipate if the context in which they work fails to support them. This is consistent with research that suggests the context in which therapists work has an impact on the number of families worked with (Fadden,1997). An organisation may have confident, competent, humane practitioners with a clear understanding of the model and engagement as an on going process. However, the context in which they are attempting to implement their practice is crucial. It needs to support them in terms of engendering a culture that promotes family work, and provides

ongoing training and supervision. Thus programmes that address systems and training issues such as those described by Fadden and Birchwood (2002) and Smith and Velleman (2002) are ultimately vital in facilitating engagement.

3.5.3 Limitations of the model

The model presented is the therapists' experience of engagement. Thus it does not examine whether they are doing what they say they are. Data from family interviews suggest that therapists' ideas are translating into practice. However, a model including families' representations of engagement may help to understand what facilitates their engagement, as well as build a shared model of the experience.

3.5.4 Methodological limitations

The participants in this study were selected from a sample of those known to be practising BFT. Thus, the views of therapists practising, but with less contact with the programme are not represented here. Furthermore, the sample did not include therapists not working with families. To an extent workers are likely to be attracted to work they enjoy and are successful in. It is possible that those who are not working with families are less positive about BFT or family work and/or may be less successful in tackling difficulties in engagement.

The questions asked in the schedule were retrospective in nature. Furthermore, it is likely that therapists were drawing on their experience of

more than one family. Thus results reflect broad themes that may be relevant in engagement, but do not capture the process as it happens, in reference to a particular family. Nor does it allow specific identification of the processes that lead to particular outcomes.

3.5.5 Implications

The above research suggests a number of research, clinical and service implications. Further research concerning the family experience of engagement in BFT is essential. It is anticipated that analysis of family data collected as part of this study will contribute to this area. User or carer led research with families, both engaged and non-engaged, would contribute to an understanding about what facilitates and hinders engagement. Research examining the beliefs, attitudes and values of therapists not working with families may further understanding about their difficulties in the clinical application of the approach. Finally, studies examining the process of engagement, in real time, from both the family and therapist perspective will establish links between therapeutic process and outcome.

In clinical work, it may be useful for practitioners to examine their own beliefs and expectations around engagement and their work with families. Furthermore, the use of self (or congruence) may facilitate the engagement process. It may also provide the practitioner, who is learning a new approach, with some solid ground to work from. In terms of engaging families, getting to know the family, listening to their stories and persisting

with engagement may facilitate take up in therapy. At the very least it will improve relations between families and services.

Sustained support in terms of training and supervision are key in supporting reflective practice and the integration of newly acquired skills. Furthermore, continued contact with trainers and supervisors will support therapists' humanity and well being in the face of the challenges of family work. It may be useful to consider aspects such as attitudes, staff-burnout, humanity and skill level in the selection of staff for posts and training in family work.

3.5.6 Reflexive account

Many of the participants knew the researcher as an ex-colleague. It is possible that this affected their decision to take part in the research, as well as the responses they gave. Furthermore, the researcher's interest in therapist issues in practice, continuing professional development, the need for reflective practice and the mental health of staff in mental health services lead to an initial focus on the therapist experience.

During the process of the research, the researcher became increasingly aware of her ideas about families and their experience. Her pre-existing understanding of client as like self, deepened with a greater awareness of, and identification with, both the therapists and families she interviewed. Furthermore, in understanding the processes a practitioner goes through when learning a new approach she became more aware of the need to support those who find this difficult.

3.6 Conclusion

Research in the field of psychoeducational approaches has focused on outcome. This has demonstrated that psychoeducational family interventions are beneficial in psychosis. However, the implementation of these approaches has been problematic. The focus of this study has been one aspect of implementation difficulties, that of engagement. Previous research addressing the impact of family factors on engagement and the process of therapy has been undertaken. However, methods used to date have largely been quantitative. In adopting a qualitative approach to understand the therapist's experience, the current study aimed to identify some of the therapist factors relevant in engagement and the clinical application of BFT. Findings suggest that in addition to contextual issues, therapists' beliefs about family work, engagement and the practice of BFT are important. Qualities such as humanity and reflective practitioner appear crucial. The presence of these qualities and the experience families described counteracts concerns that the use of manuals dehumanise practice. It suggests the issue is *how* they are implemented. Research examining families' experiences in engagement is vital and will complement this study. Further research examining the phenomenon of disengagement from both family and therapist perspective is imperative. The use of qualitative methods is recommended in capturing the complexity of the issues surrounding this neglected but crucial aspect of therapy.

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Chapter Four

Reflections on the research journey

Abstract

The following paper is a description of the research process. It outlines the starting point for the research and goes on to discuss some of the challenges and rewards of undertaking qualitative research. It closes with some reflections on the impact of the process on the researcher.

4.1 Introduction

The following paper will outline the process of this research. It will describe my thinking at the start of the project, and the challenges and rewards of undertaking research. It will end with some reflections on the impact on me as a clinician.

4.2 That was then

The main reason for undertaking the project has been outlined in section 3.3.4. However, experience as a volunteer counsellor had lead to similar observations about disengagement. The shift I worked was a Friday night and this may explain some of the DNA's or short-term involvement in therapy. However, I was mindful that it might be something to do with my practice or something in the relationship. These experiences suggested that engagement might be an area for exploration.

During my training I have been aware of how difficult it is to relate theory to practice. I may have adequate knowledge about a particular model (whether it be BFT, person-centred counselling or CBT) but applying it is a different matter. In this way it is not unlike football: I know the rules and can recognise a good game when I see one (especially after watching West Bromwich for a few seasons). Studying the rules without playing the game will not make me a footballer. In the same way, I will only become a "good enough" therapist by applying the theory through reflective practice, learning as I go. (However,

it is unlikely I will ever be able to play like Jason Roberts, even with years of coaching and practice).

Llewelyn and Hardy (2001) have argued that process research, which addresses how therapy happens, will assist clinicians in understanding and applying therapy. In particular it may increase knowledge about what happens and what processes facilitate change (Llewelyn and Hardy, 2001). They go on to argue that this will help therapists become more “appropriately responsive” and so develop their own practice. I wondered, then, if examining the process of one of the therapies I had been attempting to use may address some of the above issues.

In tackling the subject of engagement in BFT the question remained: “how should I do it?” I had maintained an interest in qualitative research since undergraduate studies. The research programme I worked on prior to my post with the Meriden programme was supervised by an educationalist who was passionate about her subject. She firmly believed that understanding the process of learning was as important as evaluating the outcome. In researching this issue we found both qualitative and quantitative methods had value in our research. Barker and Pistrang (1994) suggest the design of a project should be determined by the research question. Thus in addressing my question about engagement it seemed sensible to ask the participants about the experience of engagement rather than working on a theory myself.

4.3 The process

4.3.1 Challenges

Paperwork

The study was designed and implemented in line with ethical guidelines from the British Psychological Society (BPS, 2000) and the Division of Clinical Psychology (DCP, 1995). I applied to two local ethics committees in order to maximise access to participants. However, I had not considered the research governance procedure in each of the three participating trusts. Furthermore, whilst trainers and coordinators were aware of the project, it still required management approval in each of the three trusts and again necessitated time and energy in paper work and telephone calls. I do not have an issue with the need for such procedures: they protect participants from being exposed to unethical and repetitive research. The challenge was to remain motivated at a time when a lot of energy was being expended with, it sometimes felt like, very little result.

Addressing limitations of the study

Elliott et al (1999) make a distinction between research that fulfils a general versus specific task. At the outset I aimed to fulfil the general task of understanding the process of engagement in BFT. As part of this, I hoped to involve trained therapists with a breadth of experience. Most of the teams I approached knew of my interest in family work. It is possible that workers trained in the approach with less positive experiences of family work were reluctant to discuss their issues with me. Here the concept of functional

reflexivity (Giles, 2002) is important. Participants may have been more willing to discuss difficulties in engagement with someone more “neutral”, particularly if the underlying issues were about their attitudes and beliefs about family work. Thus I may have fulfilled a more specific task of understanding successful engagement from an experienced therapist’s perspective.

More paperwork

Strauss and Corbin (1998) state that research “really is a rather ‘messy affair’” (p32). Previously I had undertaken qualitative analysis using a computer programme and I had valued it when managing and analysing huge quantities of text material. (The conceptual work in terms of generating the codes, categories etc remains the task of the researcher (Giles,2002)). The process of data transcription and analysis, and the generation of memos and definitions, challenged even my tidy nature. Visitors were often received in a living room where index cards (of tasteful pastel shades) were spread over the living room floor.

Getting lost

The nature of qualitative research is such that it requires the researcher to “own one’s own perspective” (Elliott et al, 1999). Thus, the process of self-reflection is necessary in order to identify one’s assumptions, opinions and expectations. This task was a challenge at times, particularly when having to reflect upon about clinical work whilst on placement. Furthermore, I had not allowed for the creative energy required for the development of the model.

Regular research supervision and contact with three colleagues undertaking grounded theory projects helped me see the wood for the trees.

Writing

I have a tendency to be verbose at the best of times. However Elliott et al's (1999) recommendation regarding the inclusion of raw data when reporting results compounded my problem. Sufficient quotes should be included to allow readers to appraise the fit between the data and the author's understanding (Elliott et al, 1999). Additionally, readers should be able to formulate alternative meanings and understandings. Attempting to fulfil this criterion and keep to the word count was one of the biggest challenges in the main paper.

4.3.2 The Rewards

“What reinforcement we may gain from hope,

If not, what resolution from despair”

(John Milton, Paradise Lost)

Good companions

If there were times when I was despairing (usually over another ethics application form), the reinforcement came from the optimistic and positive approach of the people with whom I was working. The initial nerves I experienced in approaching and interviewing families soon dissipated because of their warmth and generosity. These people had, and still do, face the challenges of living with mental health problems. Their stories were, at

times, incredibly moving. Nevertheless they were also infused with a realistic hope and humour that was humbling.

Playing with ideas

Giles (2002) suggests the popularity of grounded theory is down to its intuitive nature. I found the development of theory to be a creative process. Orona (1990) describes something of this in discussing the use of memos to formulate theory. Her use of memos varied depending on the issue at hand but she would use them to unblock her thoughts, develop theory by free-associating or to integrate her ideas (Orona, 1990). Charmaz (1999) states that “diagrams are visual representations of the analysis which provide an overview of it” (p187). It was a challenge to depict the developing model in this way, but I found it helpful in summarising the analysis and came to enjoy shifting boxes, arrows and circles around.

Getting it “right”

Respondent validation should be used to improve the quality of the project (Elliott et al, 1999) and I was keen to give something back to the participants. A brief summary of the research was sent out and a number of participants replied to say that it was relevant to their experience. As one wrote:

“I truly think you have captured the essence of the factors/issues around BFT engagement...I feel it would be most useful to be able to share this valuable information as part of both supervision and training.”

It is possible that other participants did not reply because the model failed to resonate with them. Nevertheless, the idea that I had captured something of someone's experience was rewarding.

4.4 This is now

4.4.1 The research

This thesis has outlined a model depicting the therapists' representation of engagement in BFT. A final test of quality is the extent to which it is presented in a form that helps the reader make sense of the data (Elliott et al, 1999). Giles (2002) presents the argument from other researchers that findings should be "sufficiently coherent and intelligible as to make a clear impact on the literature and suggest practical application" (Giles, 2002, p220). I have written with these points in mind but time, and feedback, will tell if I have achieved this.

4.4.2 The Researcher

In my clinical work I have always endeavoured to build a collaborative working relationship. However, the project served to clarify my thoughts about this aspect in a number of ways. In the course of my reading I came across literature that reinforces my ideas that engagement and the therapeutic relationship are necessary (although not sufficient) conditions for change. The idea that the process of engagement "constructs and 'shows' the therapeutic relationship" (Flaskas, 1997, p264) has facilitated my

understanding of how the two are related. Furthermore Horvath and Luborsky's (1993) summary regarding the working alliance has given me permission to attend to it in order to facilitate the application technique.

In interviewing both therapists and families I became aware that there were as many similarities as differences between them. The project presented concrete examples of how the principles we discuss in relation to our clients are as relevant to our work and us. For example, a number of therapists told me, when learning the approach they had found it difficult for a while, until it all "clicked together". This was not unlike the process one of the fathers described when he began to understand the point of the sessions he and his family were attending. In the course of my training I had lost the sense that psychology is about understanding human beings, and the theories we discuss may apply to ourselves as much as they do to others. My logic then follows if such psychological principles apply to "them" as well as "us" there is no "them" and "us". There's just "us". What goes for clients goes for me, ergo I could just as easily be in the client's chair as the therapist's. In the course of this research a colleague sent me a paper in which the writer discusses her experiences as a researcher on a palliative care ward (Ramsey, 1995). The paper started with a quote that sums up what I am trying to say and I include it here:

"We cannot abandon the injured or the maimed, thinking to ensure our own safety or sanity. We must reclaim them, as they are part of ourselves"

(Brian Keenan, 1992)

4.5 Conclusion

Just over a year ago my sister sent me a poem written by Robert Frost. It is called "The Road Not Taken". It resonated with me, and did so again when used as the basis for a presentation at a recent conference (Fadden, 2003). During the course of this project I kept returning to the notion of therapy as a journey, with initial engagement as the point of embarkation. However, I believe it is a metaphor useful for many experiences, the research process included. The above paper has outlined my journey, and my initial reflections upon it. Doubtless I will have others, but now I shall do what I always do when I come back from an arduous trip: sit down, have a drink and put the washing on.

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