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UNDERSTANDING CHANGE IN PSYCHOTHERAPY: THE LITERATURE AND PARENTS' EXPERIENCES.

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Summary of the MRP Portfolio

Section A is a conceptual review of the literature around how change has been understood in psychotherapy. Theoretical conceptualisations of change and limitations of quantitative research are summarised. The impact of common factors in psychotherapy are discussed and deconstructed. The potential benefit of exploring service-user perspectives and encompassing frameworks are described. The findings of the review are discussed in relation to how we can helpfully understand change. Clinical implications are discussed and suggestions for future research are made.

Section B describes a qualitative study that explores how parents make sense of change in parent-child psychotherapy. Eight semi-structured interviews were conducted and results were analysed using Interpretative Phenomenological Analysis. Five master themes were identified and discussed in relation to previous research. Limitations and implications for future research and practice were examined.

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Section A: Literature Review

How Can We Helpfully Understand Change in Psychotherapy?

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Abstract

Understanding why and how some individuals experience change in psychotherapy is essential in providing a scientific background to clinical practice. The current drive for psychotherapies that are 'evidence-based' means that the question of how change occurs in psychotherapy is more relevant now than ever. The literature was reviewed to explore how change has been understood in psychotherapy. A search was conducted between August 2014 and November 2014 and 54 papers that matched inclusion criteria were found. Literature reviewed suggested that change in psychotherapy is a complex area. Quantitative research has struggled to explain how it occurs or why it is comparable across therapeutic modalities. The impact of common factors in psychotherapy were discussed and deconstructed. Service-user perspectives and encompassing frameworks appear to go some way to capturing the complexity and individual nature of change that occurs within psychotherapy. Finally, an argument was made for further qualitative research to help understand and conceptualise meaningful change that occurs for clients in psychotherapy. Limitations of this review included a wide time range of articles selected and the difficulty summarising conceptual literature. Clinical implications including fostering attunement between therapist and client and using qualitative information alongside outcome measures are discussed.

Keywords: change, psychotherapy, cognitive-behavioural therapy, psychodynamic psychotherapy, qualitative approaches

How can we helpfully understand change in psychotherapy? A review of the literature

Understanding why and how individuals experience change in psychotherapy is essential in providing a scientific background to clinical practice (Rice & Greenberg, 1984). The American Psychological Association (2012) have accepted a working definition of psychotherapy as "the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviours, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable" (Norcross, 1990, p.218). Psychotherapy is an umbrella term that includes various therapeutic models. For the sake of clarity, the current review will focus on the two most frequently applied interventions in clinical practice that are currently offered in the NHS to both adults and young people; namely Cognitive-Behavioural Therapy (CBT) and psychodynamic psychotherapy (Leichsenring, Hiller, Weissberg, & Leibing, 2006; UK Council for Psychotherapy, 2013; We need to talk coalition, 2013). However, many of the issues broached in this review will also be relevant to other therapy models.

Understanding how change occurs in psychotherapy and thus being able to provide beneficial treatment is a particularly pertinent concern in the current economic climate where financial strain has led to a drive for mental health problems to be addressed in a quick, effective and cost-efficient way. The importance of mental health is increasingly recognised within society and reflected in government drives with the Department of Health [DoH] (2011) publishing documents such as 'No health without mental health: A cross-government mental health outcomes strategy for people of all ages'. This document stressed the importance of addressing mental health problems in the UK and promoting well-being. The document spoke about

working towards improved quality of life and tackling stigma but also had a heavy economic emphasis, quoting the cost of mental health problems to society, the financial benefits of addressing mental health problems as soon as possible, and the economic benefits of getting people 'back to work'. One of the focuses of the document was entitled 'improving quality and making the most of our resources' which emphasises improving efficiency of current services. A supporting document to No Health Without Mental Health was, 'Talking therapies: A four year plan of action' (DoH, 2011). This focused on expanding access to psychological therapies, particularly the establishment of IAPT (Improving Access to Psychological Therapies), a programme that supports primary care trusts by delivering short-term evidence-based talking therapies to individuals with mental health problems as recommended by NICE (National Institute of Clinical Excellence) guidelines (Clark, 2011). This drive for efficiency and psychotherapies that are 'evidence-based' means that the question of how change occurs in psychotherapy is more relevant now than ever.

Rationale

Hundreds of different forms of psychotherapy exist, many of which have been rigorously researched and argued to be 'effective' for various mental health difficulties (Bateman, 2007). There is an abundance of literature outlining theoretical models of change but without understanding this theory in relation to practice, clinicians are forced to rely predominantly on therapeutic model and personal preferences (Rice & Greenberg, 1984).

Historically, when discussing change in psychotherapy, the focus has been on what distinguishes one therapy from another. Generally, authors have researched the benefits of their own model and attempted to provide evidence of its superiority in

comparison to competing models in producing therapeutic change (Brewin & Power, 1997). Change research has traditionally focused on two separate categories; outcome research which focuses on measurable client differences after therapy, and process research which explores the more discrete developments that occur session by session. Process research is interested in how and why changes occur in therapy (Elliott, Slatick, & Urman, 2001).

There has been a longstanding tension within psychotherapy research between quantifying change and the meaning of the psychotherapeutic process. While CBT approaches have embraced and been successful due to quantifiable evidence, psychodynamic approaches have remained invested in the meaning of change for each individual (Elliott et al., 2001). This debate has continued around the world. More recently, Tom Insel, National Institute of Mental Health (NIMH) Director, argued against evidence-based research that focuses solely on symptomatology related outcomes (Insel, 2013). Insel stated that NIMH would begin to support research that explores across rather than within certain categories. He argued that this shift away from diagnoses that lack validity would provide evidence that is more meaningful for individuals with mental health difficulties.

Plan

It is clear that understanding change in psychotherapy is pertinent both clinically and in the current socio-political context. This conceptual review will provide an overview of the literature around how change in psychotherapy has been conceptualised, including some of the limitations with current conceptualisations. Furthermore, this review will endeavour to propose ideas about how researchers and clinicians can helpfully understand change. This review will aim to:

1) Summarise how change in psychotherapy has been conceptualised.

2) Provide an overview of how change might be helpfully understood by clinicians and researchers.

Method

The literature search was conducted between August 2014 and November 2014. The terms 'psychotherapy OR therapy OR psychodynamic OR Cognitive-Behavioural AND change OR experience OR process' were entered and searched in: Psychinfo, Medline and CCCUJournals, searching titles to narrow the large number of results down to the most relevant papers. Further limits were set for the article or chapter being in the English Language and available in full text. Literature from 1975 to November 2014 was considered in order to include influential literature about psychotherapy change processes that began to be published at that time but also for the review to remain relatively current. More specifically, this time range was selected to include Luborsky, Singer, and Luborsky's (1975) classic paper; which was one of the first systematic reviews of psychotherapy outcomes. This paper's findings led to a wealth of theoretical development and similar replication studies. It has been cited 1739 times thus far on Google Scholar.

Journal titles were initially screened and then abstracts read to assess relevance. The identified relevant articles were read in their entirety and reference lists were hand-searched (see Appendix A for full details of literature search). Articles or book chapters were included if they focused on how change has been explored, conceptualised and understood in psychotherapy, particularly psychodynamic and cognitive-behavioural psychotherapies. Particular attention was given to qualitative literature, as it was most relevant to the research question. Similarly, papers that suggested helpful and qualitative ways to understand therapeutic change were

prioritised. Literature that explored change in couples, family or group therapy was excluded. Literature that examined the impact of specific therapeutic techniques (e.g. letter-writing) on psychotherapy outcomes was also excluded. Finally, papers that focused on the biological processes of change, or focused on the effect of psychotropic medication alongside psychotherapy were excluded.

Some older articles will be included, particularly in the beginning of this review to set the scene for how change was initially conceptualised and thought about in psychotherapy literature. More recent literature will also be incorporated to begin to think about how clinicians can helpfully understand change in the current context. A total of 54 papers were included in the review (See Appendix B for summary of literature reviewed below).

Literature Review

Theoretical Conceptualisations of Change in CBT and Psychodynamic Psychotherapy

CBT involves therapists and clients working together to identify and interpret problems in the context of the relationship between thoughts, emotions and behaviour. CBT focuses on the here and now and explicit therapy goals are agreed upon (Leichsenring et al., 2006). A CBT model would postulate that change happens from a modification of dysfunctional and maladaptive thinking patterns, which impact emotions and behaviour. CBT therapists argue that one way of achieving this is by teaching clients to have more control over their thoughts by learning coping strategies, monitoring negative thoughts and participating in behavioural activation. Similarly, CBT therapists encourage clients to utilise rationality and social support to challenge their negative thinking biases and thus enable therapeutic change or growth (Beck, Rush, Shaw, & Emery, 1979).

Psychodynamic models focus on bringing difficult feelings into awareness, linking current difficulties with previous experience and using the therapist-client relationship as an instrument of change (Jones & Pulos, 1993). In psychodynamic psychotherapy, therapists offer their clients interpretations in order to enhance their understanding about repetitive conflicts that sustain their difficulties (Leichsenring et al., 2006).

Psychotherapy Process

In addition to theoretical literature that has explicated how change is said to occur in each model, research has been done focusing on what actually happens within the psychotherapy process in an effort to facilitate change. Psychotherapeutic theory leads therapists to understand their clients' difficulties in a certain light and directs the type of intervention. Psychodynamic and cognitive-behavioural therapists use very different techniques (Ablon & Marci, 2004).

Jones and Pulos (1993) directly compared CBT and psychodynamic models and found significant differences between the two approaches in a number of domains. In terms of therapist technique, it was more typical of psychodynamic therapists to draw attention to client use of defenses, encourage the client to speak, highlight regular patterns in client experiences, and promote the experience of emotions. Conversely, cognitive behavioural therapists imparted directive advice and guidance, suggested activities or new ways of behaving. CBT sessions typically had a specific focus and greater consideration was given to cognitive beliefs.

Therapist style was very different across approaches. Psychodynamic therapists were rated as more distant, formal and neutral. Psychodynamic therapists were considered to be more empathic and more accurately perceive their clients emotions. Cognitive behavioural therapists were judged to be more directive,

encouraging, reassuring and approving. However, they were also regarded as more condescending, tactless and unboundaried in terms of making personal disclosures that were deemed to be unhelpful (Jones & Pulos, 1993).

Psychodynamic therapy compared to CBT, was a more evocative experience for clients (Jones & Pulos, 1993). Client's in psychodynamic therapy conveyed more angry or overwhelming emotions and were judged to achieve more self-understanding than clients in CBT. There were no differences between the therapeutic approaches in client experiences of sadness, guilt or inferiority. Similarly, both approaches were comparable in client's sense of trust and feeling understood by their therapist as well as their expectations of therapy and feeling of being helped. Both approaches showed fidelity to their theoretical frame (Jones & Pulos, 1993). Therefore, despite there being some commonalities between approaches, it appears that the theoretical assumptions underlying each model and the subsequent process of therapy are very different. Consequently, one would expect that each approach might have different therapeutic outcomes but this has been difficult to evidence.

Measuring Change in Psychotherapy: The Equivalence Paradox

Researchers have consistently failed to demonstrate any difference in effectiveness between psychotherapeutic models. Some approaches have been represented as superior for particular mental health problems but generally these studies have failed to establish effectiveness of a specific treatment that would exceed the generic benefit obtained from other models (Kozart, 2002).

Upon reviewing the psychotherapy outcome literature at the time (Luborsky et al., 1975), found that no form of psychotherapy was significantly superior to another and famously concluded in the words of the Dodo bird in Alice in Wonderland "Everybody has won, and all must have prizes". More recent research has further

validated this proposition and showed that different psychotherapies tend to have equivalent outcomes (Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006). However, literature has also cautioned about the risks of over-generalising these findings, which excluded certain client groups (young people) and made crude comparisons between psychotherapies (Luborsky et al., 2002). This 'dodo bird verdict' has been a contended issue, which has been replicated and explored, with researchers attempting to explain and justify its existence. In their research, Elliott, Stiles, and Shapiro (1993) described the 'equivalence paradox', a comparable construct to the dodo bird verdict, where interventions that described inherently different techniques and therapist-client interactions were demonstrating similar effectiveness. Thereafter, drawing on the ideas of Elliott et al. (1993), Shapiro (1995) in his seminal paper, offered four distinct approaches to resolving this paradox.

Firstly, the paradox might be a reflection of the limitations of outcome research. Shapiro (1995) specifically criticised the emphasis on randomised control trials (RCTs) as the 'gold-standard' in psychotherapy research, arguing that RCTs in this area of research cannot ensure generalisability as clients who complete an intervention are not a random cohort of all people who undertake psychotherapy. Furthermore, sample sizes are rarely large enough to rule out the influence of external confounding variables. Secondly, Shapiro (1995) suggested that the benefits of psychotherapy are factors that are common to all interventions and thus cannot be distinguished according to manualised treatment. Therefore, the paradox could be explained by the idea that the therapy relationship surpasses any specific intervention in predicting change. Thirdly, the author proposed an encompassing framework where different pathways lead to similar results. Shapiro (1995) argued that specific interventions could be incorporated into broader theories about how clients are helped

to realise change. The author suggested that this framework might include the effects of sharing difficult experiences with a therapist, and this experience equipping the client with the resources to mobilise appropriate support in other relationships. Perhaps the central component to understanding and increasing therapy's effectiveness is the balance of structure and containment in one respect with the addition of therapist responsiveness. Finally, the author suggested that the equivalence paradox could be attributed to limitations in the predominant research paradigm. This resolution combines a criticism of previous research methods and a proposition for alternative paradigms. Common research methods that might be suitable in other areas are inappropriate and crude measures of understanding how change occurs in psychotherapy. Shapiro (1995) suggested that new research paradigms could lead to less paradoxical results.

The four explanations offered by Shapiro (1995) will be used to structure the next part of this review, as they seemed to represent the broad categories the reviewed literature fell under and encapsulated the main areas of thought around how psychotherapeutic change can be helpfully understood. This review will firstly look at common factors in promoting change in psychotherapy. Thereafter, this review will combine the first and fourth explanations to illustrate the limitations of focusing on outcome measures, the problems with existing research frameworks, and suggest alternatives research paradigms. Finally, this review will summarise encompassing frameworks that have been described to explain change across psychotherapies.

Common Factors

For each type of therapy, there are therapists and clients who will argue the merits of that particular approach. However, the paucity of clear evidence for a superior approach in creating change has led some researchers to search for common

factors across psychotherapies that explain their effectiveness as mentioned above (Brewin & Power, 1997). The common factors approach has gathered considerable attention. Supporters of the common factors stance have sought to define the key ingredients that are shared across models as opposed to the factors that distinguish therapies in order to improve treatment (Lyddon, 1993).

There is no 'one-size-fits all' approach to working with individuals and relating to them in ways they want. Therefore, no regulated technical approach will meet every client's therapeutic needs. Therapists can transcend their theoretical approach by focusing on common factors, which in turn positions the client as a unique individual and an active collaborator in the therapeutic process. Research that has highlighted common factors as the most reliable variables for therapeutic success suggests that focusing on them can lay the foundation for significant and meaningful change in psychotherapy (DeFife & Hilsenroth, 2011).

Nonspecific variables or common factors can refer both to interpersonal factors in therapy such as the therapeutic relationship but also factors that are common to most if not all therapeutic approaches such as being challenged (Levitt, Butler, & Hill, 2006) providing a new understanding, and facilitating corrective experiences (Castonguay, 2005). Some of the most frequently proposed common factors include a positive therapeutic alliance, role preparation, opportunities for catharsis, collaborative goal setting, learning and practicing new adaptive behaviours, and a client's positive expectations. (DeFife & Hilsenroth, 2011; Greencavage & Norcross, 1990). These nonspecific variables vary in the extent to which they have been defined and measured. For example, therapeutic alliance has been examined using validated measures, while other factors, such as the facilitation of corrective experiences, have received little consideration (Castonguay, 2005). Therapeutic

alliance has been the common factor most frequently researched (Lambert & Barley, 2001). Therefore, this review will look at how alliance (both therapist and client's role) has been described as a fundamental common factor in bringing about change.

Importance of therapeutic alliance. Much attention has been focused on the therapist-client relationship as an important factor common across all approaches. It has been well documented that the solid basis of a therapeutic relationship is instrumental in positive treatment outcomes as well as the continuation of therapeutic work (DeFife & Hilsenroth, 2011). Some researchers have viewed therapeutic alliance as the archetypal integrative variable because its significance is not dictated by the assumptions of one psychotherapeutic model (Gaston, 1990). It is well accepted that change in therapy can be a gradual, almost undetectable process as well as distinct moments of heightened emotion and therapist-client connectedness. These moments are described across psychodynamic and cognitive-behavioural perspectives (Knox & Cooper, 2011).

The importance of the nature of the therapeutic relationship to outcomes has been highlighted and conceptualised differently by different orientations (Knox & Cooper, 2011). From early psychodynamic writings, the therapeutic relationship has been emphasised, particularly in the context of transference, which focused on how clients' previous relationship experiences impacted on how they would perceive and relate to their therapist (Gaston, 1990) Similarly, cognitive-behavioural approaches have increasingly acknowledged the importance of therapeutic alliance in enabling change, particularly describing a warm and empathic alliance as a necessary condition in which to provide clients with coping skills and enable them to identify problematic thinking styles and behaviours (Knox & Cooper, 2011).

Horvath and Symonds (1991) in their meta-analytic study, concluded that there was a 26% difference in the success of therapy contingent on the therapeutic alliance. The authors suggested that where there were differences between psychotherapeutic models, it might be reflective of the alliance as opposed to approach. A more recent meta-analysis (Martin, Garske, & Davis, 2000) came to a similar conclusion, that therapeutic alliance was moderately but consistently related to change in therapy or therapeutic outcome. Like Horvath and Symonds (1991), the authors concluded that the therapeutic alliance impacted change regardless of other variables that have been suggested to influence the relationship, such as specific techniques (Martin et al., 2000).

Numerous studies have shown that clients list the therapeutic relationship as the most significant component in therapy and the factor that is most likely to influence change (Levitt et al., 2006). Increasing attention has been given to nuances within the therapeutic relationship, such as therapist personality and attitudes, and client's perception of those attitudes.

Therapists and clients commonly hold different opinions on the strength of the therapeutic relationship, and particularly working alliance. Convergence of perspectives between client and therapist has been shown to be a significant predictor of client outcome. For example, agreement between client and therapists in their recall of pivotal session events is related to perceived change within session (Cummings, Martin, Hallberg, & Slemon, 1992). Additionally Reis and Brown (1999) found that when clients and therapists hold different expectations about preferable outcomes, clients were more likely to discontinue treatment (Marmarosh & Kivlighan, 2012). Lambert (2013) concluded that engaging the client in a

collaborative process is more central to positive outcomes than which model of therapy is provided.

Conceptualising therapeutic alliance. However, many clinicians have argued that the construct of 'therapeutic alliance' is an inadequate way of assessing effectiveness as it remains an abstract concept that is almost impossible to measure or fully understand (Jones & Pulos, 1993). Here, the tension of measuring outcome versus exploring the process of psychotherapy seems significant. While there is a common recognition that therapeutic alliance is important, attempts to conceptualise and quantify it fall short as they fail to recognise the subtle complexity of the process. Nonetheless, attempts have been made to understand what happens within the alliance, how and why it happens, and the relevance this has to change in psychotherapy.

Bordin (1994) provided a pantheoretical understanding of the therapeutic alliance and contended that a therapeutic bond is not formed simply by repeated interaction but by a mutual understanding of shared goals and collaboration in an effort to attain these goals. Kozart (2002) suggested that a bond forms due to a mutual need to achieve the agreed goals. The clinical relationship is more than a relationship in which these goals can be agreed on and worked on, indeed the goals and tasks serve to strengthen the relationship, which can produce a therapeutic effect.

Borrowing from sociological concepts Garfinkel (1996) suggested that humans are driven to make sense of every situation. To maintain a sense of equilibrium, individuals must ignore reminders of their own uniqueness and assume that they experience things in the same way that others do. Kozart (2002) concluded that for psychotherapy to be successful it needs to maintain an implicit assumption of commonality between therapist and client, that is, common perceptions, expectations

and outlook. However, this is challenged by the fact that therapists and clients exercise fundamentally different social roles in the therapy room. Kozart (2002) posited that the psychotherapy relationship is one of the only relationships where discussing distress is the norm and mutual agenda for the encounter. Thus it enables the client to maintain a sense of a culturally normative interaction while enabling the opportunity for change.

The client's role in the therapeutic alliance. Increasing attention has been given not only to the therapeutic relationship but to the client's role and agency in the therapeutic change process (Blatt, 2013; Bohart & Tallman, 1999). Client variables are rarely included in psychotherapy research, partly due to the difficulty identifying which client characteristics might be relevant to the psychotherapeutic process (Blatt, 2013). Some researchers have suggested that variations in the success of any individual's psychotherapy experience are dependent on a number of variables including their own personality, motivation and extratherapeutic variables (Kozart, 2002). This has been supported by literature reviews which have found that individual client factors and extra-therapeutic events that take place in the client's life outside the therapy room were the most significant factors in accounting for therapeutic change (Cooper, 2008). More recently, Blatt (2013) has argued that the inability to provide evidence that one psychotherapy is more effective than another is, in part, related to the assumption that all clients are expected to respond in the same ways, to the same extent. The assumption that clients are more alike than different at the start of therapy is fundamentally flawed and poses a barrier to the exploration of therapeutic change.

Bohart and Tallman (1999) emphasised that many people overcome challenges in their everyday life without therapy and reject the notion of the therapist

holding the power to 'heal'. They state rather that the therapist's role is to work collaboratively with the client, providing the space in which the client can utilise their innate ability to heal. Bohart and Tallman (1999) propose that this self-healing ability of the client overrides therapeutic model or technique and could explain the equivalence paradox across therapeutic approaches, that each school of therapy has different ways of mobilising abilities that already exist within the client. Similarly, Bohart and Wade (2013) found that clients view themselves as working hard within therapy, processing information to achieve their own insights.

Knox and Cooper (2011) reported that client's awareness of their own readiness to open up to their therapist corresponded to significant moments of change. In their research, participants portrayed themselves as the proactive agent in making this decision and steering the process. Clients described moments of change as heightened moments of emotional experience in which they experienced themselves as willingly vulnerable. Likewise, participants reported a substantial process and journey of their own occurred before the significant change event in therapy. The authors concluded that the extent to which a client will make use of and respond to their therapist depends on their own attention, awareness, and previous experience, all of which play a part in their own individual process. This pulls together both the importance of extratherapeutic factors and the concept of clients as powerful agents within the change process.

Furthermore, Blatt (2013) posited that the interpersonal process that occurs in therapy involves a continuous reciprocal influence between client and therapist, each affecting the other in multiple and complex ways, emotionally, cognitively and in determining the course of therapy. The author suggested that investigations into therapeutic change fall short if they focus solely on the client or therapist and that the

complexity of what occurs in the client-therapist dyad should be explored if therapeutic change is to be helpfully understood.

Problems With Existing Research Frameworks: A Call For Alternative Evidence

Although any discussion about psychotherapeutic change would seem incomplete without reference to the plethora of high quality quantitative research that has informed evidence-based treatments, some authors have highlighted the limitations of outcome research and argued for a different type of evidence (Shapiro, 1995). Castonguay (2013) called for clinicians to pay attention to evidence beyond outcome measures to improve the implementation and impact of quantitative evidence and improve client-care. Similarly, Hill (2005) suggested that given the idiographic nature of change, qualitative or case study methodology might be most useful.

Self-report measures which focus on symptoms of 'mental disorders' are the most frequent mode of accessing client feedback and heavily drawn upon as evidence for effective psychotherapy treatments (Clark, 2011). However, this approach has a number of limitations. Firstly, self-report measures evaluate a specific type of change, for example frequency or intensity of behaviour, and thus struggle to capture other more subtle changes that might occur. Secondly, these measures provide little information about how a therapist might helpfully respond in moment-to-moment interactions. Finally, standardised outcome measures rarely explore the meaning that symptom changes hold for the individual client's life (Levitt et al., 2006). The stance described earlier by NIMH in the United States also endorses this view (Insel, 2013).

Current UK government initiatives around tackling mental health problems have focused predominantly on symptom reduction (DoH, 2011). Notably however, individuals who undertake psychotherapy rarely mention symptomatic change in itself, as an important outcome of their therapy. Although symptom reduction may be

one favourable result of therapy, it may not be the most significant outcome for many clients. Looking at different types of change that occur both within and outside of the therapy room might be a more meaningful way to explore therapy outcome (Hill, 2005). Consequently, the widespread utilisation of symptom checklist measures as the central evaluation of change is questionable (Levitt et al., 2006).

The abundance of quantitative research methods in psychology generally has led to in-session processes being measured quantitatively. For example, counting the number of specific techniques used within a session or using standardised measures of therapist empathy. However, research with psychotherapy participants noted that although they reported specific interventions or techniques were helpful, change or insight was rarely accredited to them (Elliott et al., 2001). Perhaps quantitative research designs are an overly simplistic tool to understand the personal and nuanced process that influences change in psychotherapy. The abundance of contradictory and simplistic findings illustrates the confusion in trying to understand how individuals grow and adapt throughout the course of their own therapy. It seems that an explorative, discovery-oriented method would be more appropriate as well as helpful in developing a meaningful understanding (Elliott et al., 2001).

Qualitative Research With Psychotherapy Clients. Shapiro (1995) advocated a different type of research paradigm. Recent research into how change can be understood in psychotherapy has seen an increase in qualitative approaches. While pre-determined scales and questionnaires restrict participant feedback, in-depth interviews allow them to freely express their perceptions of change, bringing new perspectives to how change is thought about (Olivera, Braun, & Penedo, 2013). McLeod (2013) argued that qualitative research can complement mainstream approaches by representing complex ideas and opening up new lines of enquiry.

Different qualitative approaches have been taken in exploring the client's point of view. Studies have explored the client's perception of their own difficulties, their view of the therapeutic alliance, their opinion on the therapy process as a whole, and their experience of the therapist (Olivera et al., 2013).

Some qualitative interviews support the concept of common factors across therapeutic models being fundamental in producing change. In Poulsen, Lunn, and Sandros' (2010) study, participants listed the experience of being listened to, accepted, and understood as pivotal to their experience. Another qualitative study that interviewed participants who had taken part in CBT or psychodynamic therapy showed that participants from both groups described equal experiences of satisfaction with the therapy. Both reported 'common factors' that contributed to change such as motivation and strong therapeutic alliance. Participants in both groups shared theories about how change had come about including being helped by an expert, getting to 'the root' of things, and taking time and having patience (Nillsson, Svensson, Sandell, & Clinton, 2007).

As documented in other studies, Binder, Holgersen, and Nielsen (2010) found that participants who cited a positive therapeutic alliance believed they had changed, while those who were disappointed with the therapeutic relationship reported less changes. However, the authors developed this finding further and asserted that the relationship between outcome and alliance was difficult to disentangle due to the 'chicken and egg' phenomenon. Did clients not change because they were disappointed with the therapeutic alliance or were they disappointed with the therapeutic alliance because they didn't change? This question highlighted the potential benefit of exploring complex questions qualitatively, where correlational findings can be unpicked and made sense of.

As contended earlier in the review, qualitative research with clients demonstrates their perception of themselves as active agents of change in the therapeutic process. In Poulsen et al.'s (2010) study, most participants reported that they felt responsible for the changes they made and noted that this was enabled by an approach that allowed them to explore their thoughts and feelings freely. Farber, Berano, and Capobianco (2004) found that participants made conscious decisions within therapy, and described these decisions as impacting change. Interviews with participants about the process of self-disclosing in therapy and its relationship to change revealed a narrative that withholding personal information interferes with the therapeutic process. Although participants reported feeling anxious and vulnerable prior to making a personal disclosure, they reported a sense of pride, safety, and relief afterwards. Most participants alluded to a belief that despite the potential for embarrassment or distress, it is always better to share personal secrets in therapy than to withhold thoughts or feelings. All participants mentioned the quality of the therapeutic relationship as a pivotal factor in their decision to disclose.

Participants in qualitative studies differed in how they understood and conceptualised the changes that had occurred. In Poulsen et al.'s (2010) study, all participants stated that they handled and understood their difficulties in a new way. All but one participant reported that they were better able to recognise their emotions, with some noting that they were also better able to verbalise them. Most participants described themselves as more assertive, better able to ignore the expectations of other and express their own point of view. In Clarke, Rees, and Hardy's (2004) study, participants described general changes in themselves noticeable on a day-to-day basis including the way they interact in their relationships, their thoughts and feelings about themselves, and the way they behave. Furthermore, clients spoke about an increased

ability to relinquish control over aspects of their life they could not change, and to view their lives, relationships, and selves in a more compassionate way. Similarly, Binder et al.'s (2010) study found that participants cited new ways of relating to others, distress reduction, changes in the behavioural patterns that were increasing distress, increased personal understanding, and accepting oneself as the most important therapeutic change that occurred.

Many of the qualitative studies alluded to the complexity of the changes that occur and thus the difficulty conceptualising them. Binder et al. (2010) found that participants were willing and motivated to speak about their experiences of change and that this was an important endeavour as their conceptualisations of change differed from clinician's. However, they noticed that participants rarely identified one area of change without mentioning others, for example interpersonal change, intrapersonal change, and quality of life. It seemed that successful psychotherapy was a result of all these interacting factors that together created a meaningful change. The authors hypothesised that this could be due to each aspect of change impacting the others, or due to the fact that the change is too complex to disentangle into separate factors (Binder et al., 2010)

Similarly, Rayner, Thompson, & Walsh (2011) concluded that the emergent themes of change were interrelated and no one theme seemed to encapsulate the participant's whole experience of change. In their study, the changes participants attributed to therapy consisted of general shifts in their relationship with, and experiences of themselves. Participants identified increased self-confidence, self-esteem, and assertiveness as beneficial outcomes of psychotherapy but generally conceptualised therapy as a journey and described change as a slow and unpredictable

process. Therefore, the question remains, how can we helpfully conceptualise and thus understand the complex and interacting factors that are involved in therapeutic change.

Encompassing Frameworks: How Can We Helpfully Understand Change?

In their expansive literature review, Lambert and Bergin (1994) posited that there was something intrinsic in the process of psychotherapy, separate to the commonly cited variables of alliance or therapeutic model that is generally beneficial to clients. Our current models of change appear to be insufficient, perhaps we need to think outside the theoretical boxes. As argued by the common factors proponents, research that is not tied to one specific model of psychotherapy could help us to improve our understanding of change (Castonguay, 2013).

As is apparent from the literature in this review, discourses around change in therapy often include false dichotomies that suggest that change is due to either the specific techniques used, the therapeutic relationship, or client factors. Researchers can be compelled to fall into the 'either/or' trap, exploring if change is brought about primarily by specific techniques or by relationship (Castonguay, 2005). One of the biggest challenges in psychotherapy research is that these three domains are in a constant state of flux and interdependence throughout the psychotherapeutic process (Castonguay, 2013). The complexity of the process could be considered immeasurable as presumably meaning comes from the interaction of the three domains.

Castonguay (2005) called for issues of change to be addressed in a way that is more clinically relevant and conceptually interesting. This is made more important as categorising therapeutic factors into 'specific' and 'nonspecific' boxes is arguably an unreliable and meaningless approach. Butler and Strupp (1986) argued that all

technical interventions must have a relational meaning when used in psychotherapy, thus it is impossible and undesirable to conceptually separate interpersonal and technical factors.

Psychotherapy literature has attempted to provide answers to this problem and has suggested encompassing frameworks by which we could meaningfully understand change in psychotherapy (Shapiro, 1995). The literature search revealed four key encompassing frameworks that are related to each another. These frameworks and their proponents will be described below.

Contrast. Lyddon (1993) proposed that a significant factor in eliciting change common across psychotherapies might be the role of contrast, becoming aware of a discrepancy between one's existing view of the world and self. Similarly, Hanna and Puhakka (1991) argued that a therapist's role is to facilitate an environment in which their client can perceive their thoughts, feelings and experiences in a different way. The authors suggested that a key element in therapeutic change is the ability to become aware of painful or difficult experiences, which have been previously avoided or denied.

Despite different theoretical assumptions, all psychotherapies provide opportunities for new learning and change. There are multiple approaches whereby a therapist can offer novelty and contrast in their client's experience of the world. For example, psychodynamic approaches emphasise how ego defences distort the individual's view of the world in order to protect them from experiencing anxiety. A fundamental technique within psychodynamic psychotherapy is interpretation, which could be conceptualised as an intervention that offers contrast or discrepancy to the client about their experience. Similarly, through analysis of transference and counter-transference, the therapist can provide their client with a contrasting interpersonal

experience, disconfirming distressing ways of relating learned in other relationships (Leichsenring et al., 2006). Cognitive-behavioural therapists use contrast by encouraging the client to focus on disconfirmatory experiences to challenge their distressing thoughts thus eliciting cognitive change. Clients are encouraged to undertake 'behavioural experiments' to operationalise this contrast (Leichsenring et al., 2006).

Lyddon (1993) concluded that the human propensity to draw contrasts, places anticipatory constraints on how we understand our experience in the moment. When our anticipations are disconfirmed with contrasting information, change is possible. Hanna and Puhakka (1991) argued that this contrast is pivotal in change that occurs within psychotherapy. All approaches enhance or confront client's perceived discrepancies to facilitate change.

Meaning. Brewin and Power (1997) argued that although a strong therapeutic relationship and client readiness are necessary parts of the context in which change occurs, it is not the only factor. The authors contended that meaning might be a key mechanism contributing to change. Similarly, Singer, Blagov, Berry, and Oost (2013) argued that an individual's capacity to make coherent and realistic meanings from their experience would predict their wellbeing and capacity for growth.

Individuals understand their lives through making meaning of their experiences. Adler, Harmeling, and Walder-Biesanz (2013) proposed that when clients actively seek to make meaning of their therapeutic experience, they are more likely to experience shifts or improvements in their mental health. The authors argued that this is illustrated across therapeutic approaches. Psychodynamic understandings of distress posit that distress occurs when emotions and drives are excluded from consciousness, through various defense mechanisms, because the impulses are

experienced as unacceptable to the individual. Thus, psychoanalysts attempt to create situations in which these unconscious drives will be as evident as possible (for example, the analyst acting in a neutral way as a 'blank canvas') so that the analyst can make interpretations about the client's responses and thus help the client become aware of the hidden meanings of their thoughts and actions (Brewin & Power, 1997).

A cornerstone of CBT has been the assumption that the meaning individuals attribute to thoughts or events is pivotal to how they experience them. Therefore, exploring over-generalised meanings or attributions is fundamental in facilitating change (Singer et al., 2013). For example, a depressed individual might experience a distressing thought as a sign of their worthlessness whereas another individual might not. Therefore, these 'thinking errors' could be challenged by rationalising or evaluating the evidence, thus ameliorating their distressing meaning and improving well-being (Brewin & Power, 1997).

Narrative Change. The role of an individual's narrative representation of themselves and their difficulties has been suggested to be central to psychodynamic and cognitive-behavioural approaches and change, with psychodynamic approaches focusing on internal working models and cognitive-behavioural approaches focusing on the content and function of narratives (e.g. biasing cognitive judgments) (Russell & Van den Broek, 1992).

Narrative schemas enable individuals to organise and make sense of the world and help transform their behaviour and experience into meaningful entities. Therefore, restructuring or enriching an individual's narrative schemas can provide the change hoped for in these approaches (Russell & Van den Broek, 1992). Goncalves and Machado (2000) argued that a number of mental health problems could be thought of as a lack of narrative flexibility. A helpful narrative identity might

include the capacity to describe and understand emotionally evocative experiences as opposed to feeling constrained by negative narrative scripts that lead to self-damaging behaviour or thoughts (Singer et al., 2013). Hare-Mustin (1998) argued that language and internalised stories are fundamental in how individuals make sense of the world. Therefore, therapist across all approaches must help their clients to reconstruct self-narratives as well as deconstruct dominant problem-focused narratives that limit their lives.

It seems that the concept of narrative change might be conceptually related to the meaning change that Brewin and Power (1997) argued was fundamental in successful therapy. Both approaches entail a change in perspective or view that minimises distress and enable an individual to make sense of their experience. Furthermore, it seems that narrative and meaning making are associated in their relationship to change as narrative creation allows meaning to be made and vice versa (Adler et al., 2013).

Emotions. It is widely agreed that emotions are central to the understanding of change in psychotherapy (Goncalves & Machado, 2000). Greenberg (2012) proposed the idea that emotions govern and drive most of what we do and that the aim of psychotherapy might be for emotions to inform our lives rather than control them. As humans, we must be able to protect ourselves from overwhelming emotions and ultimately tolerate and regulate intense emotional experiences. In order to change emotions, they first need to be accessed by the client and then the client needs to be exposed to a new emotional experience and finally, sense and understanding need to be made of the emotion. Therapy might provide a safe space for these new understandings to occur. Similarly, Fitzpatrick and Stalikas (2008) emphasised that enabling positive emotions to be experienced and built upon is an important factor

that contributes to change across all therapeutic approaches. Within CBT, emotions are accessed explicitly with collaborative attention given to how they interact with thoughts and feelings. In psychodynamic models, the interactions between therapist and client are used as a model relationship in which emotions can be accessed and worked through. Both approaches seek to make sense of emotions and reduce the client's distress (Bateman, 2007).

It seems that the significance of emotions in psychotherapeutic change might also be conceptually linked to the narrative change described above. Goncalves and Machado (2000) proposed that the way an individual chooses to symbolise their emotion is socially constructed, so that the language used to express emotion in turn compounds the feeling. Therefore, emotions exist and are made meaningful within a narrative. Across psychotherapeutic models, therapists use language to access emotions and facilitate change.

General Critique and Considerations

This review has sought to provide a succinct summary of the psychotherapy change literature relating to CBT and psychodynamic frameworks. Throughout the review, ways of understanding change in psychotherapy have been critiqued and more meaningful ways of conceptualising change have been proposed. This review focused on the equivalence paradox, common factors such as the therapeutic alliance and questioned current research paradigms. Relevant qualitative research has been described and some of the suggested encompassing frameworks for change in psychotherapy have been summarised.

This review included relevant theoretical, quantitative and qualitative literature, which provided a holistic view on the subject but also raised issues of discrepancy as each research model holds different assumptions about what is helpful.

For example, quantitative approaches stress the importance of generalisability, whereas qualitative approaches are more interested in the individual experience. However, the scope of this review was to pull together propositions from different research paradigms to provide an understanding about change in psychotherapy. This review incorporated literature from a wide time range, from 1975 to 2014. This decision was made in order to give a complete overview of how change has been understood, ranging from the proliferation of research on this topic in the 1970's and 1980's to the more recent qualitative and client- focused literature in the past decade. Although topics pertinent to the review's question were summarised, a more detailed examination of the conceptual change literature was beyond the scope of this review.

One of the challenges in pulling together conceptual literature is that it can be difficult to make distinctions across proposed paradigms for understanding change. It seems that it is most helpful to look at how change occurs across psychotherapeutic models but between these pantheoretical conceptualisations of change it is difficult to distinguish one from another or to understand if they are in fact alluding to similar themes. A further consideration is whether it is helpful to focus on specific encompassing frameworks or if in fact that dilutes the meaning of the psychotherapy experience.

Sample sizes in the studies reviewed here are rarely large enough to rule out the influence of cofounding variables, but in fact it seems that it might not be preferable to minimise change to one distinct variable. One conclusion that can be clearly drawn from this review is that change in psychotherapy is a complex and changing process with many interacting and nuanced factors influencing change.

Implications For Future Research

Shapiro (1995) highlighted limitations of the current research paradigm and called for alternative approaches to meaningfully understand change in psychotherapy. It is well documented that psychotherapy change research has given little attention to client's perspectives and recommendations for more exploratory research have been made (Rayner et al., 2011). Research often focuses on the type of therapy and how the therapist delivers the prescribed intervention. However, the therapeutic process happens within a relationship, clients co-construct the treatment and play an equal part in it (Ablon & Marci, 2004). It has been contended that client's perspectives should be an essential part of this research as client and therapist views can diverge greatly (Rayner et al., 2011). Extensive research and clinical guidance has pointed to the need for a therapist to identify and respond to the needs of their client. Nonetheless, there is a paucity of research examining how service-users perceive and understand this process (Ablon & Marci, 2004).

The limited qualitative research that does exist has suggested that clients are interested in taking part in research that explores their therapeutic experience. Binder et al. (2010) argued that interviewing clients retrospectively about their experience of change with added information about the therapist's theoretical framework could provide clinicians with useful information about what elements of the process clients particularly value.

Implications for Clinical Practice

It is a difficult task to ascertain what clients find important about their therapy experiences. Typically, therapists seek client feedback as a way of informing research and future clinical practice. Thus, how clients perceive change can have the potential to guide treatment, inform theory, and shape how services are offered (Levitt et al.,

2006). Qualitative research has called for a deeper understanding of how clients experience and understand psychotherapy and postulated that qualitative findings could help to sensitise therapists to client's internal and explicated processes, potentially influencing a more attuned therapy with further possibility of change (Levitt et al., 2006).

Within the therapy room, clinicians consider the constant interplay among techniques, client involvement and the therapeutic relationship and adjust their behaviour on this basis. Research is only beginning to reflect this complexity and acknowledge the complexity of exploring what is an intricate human interaction (Hill, 2005). Further understanding of the convergences and divergences between client and clinician's views will facilitate compromise between the clinician's technique and meeting the needs of the client. A clearer sense of how clients understand change would enable clinicians to formulate collaboratively and subsequently plan their intervention in a more sensitive and person-centred way. Qualitative information from clients should not be used instead of but alongside outcome measures. Integrating different parts of the system in research can provide numerous helpful sources of information, which in turn could improve clinical practice (Binder et. al, 2010).

Conclusion

In conclusion, although theoretical assumptions underlie different psychotherapeutic approaches and therapists interact with their clients in different ways dependent on these assumptions, different models seem to bring about similar change for their clients. Literature around the importance of common factors across psychotherapeutic models has explored the importance of the alliance, client factors, and extratherapeutic events but nonetheless clinically, change is measured using

standardised, symptom-focused outcome measures. It seems evident that broader encompassing frameworks of change might have something to offer to how we can helpfully understand change. Perhaps what occurs in psychotherapy is more complex and meaningful than previous research has acknowledged. However, understanding how change occurs remains a crucial issue in order to inform clinical practice, particularly in the current economic climate.

Research on the importance of the client's role in therapy and arguments for involving clients in research suggests that accessing first-hand accounts of how clients understand and make sense of change in psychotherapy might be an important step in helpfully understanding change. Of the limited qualitative research that explored client's experience of psychotherapy summarised in this review, four studies explored clients' perceptions of change. However, no study specifically addressed how clients understood and made sense of change. In order for research to be clinically useful, having some understanding about how the clinician is working therapeutically would be helpful. Binder et al. (2010) suggested that a further step for qualitative change research would be to interview clients retrospectively about their experience and understanding of change with added information about the therapist's theoretical framework. This could provide clinicians with a clearer picture about what elements of psychotherapy client's particularly value and give insight into the complexity of the process from their perspective. Therefore, there seems to be a potential clinical benefit in facilitating qualitative research that explores how clients understand or make sense of change in specific psychotherapy modalities.

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Section B: Empirical Paper

Exploring How Parents Make Sense of Change in Parent-Child Psychotherapy

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SALOMONS

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Abstract

Background: Understanding how change occurs in psychotherapy is imperative in informing clinical practice. Increasing attention has been given to the role that qualitative research could play in enhancing our understanding of therapeutic change. Although quantitative research suggests that parent-child psychotherapy is effective in facilitating change, no research to date has focused on how parents make sense of their change experience.

Methods: Interpretative Phenomenological Analysis was used to analyse semi-structured interviews of eight parents who had completed parent-child psychotherapy about their understanding of change.

Results: Five master themes emerged which encapsulated participant's understanding of change. These included constructing a survivor narrative, the experience of being understood enabling further understanding, adjusting expectations and practising acceptance and feeling empowered to relinquish control. The final theme summarised how despite psychotherapy being conceptualised as a 'precious' resource, there was a sense that its limitations could negatively impact participant's wellbeing.

Conclusions: Meaningful elements of change were identified from the parents' experience. Findings were discussed in relation to previous research and limitations were examined. Implications for future research included using other qualitative methods to explore client experience. Implications for practice were noted, including enriched understanding of client change experience enabling therapists to provide a more attuned therapy.

Keywords: parent-child psychotherapy, change, parent experience, understanding, meaning

Exploring How Parents Make Sense of Change in Parent-Child Psychotherapy

Parent-child psychotherapy is a relationship-focused treatment for children who are experiencing emotional or behavioural difficulties. Parent-child psychotherapy is influenced by its psychoanalytic origins, which focused on the intergenerational transmission of emotional difficulties and parents' re-enactment of unresolved conflicts from their own childhood (Lieberman, Ippen, & Van Horn, 2006). It is based on the premise that early attachment relationships are pivotal for emotional well-being in childhood and create interactive patterns that are internalised and carried through later in life (Fonagy, 2003). Parent-child interventions aim to help parents to hold their child in mind and think about their child's difficulties in the context of relationships (Lieberman, 2004), and to develop a reflective stance in relation to their child and themselves (Slade, 2008). Through joint sessions, a therapist uses spontaneous interactions as the basis of therapeutic work and aim to facilitate a partnership in which parents can meet their child's emotional and developmental needs (Fonagy, 2003). The therapist shares new understandings with each member of the dyad and is interested in both the interaction between parent and child and the internal world of each member of the dyad (Chazan, 2003). Therefore, parent- child psychotherapy promotes a relational process in which increased parental responsiveness to the child's needs reinforces the child's trust in the parent's capacity to care for them (Lieberman et al., 2006).

Evidence of Change in Parent-Child Psychotherapy

Dowell and Ogles (2010) found that including parents in the therapeutic treatment of their child leads to greater improvements than individual child psychotherapy. Similarly, Slade (2008) posited that working with parents is essential in any child psychotherapy. Research has demonstrated the efficacy of parent-child

therapeutic work in improving children's behaviour (Hawley, Weisz, & Peterson, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998), improving parenting practices (Kazdin & Whitley, 2006) and decreasing parental distress (Lieberman et al., 2006) where parents report feeling more relaxed with their child (Pae, 2012). Furthermore, parent-child psychotherapy has been found to increase levels of secure attachment within the parent child dyad (Toth, Rogosch, Manly, & Cicchetti, 2006).

Findings have highlighted the importance of child-therapist and parent-therapist alliance in predicting therapeutic change (Kazdin & Whitley, 2006) and some research suggests that variables relating to parent-functioning are the most important to consider when predicting improved child outcomes (Packard, 2009). Consequently, it is a difficult and possibly meaningless task to disentangle who is changing in parent-child psychotherapy, the parent or the child.

Alternative Ways of Exploring Change

Understanding how change occurs in psychotherapy is important in informing clinical practice (Rice & Greenberg, 1984). Currently, self-report measures which focus on symptoms of 'mental disorders' are the most frequent mode of accessing client feedback and drawn upon as evidence for effective treatments (Clark, 2011). Likewise, the effectiveness of parent-child interventions is typically evaluated using quantitative measures (Brestan, Jacobs, Rayfield, & Eyberg, 1999). However, standardised outcome measures rarely explore the meaning that symptom changes hold for the parent or child's life (Levitt, Butler, & Hill, 2006).

Castonguay (2013) called for clinicians to pay attention to "non-empirical evidence" to improve the implementation of quantitative evidence and client-care. Similarly, Hill (2005) suggested that given the idiographic nature of change, qualitative methodology might be most useful. However, the client's contribution to

the therapeutic process is often overlooked in psychotherapy change research. Research has given little attention to client perspectives and recommendations for more exploratory research have been made (Rayner, Thompson, & Walsh, 2011). Clinically, therapists are tasked with identifying the needs of their client and responding to them in a helpful way. Nonetheless, there is a paucity of research examining how service-users perceive and understand this process (Ablon & Marci, 2004).

Qualitative Psychotherapy Change Research

Existing qualitative research has suggested that clients are interested in participating in research that explores their therapeutic experience. (Binder, Holgersen, & Nielsen, 2010). Research has explored factors that clients describe as necessary in promoting change in therapy, such as being listened to, accepted, and understood (Poulsen, Lunn, & Sandros, 2010). Other qualitative research has provided theories around how change occurs, including being helped by an expert, getting to 'the root' of things, and having patience with oneself (Nillsson, Svensson, Sandell, & Clinton, 2007).

Studies that have explored the meaning of psychotherapeutic change have found that clients report an increased ability to relinquish control over aspects of their life they cannot change, and to view their lives and relationships in a more compassionate way (Clarke, Rees, & Hardy, 2004). Similarly, Binder et al. (2010) found that participants cited new ways of relating to others, distress reduction, increased personal understanding, and accepting oneself as the most important therapeutic changes that occurred.

It seems from the existing qualitative psychotherapy research that change is a complex process. Although standardised outcome measures provide useful information about the impact of an intervention in some aspects, they do not aim to understand change or explore change from the client's perspective. Qualitative approaches have illustrated that change is often attributed to multiple factors. In their qualitative study, Rayner et al. (2011) concluded that the emergent themes of change were interrelated, no one theme seemed to encapsulate the participant's whole experience. The authors found that the changes participants attributed to therapy consisted of general shifts in their relationship with, and experiences of themselves. Participants conceptualised therapy as a journey and described change as a slow and unpredictable process.

Rationale and Aims

Although theory describes what parent-child psychotherapy sets out to do and research demonstrates changes for parents and children after participating, little research has been conducted into the parents' experience of this treatment or their understanding of therapeutic change (Pae, 2012).

Quantitative research and questionnaires can measure improvement at one level but cannot pick up the more subtle aspects of the parent's experience or how they make sense of changes that occur (Packard, 2009). Furthermore, increasing arguments have been made for the relevance and benefits of qualitative research in exploring psychotherapeutic outcomes (Castonguay, 2013). Existing qualitative research suggests that interviewing participants about their experience and understanding of change in psychotherapy is both feasible and necessary to inform future research and clinical practice (Clarke et al., 2004)

Binder et al. (2010) argued that interviewing clients about their experience of change could provide clinicians with useful information about what elements of the process clients particularly value. Thus, how clients perceive change could have the potential to guide treatment, inform theory, and shape how services are offered. (Levitt et al., 2006). Furthermore, qualitative findings could help to sensitise therapists to client's internal processes, potentially influencing a more attuned therapy (Levitt et al., 2006).

In order to explore the process of parent-child psychotherapy in a richer way it seems important to ask parents how they understand it. Therefore, this study will seek to address the following research questions:

1. How do parents understand and make sense of change in parent-child psychotherapy?
2. What meaning does this change have for parents?

Method

Design

This study used a qualitative methodology with semi-structured interviews. Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) was the method of analysis. IPA explores how individuals make sense of their world, in particular the meaning that experiences hold for them. IPA recognises the role of the researcher's world-view in shaping the research (Smith & Osborn, 2008). As IPA focuses on understanding and meaning, it seems an appropriate methodology for this study. Furthermore, other studies exploring how parents make sense of their experience (Hall, 2006; Smith, 1999) and how therapy is perceived (Lloyd & Dallos, 2008; Rizq & Target, 2008) have used IPA.

Participants

Participants were recruited through the parent-child psychotherapy service of a Child and Adolescent Mental Health Service (CAMHS) in a large suburban town. Parent-child psychotherapy sessions were held fortnightly and all sessions involved the therapist, child and parent(s). All parents who had completed treatment in the two years prior to recruitment (2011-2013) and had given consent for contact from the service were approached. This included fourteen parents, all English-speaking. Parents with a diagnosed learning disability or who had been separated from their child were excluded. With consideration of time restrictions and the suggested sample size for IPA (Smith et al., 2009), the researcher aimed to recruit 8-10 participants.

Eight participants were recruited; seven mothers and one father. Seven participants were White British, one was White Irish. Ages ranged from 36 to 52 years old. Four participants had adopted children and four had biological children. Although including parents of both adopted and biological children contradicts the recommendation for a homogenous sample when using IPA, the research question focused on participants' understanding of change in psychotherapy. Therefore, it seemed more pertinent that participants had undertaken a 'homogenous' psychotherapy with the same therapist than have a similar experience of parenting generally. Five participants were married (two to each other) and three were single, six worked outside the home. Children's ages ranged from five to eleven years at the start of psychotherapy and six were boys. One participant had one child and other participants had two to four children. Participants finished psychotherapy one to two years ago. Length of psychotherapy ranged from one to two and a half years. Participants travel expenses were reimbursed with £10, no other incentives were given.

Procedure

Potential participants were telephoned by the service's psychotherapist to briefly describe the study. They were informed that participation was optional and would not impact their future involvement with the service. Verbal consent for a further telephone call from the researcher was then sought. This method of recruitment was chosen so that participants had the option of declining participation without contact from the researcher.

Participants who expressed interest were sent an information sheet (Appendix G) and consent form (Appendix H). Two weeks later, participants were phoned by the researcher and offered the opportunity to ask further questions. Participants who consented to taking part were invited to an interview and asked to bring their completed consent form with them.

Interviews

The questions for the semi-structured interview (Appendix F) were designed to fit with IPA protocol (Smith & Osborn, 2004). A pilot interview with one participant from the psychotherapy service was undertaken to ensure that the questions were accessible. Participants were interviewed individually. Interviews lasted between 45 minutes to 1 hour 15 minutes and were recorded. Participants were reminded that the psychotherapist would not hear recordings and would only see anonymised quotes and overall themes. Limits around confidentiality due to safeguarding issues were discussed. Participants were offered a written summary of the findings at the end of the study (Appendix O).

Data Analysis

Data was analysed using IPA (Smith et al., 2009). The procedure for IPA as

described by Smith et al. (2009), was followed. Interviews were transcribed verbatim by the researcher and anoymised. The researcher read and re-read the transcripts, analysing each individually. The left-hand margin was used to note issues that seemed significant to the participants experience and relevant to the research question. The right hand margin was used to note subsequent emerging themes (See Appendix K for coded transcript). These themes were then listed on a separate document and clustered according to similarity, developing initial superordinate themes (Appendix L). Through an iterative process, the researcher interpreted the meaning behind what was said but consistently referred back to the data ensuring the interpretation captured the participant's experience. This process was repeated for each interview, themes from each were considered and connected according to similarity and richness under over-arching master-themes. Table 1 was created to document themes and identify relevant quotes. A narrative account of participant experience was written around each theme.

Quality Assurance

The second academic supervisor for this research project was also the psychotherapist who initially recruited participants. The researcher discussed this regularly with the lead academic supervisor in order to minimise potential impact on findings. Similarly, in line with Yardley's (2000) criteria for quality assurance, a number of steps were taken to address the researcher's potential biases. The researcher kept a reflective research diary (Appendix I) in order to observe their emotional responses after each interview. The researcher also partook in a bracketing interview (Appendix J) with a colleague in order to shed some light on their personal beliefs and how they might impact on their interview style, analysis and approach to the research question. (Fischer, 2009). See appendices I and J for more extensive discussion on how these approaches minimised bias.

Five out of eight transcripts were coded independently by the lead academic supervisor at each stage of the analysis. Codes were compared with the researcher's analysis to ensure validity. There was no complete disagreement throughout coding, any discrepancy between the meaning of codes/themes was discussed in order to ensure inter-coder agreement (Yardley, 2008). A traditional IPA approach was utilised and each step of data analysis was transparent in nature (Yardley, 2008).

Ethical Considerations

Ethical approval was secured by the NHS Research Ethics Committee (Appendix D) and the Research and Development department of the host NHS trust (Appendix E). Ethical considerations included the decision that if a participant became distressed during the interview, the researcher would stop the recording and discontinue the interview if necessary. Interviews were conducted within the CAMHS setting so that professionals known to the participant would be available to provide support. Participants were reminded of their right to withdraw at any time and provided with the researcher's contact details should they have any queries after the interview.

Results

Analysis resulted in five master themes and sixteen sub-themes described below. Appendix N illustrates additional quotes.

Table 1
Master Themes and Sub-Themes

Master Themes	Quote illustrating Master Theme	Sub-themes	Number of participants contributing to sub-theme (N=8)
1. **From different to survivor**	*We're obviously quite strong people to be* able to deal with it all (R7, p18, 505)	• Victim to survivor: Creating a reparative script	4
		• Making sense of own journey by focusing on strengths	8
		• Who's the patient?	8
2. Being understood enabling understanding	Somebody reaching out, and listening to you, and understanding you, and sitting in a place of non-judgment, that no matter what you *say in that room, you're* not going to come to *any harm, you're not going to be looked* down on (R2, p7, 152)	• From failure to self-compassionate	7
		• Containment and mentalizing: A parallel process	8
		• Space to understand the meaning of damage	7
3. Changing expectations/acceptance	The more you fight with it, the more *miserable you get really, there's no point* sitting there wishing that your child would turn into something its not , its not going to happen is it (R7, p11, 304)	• No quick fix	7

		• Adjusting expectations	4
		• Acceptance	6
		• Investing in the future, leaving a legacy	6
4. Sharing the protective burden of control	It did take me a while to get used to it because I kept wanting to sort of take over *because I'd always done it (R3, p7,* 162)	• Protection of parental/professional identity	8
		• Triangulation: Allowing a third	7
5. Being re-parented: A precious and punitive process	*I'm not qualified to get my son out of all* these problems that both of us have caused basically, I don't know how to do it properly, so if you've got all that support and then its *gone again, you're just living quite fear-* based (R2, p20, 479)	• Scarce and precious	6
		• Punitive system repeating trauma	6
		• Withholding expert	2
		• Is it ok to be disappointed?	3

From Different to Survivor

This master theme encapsulates parent's descriptions of their journey and role.

Victim to survivor: creating a reparative script. Many participants described backgrounds of adversity including domestic violence, difficult childhoods and poverty. Participants seemed to take pride in their survivor identity, having found strength in enduring difficult experiences:

> *At least I haven't got that dread of, god what are the teenage y*ears going to be like, cause I kind of feel that it cant get much worse (laughs) (R7, p17, 490)[1].

Participants described how adversity had empowered them as parents:

> *No one sort of believed me so I felt like I had to really fight my corner and I'm* quite good like that, because of my childhood, I always had to defend myself (R3, p8, 184).

Four parents emphasised the importance of providing a different childhood for their children. There seemed to be a reparative narrative, a sense that parents were making up for what they had missed:

> *You can't change your childhood but you can change yourself as an adult and there's no way my kids were going to go through what I went through (R3, p9,* 211).

Participants seemed proud of their journey and reflected on the difference between their current position and their previous, more vulnerable self:

> *Seeing what we've achieved, cause we've achieved amazingly…..*[2]we came down here with black bags, we had nothing(R1, p5, 228).

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[1] (Respondent number, page number, line number)

[2] Ellipses: Words removed for clarity

Making sense of own journey by focusing on strengths. Participants appeared to create strength-focused narratives to understand their lives. Many participants differentiated themselves from 'typical' parents. Although parents reflected on how their child might be particularly challenging, there was a sense that they too brought particular values as parents that could compensate for this difference. Moreover, that strength could be found in identifying as different:

> How I parent them is very different from most of my friends that have got normal children, I certainly know that I concentrate a lot more on my children (R7, p10, 287).

These strengths were framed both in parents' tenacity and their ability to manage their child's difficulties:

> *Its empowerment isn't it, you don't have to take on their opinions ….yo*u can take something from everybody and make it your own medicine (R2, p9. 207).

Some participants were explicit about their role in accessing support and eliciting change in psychotherapy. These characteristics were often framed as unusual and particular to them:

> We were the people that asked for help….. I think that a number of families wouldn't be able to look for help as quickly as we did (R6, p7, 332).

Participants integrated their old and new identities by reflecting on values that have always been integral in their lives but might now be adapted. This allowed previous behaviour to be reinterpreted in a positive way:

> *I'm a good parent now, I know I'm a good parent, and maybe I was, back then* but I just, because of my approach and how I went, I know obviously I went at it the wrong way but my intentions were always good (R1, p8, 190).

Who's the patient? This subtheme considers parent's struggle to make sense of therapy that involves exploration of parenting but where their child is the identified 'client'. Parents differed in their position to this dilemma. There was a sense that the identified patient held responsibility for the problem, thus, parents appeared to move away from this role if feeling blamed or criticised:

> *I find it hard when she was asking about my background because I'm thinking, well its got nothing to do with what's happened to him (R3, p14, 334)*.

Two participants presented practical explanations for their presence in the room:

> So we used to sit in, it was never on his own, cause he was obviously under age (R3, p2, 36).

Participants seemed to balance this tension by going between positions, describing the help the child needed:

> He was a damaged little boy, he needed help and he needed expert help, not help that we could give him (R5, p8, 351).

But also at times positioning themselves equally as clients in the process:

> It very quickly became apparent that not only was it important for them, the therapy, but also for us to come along (R6, p5, 202).

It seemed a difficult tension to manage and participants often moved quickly between positions, identifying and dis-identifying as the client:

> *As much as the sessions weren't for me, obviously, I got pulled into it at times,* and again that aided me as well so it just, enabled me to become a better parent I suppose (R1, p4, 90).

At other times, participants simply considered the mutuality of human interaction:

> Its learning how to do that dance with each other (R2, p13, 320).

Being Understood Enabling Understanding

This master theme encapsulates the meaning participants' experiences of being understood had in enabling change.

From failure to self-compassion. Seven participants recounted feeling like a failure; both in struggling to cope as a parent but also in attending CAMHS. Participants spoke about the difficulty in bearing judgments of others:

> *(Partner)'s parents didn't understand why we were parenting the way we were, oh they're just kids, but if you gave (child) an inch she would spiral….* yeah it was incredibly hard (R8, p6, 289).

Parents described therapy as a non-judgemental place to be honest and heard. This was positioned as pivotal in their journey of change:

> *You feel bad enough about yourself as it is, you know that you're fail*ing, as a parent, I was failing massively, so to sit in that room, and to be able to be *honest… and* see that there is nothing on that person's face, apart from that *they're listening t*o you and they want to help you, you know they have your best interests at heart, its phenomenal, that's the therapy in itself (R2, p7, 167).

Participants reflected on the containment they experienced. The process of sharing 'shameful' emotions, and having them normalised appeared to assuage participants' feelings of guilt:

> Yo*u always feel rubbish, as a parent… and just for somebody to let us know* that what we were doing was ok, there were times I didn't even like her, and it was great for somebody to say, that's normal, that was like (exhales)(R8, p2, 73).

This process seemed to enable reflection. In the absence of feeling attacked, participants were able to explore their backgrounds and current parenting style:

> It wasn't that we was bad parents, she never made us feel like bad parents, it was just trying to think when you were younger, how your parents treated you, there could be aspects that you are actually doing to your child without realis*ing you're doing it because you only know the way you were brought up* (R3, p6, 130).

Participants internalised this experience and took a more compassionate position to themselves. Parts of the participants' personalities that were previously viewed as weaknesses were reinterpreted as an understandable response to their experience:

> I do t*hink I've not helped, cause I think I've been too soft, but sometimes I think that's the way I survived, that's the way I've coped (R1, p9, 419)*.

By being kinder to themselves, parents were able to bear difficult thoughts and feelings:

> Yeah if she had been brought up by somebody else then she probably wouldn't have turned out the way she has but, I don't know it's hard, I can't change it either, I can't beat myself up about it (R7, p13, 367).

In being honest about imperfections, parents were liberated to reconnect with their values and contextualise flaws in the background of 'trying their best'. It seemed that moving from a punitive to compassionate position provided parents with resilience. Participants shifted from feeling incompetent to good enough:

> *Don't know if I'm doing the best* job in the world or not, I can only do what I believe is right (R7, p10, 277).

Containment and mentalizing: A parallel process. This subtheme demonstrates a parallel process whereby participants who felt contained by the psychotherapist felt equipped to mentalize the needs of their child.

Participants valued an environment where expressing emotion felt safe. Through the containment of boundaries participants were empowered to find their own solutions:

> She made me feel valued I suppose, she knew what a time I had with (child) but you know you got to be professional, she wasn't going to sit there and say *'oh poor you'…. but she just had a nice empathy (R1, p7, 313).*

This boundaried nature of therapy was contrasted to the sense of being special and given particular attention:

> I was really lucky that she was so attentive and, took such an interest in us, I think maybe she saw some sort of potential that you know we could become a good family (R2, p5, 123).

This mirrored a process of re-parenting, whereby the participant feels held in mind by the therapist and is thus able to hold their child in mind:

> Watching her with (child), how she was able to sort of coax stuff out of him and the way she spoke to him, I suppose it enabled me, I learned from her to be able to communicate with him better (R2, p4, 77).

Participants reflected on their own needs:

> It was not out of a desire of not wanting to respond to him, it was out of a desire to respond to him in a particular way, and that was about a need in me (R4, p18, 432).

It seemed that when parental needs were met, participants had increased capacity to mentalize their child's needs:

> *The ideas and the concepts and everything are fantastic but unless you're able* to carry it out and see it through and revisit it, it's very difficult to get the full benefit (R6, p1, 43).

Psychotherapy was portrayed as a secure base, a consistent source of support. This seemed to energise parents, empowering them to persevere:

> It just gives you confidence to keep going down the same road that *you're doing….. and to have that environment to bring it back to (R8, p3, 104)*.

Space to understand the meaning of damage. This subtheme depicts participants' emphasis on the value of understanding behaviour and its context. Linked to the other sub-themes, participants valued the space to process the 'damage' that had been done. Understanding their children as damaged appeared to help parents to make sense of their behaviour:

> *Nobody really turns around to you and says, these children aren't normal, they're scarred for life, they're damaged (R6, p6, 278)*.

Participants reported a shift from managing to exploring the meaning behind behaviour. Some parents described the difficulty in tolerating behaviour when faced with it everyday. Psychotherapy seemed to provide participants with space to 'see the wood for the trees':

> It got us to look at the reasons behind the behaviour rather than concentrating on the behaviour, because we were able to sit down in a safe environment, and have somebody help myself, look at it, look at the behaviour *…..we could kind of step out of it(R8, p2, 49)*.

Some participants demonstrated sophisticated understanding of interpersonal dynamics. This gave participants a different perspective and a platform from which to make sense of their own responses:

> Because she felt so unhappy, she would mirror that, she would put that out, *and I'm quite receptive to how other people are feeling so it would find a home within me, and then I'd mirror that back, and then we'd end up in this* cycle (R8, p2, 90).

Moreover, reflection allowed participants to empathise with behaviour that previously felt intolerable. Participants reflected how small insights could lead to significant changes in how they perceive and interact with their child:

> If you don't take it personally you can look at the behaviour, you can deal with *the person, because you're not dealing with your own crap (R8, p12, 566)*.

Changing Expectations/Acceptance

This master theme encapsulates how participants adjusted their expectations of themselves, their children and parenthood.

No quick fix. All participants stressed that a 'quick fix' would not be possible: *You can't expect it to work overnight so you have to work on it (R3, p23, 551)*.

Parents reflected on the realisation that there is no 'magic wand' to fix everything immediately:

> We didn't appreciate the difficulties that there would be, for the rest of their lives, or our lives, cause that is now a real change (R6, p7, 300).

Participants conceptualised change as a continuous process:

> I see it as ongoing, it doesn't stop really (R4, p20, 492).

Related to this was the understanding that participants needed to remain vigilant to future obstacles:

> It's a project, yeah, absolutely, no and you can't rest on your laurels (R8, p11, 526).

Adjusting expectations. Four participants described the need to modify expectations to be more flexible and realistic:

> *Over the years we have changed our expectations….I think we had quite high expectations really, and they've been modified… to suit with reality (lau*ghs) (R5, p5, 207).

Participants also spoke about changing expectations of parenthood, and how their experience has challenged previous assumptions:

> I think before you adopt, you do sit back and think, they; come to us and after *two years, we'll sort them* out cause we can, doesn't*t happen*…. you learn that very quickly (R6, p6, 281).

Participants' expectations of their children seemed to be refocused away from tangible achievements to emphasising the importance of their happiness:

> Subtle changes, very subtle *changes…I mean some of the problems that were there are still there….but he can cope with things better now (R5, p4, 176)*.

In this way, parents were able to find satisfaction in things they might not have before by reframing in the positive:

> Yeah small changes, small but significant little changes (R7, p16, 465).

Acceptance. This sub-theme seemed to be related to participants' ability to adjust their expectations and remain compassionate to themselves. Six participants spoke about learning to accept themselves, their children, and their situation:

> *Part of me would've liked a normal family (laughs) whatever that is,* but I *haven't got that, so,* I guess its just accepting that, it is what it is (R7, p10, 269).

Participants used acceptance as a way to tolerate painful experiences that were out of their control:

> The first years of his life, from which he can never recover…. *so it's more a feeling of, what a pity it was, that they'd gone through this, and it would've* been better if we met them earlier but, that was not to be (R6, p3, 120).

For some, this occurred by choosing not to focus on disappointments and making the best of the situation. This ability seemed to derive from parents' commitment to their children:

> You don't make sense of it you just get on with i*t, its life, they're ours, they're our family, they're not going anywhere (R6, p7, 31)*.

This stoicism and decision to ignore distressing thoughts seemed to be a skill employed by parents to tolerate the intolerable:

> *I do think to myself sometimes maybe we'*ve ruined (child) by taking her into *our messed up family (laughs) but can't think like that really (R7, p13, 360)*.

It was evident that acceptance was a continuous exercise. Participants seemed to manage a tension between holding hope and providing the best opportunities for their children, but also letting go of things that seem impossible:

> *We're still in the adjusting stage, see stages, I don't know, it's disappointing in* some ways, but then hey-ho, you do what you, with what you have in front of you, I m*ean there are certain things you can't change (R5, p5, 216)*.

Investing in the future, leaving a legacy. A prominent theme that evolved was participants' sense of looking toward the future. Participants often conceptualised psychotherapy, and their perseverance in supporting their children as an investment:

> And you know sometimes you think, oh for an easy life but, I don't think that, if *you have an easy life, then you're making a rod for you*r own back later (R5, p7, 339).

It seemed that holding hope and focusing on their own values, allowed participants to find fortitude in managing their current difficulties:

> I think hopefully it will mould them into better adults going forward, and I don't feel like school, obviously it's a major part but its just a period of her life that she needs to get through, with as much dignity and self-respect and confidence as possible, its not the be all and end all (R7, p9, 253).

Participants spoke about wanting to prepare their children for independence:

> *It's all part of him separating, and being able to go out and be alright in the* world (R4, p19, 456).

And there was a sense that parents might some day reap the rewards of their efforts:

> I love my girls more th*an anything, so they are worth it, they're just you know, hard work (laughs), hopefully they'll repay me in some nice way when* they get a bit older (R7, p18, 509).

Some participants seemed to have started this process by emphasising their child's potential:

> *I couldn't have done that at 13, so she is, she's got a lot of potential (R8, p11,* 492).

Furthermore, some participants expressed a desire to leave a legacy for their children, for their children to realise their efforts and resilience:

> I just wanted my kids to be proud of me, I think that's what was more important, I just wanted to prove to my kids that, you know what, no matter what hits you in life, just get up and get on with it (R3, p31, 771).

Sharing the Protective Burden of Control

A significant theme was participant's battle to hold on to their identity but also relinquish some control to share their burden.

Protection of parental/professional identity. All participants emphasised their identity as a parent and for some that of a professional. These identities appeared to be protective for participants and a default position in the face of adversity. All participants portrayed themselves as having a powerful role:

> I thought I was going to end up seeing him inside prison if he didn't get support and I wasn't going to allow that to happen (R3, p9, 205).

Parents spoke about their responsibility to oversee their child's care and described their role in 'holding the bigger picture'. Through this understanding of their identity, participants harnessed the energy to persevere:

> *Just because they're, they're difficult doesn't mean to say they deserve, well* they deserve even more attention don't they, because that's my job, first and foremost (R7, p11, 297).

The overlap between personal and professional seemed important with many participants describing how their experience had impacted their choice of profession and other participants describing parenting as a job in itself. It seemed that parents used this identity to make sense of difficult experiences:

> *I'm not their playmate I'm their mum, so its very nice for him to be play time, fun time dad…but I've got a bigger role (R7, p15, 416).*

Reverting to this expert position allowed participants to distance themselves from feeling vulnerable or experiencing judgments of others. The knowledge participants held about their children appeared to shield parents from threats to their identity:

> People would say that he doesn't respect me because he doesn't go to school or whatever, but in my eyes (child) does respect me and he does idolise me, and I know through our own relationship that we've got (R1, p4, 163).

However, participants also considered how this could impede their ability to access support. Some participants reflected that their self-worth was connected to their ability to parent their child. At times, holding fixed beliefs about their role appeared to leave participants isolated with difficulties:

> A social worker offered me respite and I did basically jump down her throat *and I just felt, you're saying I'm a bad mum, you're saying I cant cope, no one* is having my child, but I actually get why they do it now at the time I think I was in that bubble, I couldn't see the help I was offered (R3, p18, 438).

Triangulation: Allowing a third. One shift that seven participants described was the process of allowing a third person, such as partner or therapist, into their relationship with their child. Many participants described an extremely close relationship with their child:

> *The bond I had with him was just so overwhelming…he was my baby and, well obviously I've got other children but, I dunno, we were like joint at the hip* (R3, p6, 118).

However, participants commented that this relationship could be overwhelming at times:

> As soon as you give her attention, it was like this big black hole that you could never fill (R8, p3, 145).

Accordingly, participants valued the opportunity to 'offload':

> We dumped everything on the poor therapist, that was fa*ntastic, you'd walk out of here almost bouncing, cause you'd just laid it all off on somebody else* (R6, p5, 204).

Sharing this burden with a third party was not an easy process. Participants spoke about the conflict of feeling their role was under threat yet being aware that sharing responsibility might be necessary. By prioritising the needs of their child, participants accepted that multiple parties could have a role in precipitating change:

> He was going to his dad a bit more, which was nice to but also I'll be honest with you it was hard for me to let go… it's like oh, you don't want me anymore, but then you realise well actually he needs both parents (R3, p6, 141).

Likewise, some participants commented on the realisation that for their child to change and grow, they had to be their own person:

> *It was taking into consideration that actually he is a human being and he's not my property you know he's my child (R2, p12, 289)*.

Participants reflected on the benefits this shift could bring, transforming their role into a less consuming one and equipping them with emotional resources:

> *I can now say to her, you now need to leave me alone, I want some space…* whereas before I never felt that, I felt that was some kind of failing where I needed to be superwoman (R8, p13, 593).

Being Re-parented: A Precious and Punitive Process

Linked to other themes, participants often conceptualised psychotherapy as a process of being 're-parented', thus influencing change. The final theme involved participants' experiences of psychotherapy as a cherished commodity but also one that had the potential to harm by withdrawal or absence, much like a child's relationship to their parents.

Scarce and precious. Six participants referred to the restricted financial background of psychotherapy. For some, this awareness fed into their sense of

privilege in having accessed therapy. Participants expressed gratitude but were mindful of their unique position:

> *There's not enough funding for it… its easy for us now to turn around and say* you know CAMHS is absolutely wonderful, but the resources are finite… that's the big issue (R6, p9, 396).

This portrayal of CAMHS as a 'precious' resource enabled some participants to conceptualise change in the absence of tangible evidence:

> Its very difficult to *know where the girls would be if they didn't come …. all I* know is, its so hard to get onto CAMHS anyway, and if they enjoy coming, they must be getting something from it (R7, p5, 145).

Other participants felt unable to assert their needs because of their sense that the service was being withheld from others:

> *I still felt maybe we could've had a little bit more, but then I could've pushed but I didn't, I just accepted you know, we've had a lot of help so move on (R1,* p10, 463).

Punitive system repeating trauma. Associated with limited resources was the sense that psychotherapy could inadvertently re-enact traumas. Participants spoke about the system's constraints impinging on their child's well-being:

> She should really have had therapy at a much younger age but it was viewed that she didn't need it (R6, p9, 399).

Participants also referred to finishing therapy, which could be experienced as rejecting or abandoning. Participants seemed to fear the change they had experienced could be undone:

> It's a bit like y*ou're being kicked out of the nest so to speak and it'*s like right you've just got to go and survive now so it's quite scary (R2, p18, 436).

Withholding expert. Two participants expressed confusion around the therapist's approach and seemed to struggle with some of the mysterious aspects of psychotherapy. Participants identified access to therapy as enigmatic:

> *It's too veiled….you almost have to come through the back door, we know a* back door exists but not everybody does, and that to me seems really unfair, really unfair (R5, p4, 153).

There was the sense that the non-directive approach could be experienced as withholding:

> Maybe more of a direct approach, rather than a subtle, sit back and see which often happens, and, lack of therapist saying well do this and do that, which I fully understand but sometimes to me feels as if, they could be a bit more forward (R6, p5, 223).

Participants seemed to sometimes feel disempowered in the system:

> *They're very subtle things, and if you're in the field you're aware* of it, but *when you're outside, you're not (R5, p3, 140).*

Is it ok to be disappointed? Finally, three participants expressed ambivalence about their experience. Some participants conveyed ambivalence about the benefits of therapy, and were candid about their struggle with bringing up painful emotions:

> *It definitely worked but I do feel that when I used to come…. that coming here just kept raking up the past all the time and I'd come in feeling like I feel now, fine, but I'd end up leaving feeling quite down* (R1, p2, 70).

Other participants expressed concern about unintended consequences of psychotherapy that might occur:

> *I don't know what the research is on this but I'm sure it helps prop up this,* lack of accountability (R5, p8, 365).

However, it was notable that participants seemed hesitant to express any dissatisfaction with the service:

> It was a bit disappointing, well I wasn't disappointed with the service but I was a bit disappointed with (child) (R1, p8, 365).

Discussion

The aim of this study was to explore how parents made sense of change in parent-child psychotherapy and to consider what meaning this change had for them. In summary, parents conceptualised change as a journey. Through a process of being 're-parented' or understood, parents felt held in the mind of the psychotherapist and were thus enabled to hold their child's needs in mind. Participants' difficult experiences were reinterpreted as strengths, which seemed to change their attitudes towards themselves and their children. In the absence of feeling blamed, parents felt able to be honest and access the necessary support. For some participants, ambivalence about their experience remained, and the 'precious' nature of their experience was positioned as either a facilitating or hindering environment for change to occur within.

The findings are discussed below in relation to the research question and existing literature. Notably, many themes were related to each other. This corresponded with previous literature, which found that no one theme could encapsulate a participant's change experience (Rayner et al., 2011). Furthermore, the richness of the themes highlighted the appropriateness of a qualitative approach in exploring complex phenomena, such as change in psychotherapy.

Participants created narratives to make sense of their journey. The process of story-making has been described as significant in how individuals understand their lives (Wrye, 1994). This also relates to the proposition that restructuring narrative

schemas can transform an individual's perception of the world (Russell & Van den Broek, 1992).

Participants described their own childhood and their decision to parent differently. This seems connected to the psychoanalytic understanding that resolving childhood conflict allows parents to avoid unconsciously re-enacting the same patterns (Lieberman et al., 2006). Furthermore, parents portrayed themselves as active agents that had facilitated change within therapy. This supports Bohart and Tallman's (1999) argument that the therapist's task is to provide a space in which the client can utilise their innate ability to heal.

'Who's the patient?' is a tension illustrated both in this study's findings and in research around the efficacy of parent-child psychotherapy. Parents oscillated between descriptions of how they or their child had changed. Research reflects this tension, with some studies reporting quantifiable behaviour changes in children (Hawley et al., 2003; Schuhmann et al., 1998), and others suggesting that parent functioning variables are the most important to consider (Packard, 2009).

Parents' experience of being understood enabled them to be more reflective and attuned to their child. This finding is aligned with the basis of parent-child psychotherapy, which aims to enable parents to develop a reflective stance (Slade, 2008). Furthermore, this increased attunement supports findings that levels of secure attachment in the parent-child dyad increase after partaking in parent-child psychotherapy (Toth et al., 2006).

Participants described shifting from a reactive to reflective stance. This supports literature that argues that once emotions are understood, an individual can use them to inform rather than control their lives (Greenberg, 2012). Furthermore, the

findings emphasising the importance of a safe relationship support studies that have shown the therapeutic alliance to be the most influential component in therapy (Levitt, et al., 2006).

Parents spoke about the ability to relinquish control. This ability is identified as an important transformation in the qualitative psychotherapy change literature (Clarke et al., 2004). The process of allowing a third into the parent-child relationship also seemed connected to the separation-individuation phase outlined in psychodynamic literature (Mahler, 1974).

Participants' descriptions of becoming more self-compassionate and accepting concurs with research showing that participants view their lives, relationship and selves in a more compassionate way after psychotherapy (Clarke et al., 2004). Furthermore, facilitating parents' ability to practise acceptance and self-compassion has been shown to improve the quality of parent child-relationships and enable parents to engage with the changing needs of their child (Duncan, Coatsworth, & Greenberg, 2009). This finding was interesting as self-compassion and acceptance are changes not typically referred to in psychodynamic literature but are prominent in 'third-wave approaches', e.g. Acceptance and Commitment Therapy (ACT). However, authors have suggested that psychodynamic approaches might alter patients' mindfulness, self-compassion and acceptance despite these not being targeted outcomes (Hayes, Stricker, & Stewart, 2014).

Participants conceptualised change as shifts in their attitudes, understandings and relationships. Although behaviour was often identified as the reason for attending parent-child psychotherapy, changes in behaviour were rarely described as a meaningful outcome. This challenges the current climate whereby standardised outcome measures, evaluating 'symptoms' such as behaviour, inform the application

of ‘evidence-based’ interventions in mental health services (Kazdin, 2005). Therefore, the findings of this study support arguments that qualitative research might be a helpful addition to quantitative research in capturing meaningful change (Levitt et al., 2006). Moreover, the findings seem to support ‘encompassing frameworks’ to conceptualise change in psychotherapy, where different pathways lead to similar results (Shapiro, 1995). In this study, participants with different life and parenting experiences seemed to make sense of change in similar ways. Therefore, the importance of a framework such as ‘meaning- making’ in psychotherapy could be a more clinically relevant way of understanding change.

Participants’ descriptions of the ‘expert’ psychotherapist corresponded with previous research that found that clients valued being helped by a specialist (Nillsson et al., 2007). Findings suggested that participants feared their progress would be undone when therapy finished. This concept is documented in psychodynamic literature, which emphasises the importance of ending in consolidating therapeutic gains that have been achieved (Joyce, Piper, Ogrodniczuk, & Klien, 2007).

Limitations

One limitation of this study was the involvement of the psychotherapist who delivered the intervention in recruitment. This could have impacted participant’s decision to partake in the research and the content of the interview. Participants were assured that participation was anonymous, optional and would not influence future involvement with CAMHS. However, it is still possible that parents felt obliged to participate or reluctant to express dissatisfaction. Moreover, it is possible that parents who were satisfied with their experience were more likely to take part in the study, thus biasing the sample. Furthermore, it is likely that the researcher’s position as a trainee psychologist influenced the participant’s responses. Parents might have felt

that particular answers were expected from them.

Most participants expressed a wish for more funding in CAMHS. This could have influenced participants' comments if interviews were perceived as a platform for promoting investment.

It was notable that seven of the eight participants were female. Although this was representative of the parents who attended parent-child psychotherapy and is in line with IPA's recommendation for a homogenous sample (Smith & Osborn, 2008), it is possible that the findings are more representative of mothers' experiences than those of 'parents'. Similarly, seven participants were white British. Therefore, the findings of this study may not be relevant to parents of other ethnicities.

Finally, although a number of steps were taken to address quality assurance, it is always possible that the researcher's beliefs could influence findings. This was particularly pertinent as the researcher worked within a Looked After Children's team with clients who had similar experiences to many of the participants.

Practice Implications

This study confirmed that using a qualitative approach to explore change in psychotherapy is a feasible method. Therefore, qualitative approaches could be used to access service-user feedback and influence how services are shaped.

The findings of this study highlight elements of change parents found most meaningful. Enriching understanding about change in psychotherapy could help to inform clinician's work and how they interact with their clients. Building theory and research that focuses on client experience could be a helpful resource for clinicians to be lead by. For example, the importance of a safe therapeutic relationship in enabling understanding was emphasised. Therefore, it seems pertinent that therapist's allow

time for this relationship to form. Furthermore, the importance of feeling understood in enabling change is a concept that the researcher will hold in mind in future clinical work. In pressurised CAMHS services, there is often the temptation to provide parents with large amounts of psychological 'knowledge'. However, these findings have illustrated parent's abilities to make their own meanings and 'knowledge' when provided with a compassionate space.

Financial limitations impacted participant's experiences. Perhaps providing clear rationale about the service criteria and length of intervention could help to alleviate the guilt parents felt about others not accessing services. Conversely, participants' experiences of financial restrictions negatively impacting their well-being could be used as an argument for further investment in CAMHS.

Future Research

Qualitative methods seem to be a useful approach to further understand the complex phenomenon of change in psychotherapy. Future research could use Narrative Analysis (NA) to explore how parents speak about their change experience. NA has been described as an appropriate methodology for considering change in psychotherapy (Balamoutsou & McLeod, 2001). This study found that participants attributed meaning to transforming narratives. Therefore, NA could provide further insight into this process.

Seven of the participants in this study were mothers. This reflected parents who attended the service and literature on parent-child interventions, which focuses predominantly on the mother-child dyad (Cohen et al., 1999). However, further research could aim to focus specifically on father's understanding of change in parent-child psychotherapy.

Finally, participants in this study generally reported satisfaction with parent-child psychotherapy. Further research could aim to recruit participants who were dissatisfied with their experience and explore what the process meant for them.

Conclusions

This was the first study to explore how parents made sense of change in parent-child psychotherapy and to consider what meaning these changes held for them. Parents told their stories of growth and transformation of identity into a more empowered position. The importance of therapeutic alliance was identified in enabling parents' understanding of their child and themselves. Parents reported increased self-compassion and acceptance for themselves, their relationships and their lives. Adjusting expectations and looking towards the future was described as crucial in this process. Participants balanced the tension of allowing another person into their relationship with their child to enable change whilst recognising some loss of role or identity. These findings add to the qualitative literature on how change is understood in psychotherapy. Some understandings of change link to psychodynamic theory and features of change that are most meaningful to parents are illustrated. The findings indicate the need for future research, which could have significant clinical implications for professionals working with parents and for CAMHS.

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Section C: Appendices of Supporting Material

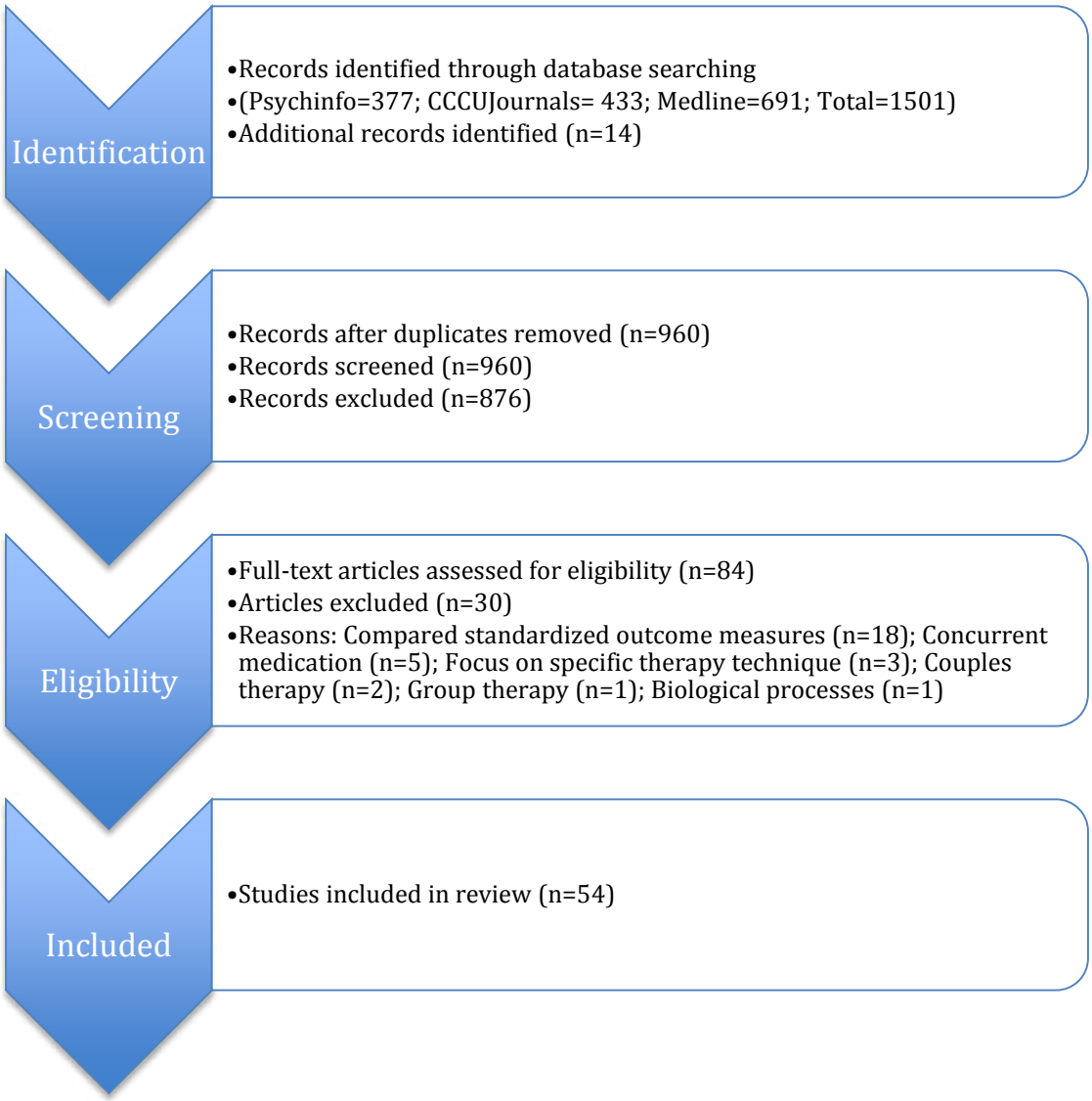
A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology
April 2015

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Please note: Any identifying features have been removed to ensure anonymity and maintain confidentiality

Appendix A

Literature Search: Flow chart based on PRISMA (Moher, Liberati, Tetzlaff, & Altman, 2009)



Appendix B

Summary of Literature Included in Review

Part of Review first referenced	Authors	Title	Type of literature	Participants	Summary/Relevant findings
Theoretical conceptualisations of change	1.**Leichsenring, Hiller, Weissberg, & Leibing (2006)**	Cognitive-Behavioural Therapy and Psychodynamic Psychotherapy: Techniques, Efficacy, and Indications	Literature Review	n/a	Described both therapies and gave a summary of their empirical evidence base.
	2. **Beck, Rush, Shaw, & Emery (1979)**	An overview: In 'Cognitive therapy of depression'	Book chapter	n/a	Provided an overview of cognitive therapy for depression
	3. **Jones & Pulos (1993)**	Comparing the process in psychodynamic and cognitive-behavioural therapies	Quantitative study	N=186	Results demonstrated that although some features were common, there were differences between the therapies including the evocation or control of affect, rationality versus using transference as an agent of change and encouragement or support versus integrating current difficulties with past experience.
Psychotherapy Process	4. **Ablon & Marci (2004)**	Psychotherapy process: The missing link: Comment on Westen, Novotny, and Thompson-Brenner	Theoretical paper	n/a	Recommended a shift from symptom focused outcomes, to change processes co-constructed between therapist and client.
	Jones & Pulos (1993)	As above			

Measuring change	5. **Kozart (2002)**	Understanding efficacy in psychotherapy: An ethnomethodological perspective on the therapeutic alliance	Theoretical paper	n/a	Author proposed novel perspective on therapeutic alliance using concepts from sociology.
	6. **Luborsky, Singer, & Luborsky (1975)**	Comparative studies of psychotherapies. Is it true that 'everywon has one and all must have prizes?'	Quantitative study	n/a	Found that participants who received different models of psychotherapy did not differ significantly on outcome.
	7. **Stiles, Barkham, Twigg, Mellor-Clark, & Cooper (2006)**	Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practiced in UK National Health Service settings.	Quantitative study	N=1309	Results were consistent with previous findings that theoretically different psychotherapies had equivalent outcomes
	8. **Luborsky, Rosenthal, Diguet, Andrusyna, Berman, Levitt… Krause (2002)**	The Dodo bird verdict is alive and well-mostly	Quantitative study	n/a	Meta-analysis revealed similar results that psychotherapies have equivalent outcomes, but cautioned about interpretation.
	9. **Elliott, Stiles, & Shapiro (1993)**	Are some psychotherapies more equivalent than others?	Book chapter	n/a	Debated the equivalence or nonequivalence of different psychotherapies
	10. **Shapiro (1995)**	Finding out how psychotherapies help people change	Theoretical paper	n/a	Described approaches to the resolution of the equivalence paradox
1. Common factors	11. **Brewin & Power (1997)**	Meaning and psychological therapy:	Book chapter	n/a	Argued the importance of meaning and meaning change as a successful outcome of

	Overview and introduction			psychotherapy
12. **Lyddon (1993)**	Contrast, contradiction and change in psychotherapy	Literature review	n/a	Experience of contrast described as a fundamental ingredient in moment-to-moment and long-term change across psychotherapeutic models.
13. **DeFife & Hilsenroth (2011)**	Starting off on the right foot: Common factor elements in early psychotherapy process	Literature review	n/a	Three core therapeutic principles were identified as important to clinical practice: fostering positive expectancies, role preparation, and collaborative goal formation.
14. **Levitt, Butler, & Hill (2006)**	What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change	Qualitative study	N=26	Demonstrated how qualitative outcome studies can use client experiences to facilitate future clinical and meaningful change.
15. **Castonguay (2005)**	Change in Psychotherapy: A plea for no more "nonspecific" and false dichotomies	Conceptual paper	n/a	Argued that the way process variables are predominately defined in psychotherapy fails to do justice to the complexity of change in therapy.
16.**Greencavage & Norcross (1990)**	What are the commonalities among the therapeutic common factors	Literature review	n/a	Concluded that the most frequently cited common factors in predicting change were therapeutic alliance, opportunities for catharsis, practicing new behaviours and positive expectancies.
17. **Lambert & Barley (2001)**	Research summary on the therapeutic relationship and psychotherapy outcome	Literature review	n/a	Concluded that therapy is an interpersonal process and the alliance is the main curative component. Change might be best accomplished by tailoring the relationship to fit with individual clients.

Therapeutic alliance	DeFife & Hilsenroth (2011)	As above			
	18. **Gaston (1990)**	The concept of alliance and its role in psychotherapy: Theoretical and empirical considerations	Literature review	n/a	Theoretical perspectives and empirical evidence for effect of therapeutic alliance are discussed in relation to change in psychotherapy
	19. **Knox & Cooper (2011)**	A state of readiness: An exploration of the client's role in meeting at relational depth	Qualitative study	N=14	Concluded that client's make decisions about bringing their vulnerability to the fore in therapy, dependent on their readiness to do so, and that this facilitates change.
	20. **Horvath & Symonds (1991)**	Relation between working alliance and outcome in psychotherapy: A meta-analysis	Quantitative study	n/a	A moderate but reliable association between good working alliance and therapeutic outcome was found. Working alliance was not related to type of therapy.
	21. **Martin, Garske, & Davis (2000)**	Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review	Quantitative study	n/a	Found that overall relationship between alliance and outcome was moderate but consistent.
	Levitt, Butler, & Hill (2006)	As above			
	22. **Cummings, Martin, Hallberg, & Slemon (1992)**	Memory for therapeutic events, session effectiveness, and working alliance in short-term counselling	Quantitative study	N=20	Counsellors exhibited greater specificity of recall for sessions rated as more effective. There was a reliable increase in working alliance over time.
	23. **Reis & Brown (1999)**	Reducing psychotherapy dropouts: Maximising perspective convergence in	Literature review	n/a	Suggested that psychotherapy dropouts could be minimized if differences between therapist and client perspectives are

		the psychotherapy dyad			acknowledged.
	24. **Marmarosh & Kivlighan (2012)**	Relationships among client and counselor agreement about the working alliance, session evaluations, and change in client symptoms using the response surface analysis	Quantitative study	N=198	Found that session smoothness was greater when client and therapists perception of alliance were in agreement and high. Similarly, more positive agreement about alliance at the beginning of therapy was related to greater symptom change.
	25. **Lambert (2013)**	The efficacy and effectiveness of psychotherapy	Book chapter	n/a	Reviewed evidence and theoretical arguments around the efficacy and effectiveness of psychotherapy.
Conceptualizing alliance	Jones & Pulos (1993)	As above			
	26. **Bordin (1994)**	Theory and research on the therapeutic working alliance: New directions	Book chapter	n/a	Reviewed theory around the therapeutic relationship and highlighted clinical implications
	Kozart (2002)	As above			
	27. **Garfinkel (1996)**	Ethnomethodology's program	Conceptual paper	n/a	Used concepts from sociology to conceptualise the therapeutic relationship
Clients role in alliance	28. **Blatt (2013)**	The patient's contribution to the therapeutic process: A rogerian-psychodynamic perspective	Literature review	n/a	Focused on the importance of the client's experiential world in psychotherapy. Argued that equally desirable outcomes could arrive from different change processes.
	29. **Bohart & Tallman (1999)**	How clients make therapy work: The process of active self-healing	Book chapter	n/a	Concluded that the client is a powerful agent within the therapy relationship, that can utilize internal and external resources to

					change.
	Kozart (2002)	As above			
	30. **Cooper (2008)**	Client factors: The heart and soul of therapeutic change	Book chapter	n/a	Argued that internal and external client factors could be the most fundamental elements in facilitating therapeutic change
	31. **Bohart & Wade (2013)**	The client in psychotherapy	Book chapter	n/a	Reviewed the importance of the client's role in psychotherapy and aspects of their experience.
	Knox & Cooper (2011)	As above			
2. Problems with existing frameworks	32. **Castonguay (2013)**	Psychotherapy outcome: An issue worth re-revisiting 50 years later	Literature review	n/a	Outlined three ways the impact of psychotherapy might be improved: assimilating empirical principles of change into the therapy room, fostering outcome and process research and facilitating active collaboration of researchers and clinicians
	33. **Hill (2005)**	Therapist techniques, client involvement, and the therapeutic relationship: Inextricably intertwined in the therapy process	Conceptual review	n/a	Proposed a pantheoretical model of how therapist techniques, client involvement and therapeutic relationship can evolve over stages of therapy to produce change.
	34. **Clark (2011)**	Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience	Literature review	n/a	Described the background and arguments for IAPT and outlined future developments and challenges.
	Levitt, Butler, & Hill (2006)	As above			

	Insel (2013)	As described in introduction (not part of review)			
	Department of Health (2011)	As described in introduction (not part of review)			
	35. **Elliott, Slatick, & Urman (2001)**	Qualitative change process research on psychotherapy: Alternative strategies	Book chapter	n/a	Made an argument for the benefit of qualitative research to explore meaningful change in psychotherapy.
Qualitative Research	36. **Olivera, Braun, & Penado (2013)**	A qualitative Investigation of Former Clients' perception of change, reasons for consultation, therapeutic relationship, and termination	Qualitative study	N=17	Participants described therapeutic relationship, interpersonal and intrapersonal change, and quality of life as fundamental parts of the experience.
	37. **McLeod (2013)**	Qualitative research: methods and contributions	Book chapter	n/a	Reviewed the role of qualitative research in exploring change in psychotherapy.
	38. **Poulsen, Lunn, & Sandros (2010)**	Client experience of psychodynamic psychotherapy for bulimia nervosa: An interview study	Qualitative study	N=14	Most participants described psychotherapy as a challenge, from which they benefited symptomatically, interpersonally and in terms of emotional regulation.
	39. **Nillsson, Svensson, Sandell, & Clinton (2007)**	Patients' experiences of change in cognitive-behavioural and psychodynamic therapy: A qualitative comparative	Qualitative Study	N=32	Described the differences and similarities between clients who had participated in CBT or psychodynamic therapy.

		study			
	40. **Binder, Holgersen, & Nielsen (2010)**	What is a "good outcome" in psychotherapy? A qualitative exploration of former patients' point of view	Qualitative study	N=10	Themes arose including establishing new ways of relation to others, change in behavioural patterns, improving symptomatic distress, increased insight and self-compassion.
	41. **Farber, Berano, & Capobianco (2004)**	Clients' Perceptions of the process and consequences of self-disclosure in psychotherapy	Mixed method study	N=21	Participants perceived therapy as a safe place to disclose, particularly in the context of a strong therapeutic relationship. Emotions that come with disclosure were described.
	42. **Clarke, Rees, & Hardy (2004)**	The big idea: Clients' perspectives of change processes in cognitive therapy	Qualitative study	N=5	Themes centred around clients experience of their therapist or common factors, specific ingredients of cognitive therapy and outcomes of psychotherapy.
	43. **Rayner, Thompson, & Walsh (2011)**	Clients' experience of the process of change in cognitive analytic therapy	Qualitative study	N=15	Participants found therapy to be an active and emotional experience, which took place in a trusting and collaborative relationship.
3. Encompassing frameworks	44. **Lambert & Bergin (1994)**	The effectiveness of psychotherapy	Book chapter	n/a	Described the complexity of psychotherapy, argued that change is an individual construct that can be explained across different therapeutic models.
	Castonguay (2013)	As above			
	Castonguay (2005)	As above			
	45. **Butler & Strupp (1986)**	"Specific" and "nonspecific" factors in psychotherapy: A problematic paradigm for psychotherapy research.	Literature review	n/a	Emphasised the relational process of psychotherapy as fundamental in facilitating change

	Shapiro (1995)	As above			
Contrast	Lyddon (1993)	As above			
	46. **Hanna & Puhakka (1991)**	When psychotherapy works: Pinpointing an element of change	Theoretical paper	n/a	Described resolute perception as a significant factor in successful psychotherapy. Resolute perception is defined as giving deliberate attention to painful content with therapeutic intent.
	Leichsenring, Hiller, Weissberg, & Leibing (2006)	As above			
Meaning	Brewin & Power (1997)	As above			
	47. **Singer, Blagov, Berry, & Oost (2013)**	Self-defining memories, scripts, and the life story: Narrative identity in personality and psychotherapy	Theoretical paper	n/a	Proposed an integrative model of narrative identity that combines memory specificity with meaning-making to achieve insight and well-being.
	48. **Adler, Harmeling, & Walder-Biesanz (2013)**	Narrative meaning making is associated with sudden gains in psychotherapy clients' mental health under routine clinical conditions	Quantitative study	N=54	Findings suggested that two key narrative meaning-making processes in psychotherapy were significantly related to sudden gains or improvements in mental health.
Narrative Change	49. **Russell & Van den Broek (1992)**	Changing narrative schemas in psychotherapy	Theoretical paper	n/a	A model of narrative structure is described to represent meaningful changes in client's representations of their life experience.
	50. **Goncalves & Machado (2000)**	Emotions, narrative and change	Theoretical paper	n/a	Presented a view of emotions as a socially constructed phenomenon that operate through language and narratives. Argued that

					this understanding is pivotal in understanding psychotherapeutic change.
	Singer, Blagov, Berry & Oost (2013)	As above			
	51. **Hare-Mustin (1998)**	Challenging traditional discourses in psychotherapy	Theoretical Paper	n/a	Considered the significance of discourses and narratives in psychotherapy and described how meaning arises from a social context.
	Brewin & Power (1997)	As above			
	Adler, Harmeling, & Walder-Biesanz (2013)	As above			
Emotions	Goncalves & Machado (2000)	As above			
	52. **Greenberg (2012)**	Emotions, the great captains of our lives: Their role in the process of change in psychotherapy	Theoretical paper	n/a	Suggested a theory by which emotional change could explain the successful outcomes of psychotherapy.
	53. **Fitzpatrick & Stalikas (2008)**	Positive emotions as generators of therapeutic change	Theoretical paper	n/a	Proposed that the facilitation of 'broadening' views and promoting positive emotions offers the possibility of therapeutic change across all therapeutic approaches.
	54. **Bateman (2007)**	Research in psychotherapy	Book chapter	n/a	Provided an overview about how change research has been conducted across different therapeutic modalities.
General Critique	No papers				
Implications	Rayner, Thompson,	As above			

Research	& Walsh (2011)	
	Ablon & Marci (2004)	As above
	Binder, Holgersen, & Nielsen (2010)	As above
Clinical	Levitt, Butler, & Hill (2006)	As above
	Hill (2005)	As above
	Binder, Holgersen, & Nielsen (2010)	As above
Conclusion	Binder, Holgersen, & Nielsen (2010)	As above

Appendix C

Timeline of Research

December 2012: Meet external supervisor at research fair

January 2013: Meet with external and internal supervisors and agree upon project

February 2013: Hand in supervisor selection form

May 2013: Hand in MRP proposal

June 2013: MRP proposal review

July 2013: Make minor revisions to proposal and resubmit to Research Committee

January 2014: Submit IRAS (NHS) ethics application

January 2014: Receive conditional approval

February 2014: Make revisions and receive full approval

March 2014: Receive approval from R&D application to local trust for recruitment

April 2014: Begin recruitment

May- June 2014: Carry out interviews

July- August 2014: Transcribe interviews

September- November 2014: Prepare and submit draft Section A

November 2014: Work on revisions from feedback for Section A

December 2014: Submit final draft Section A

December 2014- February 2015: Data analysis and write up draft Section B

March 2015: Submit draft Section B

March 2015: Make amendments

April 2015: Submit final draft Section B

April 2015: Submit completed MRP

June 2015: Viva examinations

July- September 2015: Make any revisions and submit for publication

Appendix D

NHS Approval Letter

Removed

Appendix E

Trust R&D Approval Letter

Removed

Appendix F

Interview Schedule

Introduction

Answer any questions arising from information sheet

Remind participants of limits of confidentiality

Clarify that the recruiting psychotherapist will not hear tape-recordings or full transcripts and that quotes or themes will not be identifiable

Check consent and collect consent form

Reimburse travel expenses

Collect demographic and duration of intervention information

Interview

1) Can you tell me a little bit about how taking part in parent-child psychotherapy was for you?

   (Prompts: What was it like for you and your child? What do you remember about it? What made it like that for you?)

2) Did things change over the course of this therapy or not?

   (Prompts: Did you notice anything begin to change for you or not? Did you notice anything begin to change for your child or not? Can you tell me a little bit more about that?)

3) What did this mean for you?

   (Prompts: What meaning did this therapy have for you? What do you think it meant for your child? How did you make sense of that? What was it like for you to feel that way?)

4) Have things changed since you finished this therapy?

   (Prompts: What have you been thinking about it? Have your thoughts about the process changed? Has anything changed for you or your child since finishing? What are your thoughts about this? How do you understand that?)

5) Is there anything else that is important for us to talk about today?

   (Prompts: Is there anything about your experience that we haven't touched on? Is there anything you would like to add?)

Appendix G

Participant Information Sheet

Information Sheet for Parents

Title of Project: Exploring how parents make sense of change in parent-child psychotherapy.

Introduction
My name is [redacted] and I am conducting this study as part of my Doctorate in Clinical Psychology at Canterbury Christ Church University. As you have already agreed with [redacted] to be contacted, I would like to invite you to take part in my research project.
Before you decide whether you want to take part, it is important for you to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear to you or if you would like more information.

About the study
As you know, [redacted] CAMHS runs a parent-child psychotherapy service. I am interested in speaking with parents who took part in this service and exploring their individual experience. In particular, finding out how parents make sense of the change that occurs for them and their child through therapy and what the meaning of this change is for them.

What is involved?
If you give permission, I would like to meet with you for approximately 45-60 minutes to ask you some questions about your experience of parent-child psychotherapy. This meeting would take place at a time that is convenient for you and in the familiar environment of CAMHS The meeting will be audiotaped so that I can listen to it later and get a clearer picture of what you said. I do not anticipate the content of the interviews to be distressing, however talking about therapy is a personal experience and you will be welcome not to answer any questions or stop the interview at any time if you feel uncomfortable. If you choose to take part in this research you will be reimbursed £10 for travel expenses.

Who is the researcher?
I am a trainee clinical psychologist and am doing this project as part of my Doctorate in Clinical Psychology at Canterbury Christ Church University. My contact details are displayed at the end of this sheet. Due to the nature of the Doctorate, I, like my colleagues, have received full police clearance.

What will happen to the information from the meeting?
All information is confidential and will be held anonymously. Tape recordings will be immediately transferred to an encrypted memory stick, which will be stored in a locked cupboard in one of the Clinical Psychology programme offices at Canterbury Christ Church University. The original recordings will be destroyed once transcribed. The anonymised transcriptions will be kept confidential on a password protected CD which will be stored in a locked cupboard in one of the Clinical Psychology programme offices at Canterbury Christ Church University. Transcriptions will be held securely by the university for ten years and then destroyed. Only the research team, including myself and my supervisors; [redacted] will have access to any of the

information. [redacted] will only have access to small sections of the anonymised interviews.

Information emerging from this research may be shared with the clinical team who run the parent-child psychotherapy service in order to better understand parent's experience of the service and potentially improve it in the future. You may also receive a summary of the findings if you wish to do so. Quotes from your interview may be used in the write up of the research. Findings may also be published in an academic journal but what you say about your experience, yourself and your child in the meeting will not be identifiable in any way. All data will be collected and stored in accordance with the Data Protection Act 1998.

What do I do if I don't want to take part?
If you do not want to take part in this research simply state so when I contact you or do not sign the attached consent form.

Do I have to take part in this study?
If you decide now or at a later stage that you do not wish to participate in this research project, it is your right to say so. It does not effect whether you or your child will be considered eligible to receive any additional support now or at a later stage. You are free to withdraw at any time without giving a reason.

Who has reviewed the study?
The [redacted] Research Ethics Committee REC 1, which has responsibility for scrutinising all proposals for medical research on humans, has examined the proposal and has raised no objections from the point of view of medical ethics. It is a requirement that your records in this research, together with any relevant records, be made available for scrutiny by monitors from Canterbury Christ Church University and [redacted] NHS Foundation Trust, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

Who do I contact if I want more information about the study?
If you have read this and would like further information before meeting with me, please feel free to contact my research supervisor, [redacted] or me. Our contact information is given below.

Who do I contact if difficulties arise?
You may discuss any difficulties with [redacted] or myself.

Who can I contact if I have a complaint?
If you have any complaints you can contact [redacted], research director at Salomons Centre, Canterbury Christ Church University. His contact details are also listed below.

Otherwise you can contact [redacted] Trust directly at:

[redacted]

The research team's contact details are:

[redacted]

Appendix H

Participant Consent Form

Consent Form for Parents

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Project: **Exploring how parents make sense of change in parent-child psychotherapy**

This study has been approved by [redacted] Research Ethics committee and all data will be stored in accordance with the Data Protection Act 1998.

Please initial box

1. Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. ☐
2. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether you would like to participate. You will be given a copy of this Consent Form to keep and refer to at any time. ☐
3. I understand that my participation will be tape-recorded and I am aware of and consent to the use of the recordings until the end of the project. The audiotapes will be destroyed within 10 years of completion of this project. ☐
4. I understand that if I decide at any other time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without having to give a reason. ☐
5. I understand that another member of the research team may look at sections of my interview and give permission for this to happen. ☐
6. I agree for quotes from my interview to be used in the write up of the study. ☐
7. I understand that a general summary of the findings may be fed back to staff at the parent-child psychotherapy service or may be published in an academic journal. No personal details that could identify any personal information about me, my child or family will be included. ☐

Participant's Statement

I …….....(name of parent/carer)

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed: Date:

Researcher's Statement

I …….(name of researcher)
confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonable foreseeable risks or benefits.

Signed: Date:

Appendix I

Extracts From Reflective Research Diary

Removed

Appendix J

Bracketing Interview Questions and Themes

Questions adapted from Fischer (2009)

1) What are you interested in as a researcher?
2) What attracted you to this area of research?
3) What in your own personal history connects you to themes in your research?
4) How might personal connections to your research influence the approach you take?
5) Has anything about reflecting on these questions surprised you?
6) What avenues might you be curious to explore further?

Key themes arising from the interview:

Removed

Appendix K

Coded Interview Transcript

Removed

Appendix L

Table of Developing Themes

Master theme	Sub theme	Emergent theme connected to sub theme	Participants with emergent theme	Total number involved in theme
From different to survivor	Victim to survivor: Creating a reparative script	Victim to survivor	1,2,3,8	4
		Resilience	2,3,8	3
		Reflect and repair	1,2,3,8	4
	Making sense of own journey by focusing on strengths	Values	2,3,4,5,6,7,8	7
		Sense of self/agency	1,2,3,4,5,6,7,8	8
		Integrated identity	2,3,6,7,8	5
		Different child for different parent	1,2,3,4,5,6,7,8	8
			1,3,4,5,6,8	6
	Who's the patient?	Child as problem	1,2,3,7,8	5
		Blame	1,3,4,5,6,8	6
		Not my fault		
Being understood enabling understanding	From failure to self-compassionate	Desperation	2,3,5,6,7	5
		Failing to ok	1,2,3,7	4
		Tune in to own strengths	2,3,5,7,8	5
	Containment and mentalizing: A parallel process	Parents parented(enabled)	1,2,3,4,5,6,7,8	8
		Parallel containment and mentalizing	1,2,3,4,5,6,7,8	8
		Being heard	1,2,3,4,6,7,8	7
	Space to understand the meaning of damage	Background overshadowing life	2,3,4,5,6,7,8	7
		Damaged child	3,5,6,7,8	5
		Meaning of behaviour	2,3,4,5,6,7	6

Changing expectations/Acceptance	No quick fix	Journey continues	1,3,4,5,6,7,8	7
		No magic wand	1,3,5,6,7,8	6
	Adjusting expectations	Ongoing expectation management	5,6,8	3
		Reframing parenthood	5,6,7,8	4
	Acceptance	Focus on positive	1,3,5,6,7,8	6
		Tolerate the intolerable	1,3,5,7,8	5
		Some things you cant change	3,5,6,7,8	5
	Investing in the future, leaving a legacy	Hope	2,3,5,6,7,8	6
		Work will pay off	2,3,5,6,7,8	6
		Leaving a legacy	2,3,7,8	4
Sharing the protective burden of control	Protection of parental/professional identity	Staying objective	3,4,5,6,8	5
		Being in control	1,2,3,4,5,6,7,8	8
		Strong protector	2,3,4,5,7,8	6
		Privileged professional	2,3,4,5,6	5
	Triangulation: Allowing a third	Allowing pain & vulnerability	1,2,3,4,7	5
		Dispelled preconceptions	2,4,5,6,7	5
		Best interests of child	1,3,4,5,6,7	6
		Others involved	3,5,6,7	4
Psychotherapy: The precious and punitive saviour	Scarce and precious	Precious resource	3,4,5,6,7,8	6
		Therapy as privilege	4,5,6,7,8	5
		Awareness of service limits	3,4,5,6,7,8	6
	Punitive system repeating trauma	Therapy repeating loss	1,2,7	3
		The other side of therapy	1,2,5,6,7,8	6
	Withholding expert	Mysterious saviour	5,6	2
		Withholding specialist	5,6	2

Is it ok to be disappointed?	Desire to ‘get’ something from it	1,6 1	2 1
	Therapist in mind	1,5,6	3
	Ambivalence		

Appendix M

Audit Trail Process

The following documents were reviewed by the lead academic supervisor:

1) Two annotated transcripts in the initial stages of coding
2) Three complete, annotated transcripts
3) One document with emerging themes listed for transcripts reviewed
4) Theme table which documented emerging master-themes and associated sub-themes with example quotes from multiple interviews.

Appendix N

Additional Quotes

Removed

Appendix O

Research Summary Sent to Participants

Study Title: Exploring how parents make sense of change in parent-child psychotherapy

Dear Participant,

I am writing to you as agreed to summarise the findings of the above study that you took part in. Once again, I want to thank you for participating in the study, and for sharing your thoughts and experiences. I feel privileged to have heard your story.

Please find below a brief summary of the background, aims, method and findings of the study you participated in.

Background

Research has demonstrated the efficacy of parent-child therapeutic work in improving children's behaviour (Hawley, Weisz, & Peterson, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998), improving parenting practices (Kazdin, & Whitley, 2006) and decreasing parental distress (Lieberman, Ippen, & Van Horn, 2006). However, increasing attention has been given to the role that qualitative research could play in enhancing our understanding of therapeutic change. Quantitative research and questionnaires can measure improvement at one level but cannot pick up the more subtle aspects of the parent's experience or how they make sense of changes that occur (Packard, 2009). Furthermore, increasing arguments have been made for the relevance and benefits of qualitative research in exploring psychotherapeutic outcomes (Castonguay, 2013).

Aims

Binder, Holgersen, and Nielsen (2010) argued that interviewing clients about their experience of change could provide clinicians with useful information about what elements of the process client's particularly value. Thus, how clients perceive change could have the potential to guide treatment, inform theory and shape how services are offered. (Levitt, Butler, & Hill, 2006). In order to explore the process of parent-child psychotherapy in a richer way it seems important to ask parents how they understand it. Therefore, this study sought to address the following research questions:

1. How do parent's understand and make sense of change in parent-child psychotherapy?
2. What meaning does this change have for parents?

Method

A qualitative design using Interpretative Phenomenological Analysis (IPA)(Smith, Flowers, & Larkin, 2009) was used. IPA is a method of analysis that explores how individuals make sense of their world, in particular the meaning that experiences hold for them. Eight semi-structured interviews with parents who had completed parent-child psychotherapy were conducted.

Findings

Five master themes emerged from the interviews; 'from different to survivor', 'being understood enabling understanding', 'changing expectations/acceptance', 'sharing the protective burden of control' and 'psychotherapy: the precious and punitive saviour'.

From Different to Survivor

Many participants described backgrounds of adversity and took pride in their identity as a survivor. Participants differentiated themselves from 'typical' parents and described their journey of empowerment, focusing on the strengths and resilience they utilised in therapy and as a parent. Participants seemed to battle with different understandings of who the 'patient' was. It appeared that feelings of blame lead parents to distance themselves from this role.

Being Understood Enabling Understanding

Parents spoke about the impact of the therapeutic space and relationship in enabling them to be more compassionate to themselves, hold their child's needs in mind and understand their child in a more meaningful way. It seemed that the experience of being understood and validated helped participants to move from a position of feeling they were failing to feeling good enough. This space imbued parents with the compassion and emotional resources to carry out their role.

Changing Expectations/Acceptance

One significant theme that arose was the importance of participants adjusting their expectations of themselves, their children and parenthood. Participants were clear in their belief that there is no 'quick fix' and that their role as a parent would be an ongoing one. Therefore, participants emphasised the necessity of learning to accept their lives, and seemed to refocus attention away from tangible achievements to the wellbeing of their children. Parents conceptualised the time and energy they have spent focusing on their children as an investment in the future.

Sharing the Protective Burden of Control

Participants seemed to find strength in their identity as a parent and for some as that of a professional. There was a sense that these identities could be protective,

particularly in bearing judgments of others. However, participants also reflected on the relentless nature of their roles and the difficulty their identity as a protective parent could raise in accessing support. Many parents described a shift in learning to allow a third person, either therapist or partner, into their relationship with their child. It seemed that this transition enabled parents to feel less isolated in their role and allowed their children to continue to develop.

Psychotherapy: The Precious and Punitive Saviour

The final theme encapsulated participant's experience of psychotherapy as both a 'precious' commodity and one that could negatively influence its clients through premature termination or lack of resources. Most participants seemed very aware of the limited financial context of CAMHS and spoke about the impact of this on clients. Similarly, some parents described how the limitations of psychotherapy could inadvertently lead to experiences of rejection or abandonment being re-enacted. Some participants expressed remaining ambivalence about the benefits of talking therapy and the mysteriousness of the psychotherapist's approach.

Conclusions

The findings of this study highlight elements of change parents found most meaningful and therefore have important implications for professionals working with parents and for CAMHS more broadly. Enriching understanding about the change process in psychotherapy can help to inform clinician's and guide their work in a way that is most helpful for their clients. Building research that focuses on client experience could be a useful resource for clinicians to draw upon in practice

I hope this summary has been interesting to read. I have thoroughly enjoyed this research and truly appreciate your participation. Please do not hesitate to contact me should you have any questions or concerns regarding the above summary.

Yours Sincerely,

Maeve Kenny

Trainee Clinical Psychologist.

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Appendix P

Proposed Research Summary for Ethics Panel and Research and Development

Removed

Appendix Q

End of Study Form For Ethics Panel

Removed

Appendix R

Journal Author Submission Guidelines

Removed